

IR Documentation Checklist

DOCUMENT EVERY CASE

- Medical necessity clearly stated
- Diagnostic imaging justified (if repeated)
- Diagnostic \neq guiding shots
- % stenosis documented (numeric)
- All access sites listed
- Most distal catheter placement noted
- Exact vessels/branches named
- Avoid vague terms (e.g. several, multiple, moderate)
- No CPT codes in note
- Respond to coder queries

HIGH-RISK AREAS

- Thrombus present? Document it
- Residual fixed stenosis treated?
Note PTA/stent
- Fibrin sheathoplasty \neq angioplasty (unlisted)
- LE interventions:
 - $<100\%$ = straightforward
 - 100% = complex
- US-guided access (76937):
 - Patency
 - Real-time guidance
 - Permanent image

HIGH-RISK AREAS, *continued*

- Moderate sedation:
 - Independent observer
 - Only short interruptible tasks
 - Face-to-face time documented
 - Not room in/out time
- 75774 = additional selective imaging after basic angiogram
- Urinary access route specified
- Ablation modality + imaging guidance
- Biopsy type clearly stated
- IVL ≠ atherectomy
- Stents coded to most distal segment treated

DOCUMENTATION PRINCIPLES

- ✓ Documentation must clearly reflect clinical decision-making
- ✓ Each service should be supported by intent, technique, and findings
- ✓ Clear, specific language supports accurate interpretation of care provided

Learn how Etch can help improve your IR documentation and coding

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