Government of **Western Australia**
Department of **Health**

Western Australian Coding Rule

0915/10 AngioSeal for closure of arterial puncture

WA Coding Rule 0115/02 *AngioSeal for closure of arterial puncture* is superseded by ACCD Coding Rule ***Vascular closure devices*** (Ref No: Q2970) effective 1 October 2015; (log in to view on the ACCD CLIP portal).

DECISION

WA Coding Rule 0115/02 *AngioSeal for closure of arterial puncture* is retired.

[Effective 01 October 2015, ICD-10-AM/ACHI/ACS 9th Ed.]

Government of Western Australia
Department of Health

Western Australian Coding Rule

0115/02 AngioSeal for closure of aterial puncture

Q.

Should the use of an AngioSeal device to close the arterial puncture after the removal of a catheter be coded separately to the procedure or is it inherent in the procedure?

A.

The insertion of an AngioSeal device is one of a number of methods of arterial closure to achieve haemostasis after a diagnostic or interventional angiographic procedure.

Deployment of the AngioSeal involves inserting a guidewire and catheter through the arterial puncture site and then implanting a collagen sponge on the outside of artery and polymer anchor inside the artery connected by a suture, which closes the puncture. The collagen sponge, anchor and suture are absorbed within 60 to 90 days.

Despite the relative high cost and potential higher level of clinical risk to patients compared with other methods to achieve haemostasis, AngioSeal should not be coded separately to angiographic procedure. Closure of the puncture site is inherent in the procedure, regardless of the method used for closure.

According to ACS 0016 *General procedure guidelines – Procedure components* “Do not code procedures which are individual components of another procedure. These components would usually be considered a routine or inherent part of the more significant procedure being performed. Example: Suture of abdominal incision after surgery.”

DECISION

The use of an AngioSeal device to close an arterial puncture after the removal of a catheter should not be coded separately to the procedure. Achieving post procedural haemostasis is an inherent component of any procedure and should not be coded separately.

[Effective 28 January 2015, ICD-10-AM/ACHI/ACS 8th Ed.]