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# Chapter 8

**Cardiology/Cardiovascular/ Cardiac Catheterization**

## THERAPEUTIC SERVICES

### CPT® and HCPCS Level II Codes

The table below shows the information recommended for this chargemaster area, department, or unit. This information includes CPT® or HCPCS Level II codes, the American Medical Association’s (AMA) clinical short description, the corresponding revenue code, the OPPS payment status indicator, APC number, and national unadjusted payment rate. Also included are CMS’s HCPCS Level II short descriptions, which may have been modified by Optum. The information should be used to verify the information assigned in the hospital’s chargemaster.

Beginning with the August 2013 edition, Optum is including the AMAs 2013 CPT® Consumer Friendly Descriptors in green font in addition to the short clinical descriptors (in black font). Patient- or consumer-friendly descriptors for HCPCS Level II codes are under development and the column has been left blank.

<table>
<thead>
<tr>
<th>HCPCS Level II/ CPT</th>
<th>Clinical Descriptions</th>
<th>Consumer-Friendly Descriptions</th>
<th>Revenue Code</th>
<th>OPSI</th>
<th>APC</th>
<th>Payment</th>
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</thead>
<tbody>
<tr>
<td>0319T</td>
<td>INS/REPLCMT SUBQ IMPLT DEFIB SYSTEM W/SUBQ ELTRD</td>
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<td>T</td>
<td>0107</td>
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<td>0320T</td>
<td>INSERTION SUBCUTANEOUS DEFIBRILLATOR ELECTRODE</td>
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<td>REMOVAL SUBQ IMPLT DEFIB PULSE GENERATOR</td>
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<td>T</td>
<td>0105</td>
<td>$1,683.13</td>
<td></td>
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<th>OPSI</th>
<th>APC</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>90935</td>
<td>HEMODIALYSIS PROCEDURE W/ PHYS/QHP EVALUATION</td>
<td>HEMODIALYSIS PROCEDURE WITH ONE PHYSICIAN EVALUATION</td>
<td>0820, 0829</td>
<td>S</td>
<td>0170</td>
<td>$496.32</td>
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<tr>
<td>90940</td>
<td>HEMODIALYSIS ACCESS FLOW STUDY</td>
<td>HEMODIALYSIS ACCESS BLOOD FLOW STUDY (GRAFT AND ARTERY-VEIN FISTULA)</td>
<td>0820, 0829, 0880, 0889, 0920, 0921</td>
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<td></td>
<td></td>
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<tr>
<td>90945</td>
<td>DIALYSIS OTHER/THAN HEMODIALYSIS 1 PHYS/QHP EVAL</td>
<td>DIALYSIS PROCEDURE (OTHER THAN HEMODIALYSIS) INCLUDING ONE EVALUATION</td>
<td>0831, 0835, 0840, 0841, 0845, 0850, 0851, 0859, 0880, 0881, 0889</td>
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<td>0608</td>
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<tr>
<td>93990</td>
<td>DUPLEX SCAN HEMODIALYSIS ACCESS</td>
<td>ULTRASOUND OF DIALYSIS ACCESS</td>
<td>0921, 0929</td>
<td>S</td>
<td>0266</td>
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<td>G0257</td>
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<td>$496.32</td>
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<td>G0365</td>
<td>VESSEL MAPPING OF VESSELS FOR HEMODIALYSIS ACESS</td>
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<td>0267</td>
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### Coding and Billing Instructions

End-stage renal disease (ESRD) is a chronic condition in which kidney impairment is considered irreversible and permanent. Patients with ESRD require a regular course of dialysis or a kidney transplant to maintain life. Hospitals must have a separate certification to provide routine, maintenance dialysis services to ESRD patients.

There are two instances where a separate ESRD certification is not required. The first is when the service is performed on patients who have acute renal failure that is considered short term and reversible. When dialysis is performed on an outpatient basis for an acute renal failure patient, use TOB 013X or 085X with CPT code 90935 for hemodialysis and 90945 for other dialysis. Report CPT code 90935 for a hemodialysis treatment, or CPT code 90945 for dialysis other than hemodialysis, on TOB 012X or 085X when the patient is an inpatient, with or without ESRD, and has no coverage under Part A, but has Part B coverage. In these scenarios, hemodialysis is treated as a prosthetic device. ([Medicare Claims Processing Manual, Pub. 100-04, chap. 4, sec. 200.2 [trans. 2455, April 26, 2012]](https://www.cms.gov/CMS-Publications-1/1331-PUB/100-04-Medicare-Electronic-Claims-Manual.html))

The second instance is when an ESRD patient needs an unscheduled dialysis treatment in an exceptional situation. Medicare will reimburse a facility that is not ESRD certified when a dialysis treatment is given in the following scenarios:
**Chapter 15**  
Emergency Room

**CPT® and HCPCS Level II Codes**

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<th>APC</th>
<th>Payment</th>
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</thead>
<tbody>
<tr>
<td>99281</td>
<td>EMERGENCY DEPARTMENT VISIT LIMITED/MINOR PROB</td>
<td>EMERGENCY DEPARTMENT VISIT, SELF LIMITED OR MINOR PROBLEM</td>
<td>0450, 0451, 0452, 0456, 0459, 0981</td>
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<td>0609</td>
<td>$51.82</td>
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<td>99282</td>
<td>EMERGENCY DEPARTMENT VISIT LOW/MODER SEVERITY</td>
<td>EMERGENCY DEPARTMENT VISIT, LOW TO MODERATELY SEVERE PROBLEM</td>
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<td>0615</td>
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<td>99285</td>
<td>EMERGENCY DEPT VISIT HIGH SEVERITY&amp;T/THREAT FUNCJ</td>
<td>EMERGENCY DEPARTMENT VISIT, PROBLEM WITH SIGNIFICANT THREAT TO LIFE OR FUNCTION</td>
<td>0450, 0451, 0452, 0456, 0459, 0681, 0682, 0683, 0684, 0689, 0981</td>
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<td>0616</td>
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<tr>
<td>99291</td>
<td>CRITICAL CARE ILL/INJURED PATIENT INIT 30-74 MIN</td>
<td>CRITICAL CARE DELIVERY CRITICALLY ILL OR INJURED PATIENT, FIRST 30-74 MINUTES</td>
<td>0360, 0361, 0450, 0452, 0456, 0459, 0510, 0512, 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0526, 0529, 0681, 0682, 0683, 0684, 0689, 0981</td>
<td>Q3</td>
<td>0617</td>
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</tr>
<tr>
<td>99292</td>
<td>CRITICAL CARE ILL/INJURED PATIENT ADDL 30 MIN</td>
<td>CRITICAL CARE DELIVERY CRITICALLY ILL OR INJURED PATIENT, EACH ADDITIONAL 30 MINUTES</td>
<td>0360, 0361, 0450, 0452, 0456, 0459, 0510, 0512, 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0529, 0681, 0682, 0683, 0684, 0689, 0981</td>
<td>N</td>
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