Coding Companion for Cardiology/Cardiothoracic/Vascular Surgery

A comprehensive illustrated guide to coding and reimbursement

2016
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting Started with Coding Companion</td>
<td>i</td>
</tr>
<tr>
<td>Chest Wall</td>
<td>1</td>
</tr>
<tr>
<td>General Musculoskeletal</td>
<td>2</td>
</tr>
<tr>
<td>Neck and Thorax</td>
<td>4</td>
</tr>
<tr>
<td>Larynx</td>
<td>23</td>
</tr>
<tr>
<td>Trachea and Bronchi</td>
<td>27</td>
</tr>
<tr>
<td>Lungs and Pleura</td>
<td>55</td>
</tr>
<tr>
<td>Heart and Pericardium</td>
<td>128</td>
</tr>
<tr>
<td>Arteries and Veins</td>
<td>309</td>
</tr>
<tr>
<td>Lymph Nodes</td>
<td>600</td>
</tr>
<tr>
<td>Mediastinum</td>
<td>603</td>
</tr>
<tr>
<td>Diaphragm</td>
<td>607</td>
</tr>
<tr>
<td>Esophagus</td>
<td>610</td>
</tr>
<tr>
<td>Abdomen</td>
<td>660</td>
</tr>
<tr>
<td>Thyroid Gland</td>
<td>665</td>
</tr>
<tr>
<td>Parathyroid</td>
<td>666</td>
</tr>
<tr>
<td>Nervous System</td>
<td>669</td>
</tr>
<tr>
<td>Medicine</td>
<td>673</td>
</tr>
<tr>
<td>HCPCS</td>
<td>746</td>
</tr>
<tr>
<td>Appendix</td>
<td>751</td>
</tr>
<tr>
<td>Correct Coding Initiative Update 20.3</td>
<td>819</td>
</tr>
<tr>
<td>Evaluation and Management</td>
<td>927</td>
</tr>
<tr>
<td>Index</td>
<td>947</td>
</tr>
</tbody>
</table>
33722 Closure of aortico-left ventricular tunnel

A previously placed tunnel from the left ventricle to the aorta is surgically isolated and ligated.

Depiction of an aortico-left ventricular tunnel

Explanation
The physician closes a previously formed aortico-left ventricular tunnel. The physician performs a midline sternotomy, incising the skin, fascia, muscles, and sternum. The pericardium is incised and lines are placed for cardiopulmonary bypass. When bypass is established, the tunnel is isolated and ligated. The cardiac incision is closed. The pericardium is repaired loosely, leaving gaps for blood and fluid to drain into the pleural space. The sternum is reanastomosed with sternal wires and the skin is sutured in layers.

Coding Tips
When 33722 is performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure and subsequent procedures are appended with modifier 51. For repair of sinus of Valsalva fistula, with cardiopulmonary bypass, see 33702 or 33710. For repair of sinus of Valsalva aneurysm, with cardiopulmonary bypass, see 33720.

ICD-9-CM Diagnostic
745.8 Other bulbus cordis anomalies and anomalies of cardiac septal closure

HCPCS Equivalent Codes
N/A

Terms To Know
anastomosis. Surgically created connection between ducts, blood vessels, or bowel segments to allow flow from one to the other.
anomaly. Irregularity in the structure or position of an organ or tissue.
bypass. Auxiliary or diverted route to maintain continuous flow.
cardiopulmonary bypass. Venous blood is diverted to a heart-lung machine, which mechanically pumps and oxygenates the blood temporarily so the heart can be bypassed while an open procedure on the heart or coronary arteries is performed. During bypass, the lungs are deflated and immobile.
closure. Repairing an incision or wound by suture or other means.
fascia. Fibrous sheet or band of tissue that envelops organs, muscles, and groupings of muscles.
fistula. Abnormal tube-like passage between two body cavities or organs or from an organ to the outside surface.
incision. Act of cutting into tissue or an organ.
pericardium. Thin and slippery case in which the heart lies that is lined with fluid so that the heart is free to pulse and move as it beats.
suture. Numerous stitching techniques employed in wound closure.
buried suture. Continuous or interrupted suture placed under the skin for a layered closure.
continuous suture. Running stitch with tension evenly distributed across a single strand to provide a leakproof closure line.
interrupted suture. Series of single stitches with tension isolated at each stitch, in which all stitches are not affected if one becomes loose, and the isolated sutures cannot act as a wick to transport an infection.
purse-string suture. Continuous suture placed around a tubular structure and tightened, to reduce or close the lumen.
retention suture. Secondary stitching that bridges the primary suture, providing support for the primary repair; a plastic or rubber bolster may be placed over the primary repair and under the retention sutures.

Medicare Edits

<table>
<thead>
<tr>
<th>Code</th>
<th>Fac RVU</th>
<th>Non-Fac RVU</th>
<th>FUD</th>
<th>Status</th>
<th>MUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>33722</td>
<td>47.35</td>
<td>47.35</td>
<td>90</td>
<td>A</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifiers</th>
<th>Medicare Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>33722</td>
<td>51</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>62*</td>
<td></td>
</tr>
</tbody>
</table>

* with documentation
G0288

G0288  Reconstruction, computed tomographic angiography of aorta for surgical planning for vascular surgery

Explanation
Report this code for the computer reconstruction of computed tomography (CT) generated angiographic images of the aorta for the purpose of planning vascular surgery.

G0422-G0423

G0422  Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session
G0423  Intensive cardiac rehabilitation; with or without continuous ECG monitoring; without exercise, per session

Explanation
Cardiac rehabilitation is a medically supervised program intended to help people with heart problems. The program includes training and education on the risk factors of heart disease, such as smoking, high blood pressure, and lack of exercise. Encouragement is given to adopt a healthy lifestyle by increasing physical activity, developing stress coping techniques, and adopting a healthy diet. The program may or may not include exercise and continuous ECG monitoring. Intensive cardiac rehabilitation (ICR) sessions are limited to 72 one-hour sessions, up to six sessions per day, over a period of up to 18 weeks.

G0446

G0446  Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes

Explanation
Annual intensive behavioral therapy for cardiovascular disease for risk reduction is reported with this code. Risk reduction includes encouraging aspirin therapy for the primary prevention of cardiovascular disease when the benefits outweigh the risks for men ages 45 to 70 years and women 55 to 79 years; screening for high blood pressure for patients 18 years and older; and intensive behavioral counseling to promote a healthy diet for adults with hyperlipidemia, hypertension, advancing age, and any other risk factors for cardiovascular and diet-related chronic disease. Behavioral counseling interventions should include the following Five A’s approach that has been adopted by the United States Preventive Services Task Force (USPSTF): Assess: Ask about/assess behavioral health risk(s) and factors affecting choice of behavior and change goals/methods; Advise: Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits; Agree: collaboratively select appropriate treatment goals and methods based on the patient’s interest in and willingness to change the behavior; Assist: Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate; Arrange: Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

G0447

G0447  Face-to-face behavioral counseling for obesity, 15 minutes

Explanation
Behavioral counseling for obesity is reported with this code. The United States Preventive Services Task Force (USPSTF) considers body mass index (BMI) a good indication of morbidity and mortality as a result of being overweight or obesity. BMI is calculated using the following formula: BMI = (weight in pounds / (height in inches x height in inches)) x 703. Obese adults are considered those that have a BMI >=30 kg/m2. Behavioral counseling and behavior modification can be an effective combination to produce moderate, sustainable weight loss. The patients should have the following services: screening for obesity using BMI, assessment of food and nutritional intake, and counseling to include diet and exercise. Behavioral counseling interventions should include the following Five A’s approach that has been developed by the United States Preventive Services Task Force (USPSTF): Assess: Ask about/assess behavioral health risk(s) and factors affecting choice of behavior and change goals/methods; Advise: Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits; Agree: collaboratively select appropriate treatment goals and methods based on the patient’s interest in and willingness to change the behavior; Assist: Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate; Arrange: Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

G9157

G9157  Transesophageal Doppler used for cardiac monitoring

Explanation
Transesophageal Doppler is an ultrasound diagnostic procedure that uses low energy sound waves to provide noninvasive visualization. This code is specific to Medicare coverage of transesophageal Doppler monitoring of cardiac output for ventilated patients in the ICU and operative patients with a need for intraoperative fluid optimization. This service is only covered in a hospital setting or ambulatory surgical center and is included in the Inpatient Prospective Payment System payment.

Q0035

Q0035  Cardiokymography

Explanation
Cardiokymography involves the use of a noninvasive device to record the anterior left ventricle segmental wall motion. The device typically consists of a 5 cm diameter capacitive plate transducer as part of a high-frequency, low-power oscillator with recording probe. Changes in wall motion affect the magnetic field and thus the oscillatory frequency, which is then recorded on a multichannel analog waveform polygraph. Medicare and most payers cover this type of test only as an adjunct to electrocardiographic stress testing to evaluate coronary artery disease and only when specific clinical indications are present. For male patients there must be atypical angina pectoris or nonischemic chest pain. For female patients, there must be angina, either typical or atypical.

36400

36400  Venipuncture, younger than age 3 years, necessitating the skill of a physician or other qualified health care professional, not to be used for routine venipuncture; femoral or jugular vein

Explanation
A needle is inserted through the skin to puncture the femoral or jugular vein of a child younger than age 3. The needle is inserted into the vein and used for the withdrawal of blood for diagnostic study or for the therapeutic infusion of intravenous medication. A soft flexible catheter may be placed for prolonged therapy. Once the procedure is complete, the needle or catheter is withdrawn and pressure is applied over the puncture site to control bleeding. Use this code...
This section provides an overview of evaluation and management (E/M) services, tables that identify the documentation elements associated with each code, and the federal documentation guidelines with emphasis on the 1997 exam guidelines. This set of guidelines represent the most complete discussion of the elements of the currently accepted versions. The 1997 version identifies both general multi-system physical examinations and single-system examinations, but providers may also use the original 1995 version of the E/M guidelines; both are currently supported by the Centers for Medicare and Medicaid Services (CMS) for audit purposes.

Although some of the most commonly used codes by physicians of all specialties, the E/M service codes are among the least understood. These codes, introduced in the 1992 CPT® manual, were designed to increase accuracy and consistency of use in the reporting of levels of non-procedural encounters. This was accomplished by defining the E/M codes based on the degree that certain common elements are addressed or performed and reflected in the medical documentation.

The Office of the Inspector General (OIG) Work Plan for physicians consistently lists these codes as an area of continued investigative review. This is primarily because Medicare payments for these services total approximately $33.5 billion per year and are responsible for close to half of Medicare payments for physician services.

The levels of E/M services define the wide variations in skill, effort, and time and are required for preventing and/or diagnosing and treating illness or injury, and promoting optimal health. These codes are intended to represent physician work, and because much of this work involves the amount of training, experience, expertise, and knowledge that a provider may bring to bear on a given patient presentation, the true indications of the level of this work may be difficult to recognize without some explanation.

At first glance, selecting an E/M code may appear to be difficult, but the system of coding clinical visits may be mastered once the requirements for code selection are learned and used.

**Providers**

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, the service or procedure itself is not limited to use only by that specialty group (see paragraphs 2 and 3 under “Instructions for Use of the CPT Codebook” on page xii of the CPT Book). Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies).

The use of the phrase “physician or other qualified health care professional” (QHP(KP)) was adopted to identify a health care provider other than a physician. This type of provider is further described in CPT as an individual “qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable).” State licensure guidelines determine the scope of practice and a qualified health care professional must practice within these guidelines, even if more restrictive than the CPT guidelines. The qualified health care professional may report services independently or under incident-to guidelines. The professions within this definition are separate from “clinical staff” and are able to practice independently. CPT defines clinical staff as “a person who works under the supervision of a physician or other qualified health care professional and who is allowed, by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service.” Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

**Types of E/M Services**

When approaching E/M, the first choice that a provider must make is what type of code to use. The following tables outline the E/M codes for different levels of care for:

- Office or other outpatient services—new patient
- Office or other outpatient services—established patient
- Hospital observation services—initial care, subsequent, and discharge
- Hospital inpatient services—initial care, subsequent, and discharge
- Observation or inpatient care (including admission and discharge services)
- Consultations—office or other outpatient
- Consultations—inpatient

The specifics of the code components that determine code selection are listed in the table and discussed in the next section. Before a level of service is decided upon, the correct type of service is identified.

Office or other outpatient services are E/M services provided in the physician or other qualified health care provider’s office, the outpatient area, or other ambulatory facility. Until the patient is admitted to a health care facility, he/she is considered to be an outpatient.

A new patient is a patient who has not received any face-to-face professional services from the physician or other qualified health care provider within the past three years. An established patient is a patient who has received face-to-face professional services from the physician or other qualified health care provider within the past three years. In the case of group practices, if a physician or other qualified health care provider of the exact same specialty or subspecialty has seen the patient within three years, the patient is considered established.

If a physician or other qualified health care provider is on call or covering for another physician or other qualified health care provider, the patient’s encounter is classified as it would have been if the physician or other qualified health care provider who is not available. Thus, a locum tenens physician or other qualified health care provider who sees a patient on behalf of the patient’s attending physician or other qualified health care provider’s office, the outpatient area, or other ambulatory facility. Until the patient is admitted to a health care facility, he/she is considered to be an outpatient.