Coding Companion for Cardiology/Cardiothoracic/Vascular Surgery

A comprehensive illustrated guide to coding and reimbursement
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Heart and Pericardium

33675 Closure of multiple ventricular septal defects;

ICD-9-CM Procedural
35.53 Repair of ventricular septal defect with prosthesis, open technique
35.55 Repair of ventricular septal defect with prosthesis, closed technique
35.62 Repair of ventricular septal defect with tissue graft
35.70 Other and unspecified repair of unspecified septal defect of heart
35.72 Other and unspecified repair of ventricular septal defect
39.61 Extracorporeal circulation auxiliary to open heart surgery

Anesthesia
33675 00561, 00562, 00563

ICD-9-CM Diagnostic
410.00 Acute myocardial infarction of anterolateral wall, episode of care unspecified — (Use additional code to identify presence of hypertension: 401.0-405.9)
410.10 Acute myocardial infarction of other anterior wall, episode of care unspecified — (Use additional code to identify presence of hypertension: 401.0-405.9)
410.20 Acute myocardial infarction of inferolateral wall, episode of care unspecified — (Use additional code to identify presence of hypertension: 401.0-405.9)
410.30 Acute myocardial infarction of inferoposterior wall, episode of care unspecified — (Use additional code to identify presence of hypertension: 401.0-405.9)
410.40 Acute myocardial infarction of other inferior wall, episode of care unspecified — (Use additional code to identify presence of hypertension: 401.0-405.9)
410.50 Acute myocardial infarction of other lateral wall, episode of care unspecified — (Use additional code to identify presence of hypertension: 401.0-405.9)
410.60 Acute myocardial infarction, true posterior wall infarction, episode of care unspecified — (Use additional code to identify presence of hypertension: 401.0-405.9)
410.70 Acute myocardial infarction, subendocardial infarction, episode of care unspecified — (Use additional code to identify presence of hypertension: 401.0-405.9)
410.80 Acute myocardial infarction of other specified sites, episode of care unspecified — (Use additional code to identify presence of hypertension: 401.0-405.9)
410.90 Acute myocardial infarction, unspecified site, episode of care unspecified — (Use additional code to identify presence of hypertension: 401.0-405.9)
429.71 Acquired cardiac septal defect — (Use additional code to identify the associated myocardial infarction: with onset of 8 weeks of less, 410.00-410.92; with onset of more than 8 weeks, 414.8)
745.4 Ventricular septal defect
745.7 Cor biloculare
745.8 Other bulbus cordis anomalies and anomalies of cardiac septal closure
745.9 Unspecified congenital defect of septal closure
746.01 Congenital atresia of pulmonary valve
746.02 Congenital stenosis of pulmonary valve
746.9 Unspecified congenital anomaly of heart

CCI Version 16.3
0166T, 0167T, 0213T, 0216T, 0228T, 0230T, 32100, 32422, 32531, 33140-33141, 33210-33211, 33254-33256, 33310-33315, 33681, 33684-33688, 33226, 36000, 36400-36410, 36420-36430, 36440, 36600, 36640, 37202, 39000-39010, 43752, 51701-51703, 62310-62319, 64400-64435, 64445-64450, 64479, 64483, 64490, 64493, 64505-64530, 69990, 93000-93010, 93040-93042, 93381, 93384, 94002, 94200, 94250, 94680-94690, 94770, 95812-95816, 95819, 95822, 95829, 95955, 95960, 96360, 96365, 96372, 96374-96376, 99148-99149, 99150
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

Medicare Edits
Fac  Non-Fac  RVU  FUD  Assist
33675 60.97 60.97 90

Medicare References: None

Explanation
The physician repairs multiple defects in the tissue separating the right and left ventricles of the heart in an open heart procedure. Cardiopulmonary bypass is established with tubes in both the caval veins. The ventricular septal defects can almost always be accessed and repaired through an incision in the right atrium. Each ventricular septal defect is usually repaired with a pair of Dacron or pericardium, but may be closed using only sutures. The septal defects may be repaired with a pair of patches, one in each ventricle. After the ventricular septal defects are repaired, the access incision in the right atrium is closed with sutures. Cardiopulmonary bypass is discontinued when heart function returns. The chest incision is repaired.

Coding Tips
Insertion of a chest tube (32422, 32551) is included and should not be reported separately. Do not report thoracotomy (32100) separately. Temporary transvenous pacemaker placement (33210) is also included and should not be reported separately. Do not report closure of a single ventricular septal defect (33681-33688) separately. For closure of multiple ventricular septal defects with pulmonary valvotomy or infundibular resection, see 33676; with removal of pulmonary artery band, with or without gusset, see 33677. For percutaneous closure, see Category III codes 0166T-0167T.
36400  
Venipuncture, younger than age 3 years, necessitating physician’s skill, 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 for venipuncture necessitating a physician’s skill, not when routine venipuncture is performed.

36405-36406  
36405  Venipuncture, younger than age 3 years, necessitating physician’s skill, not to be used for routine venipuncture; scalp vein  
36406  other vein

Explanation  
A needle is inserted through the skin to puncture a vein of a child younger than age 3. In 36405, the scalp vein is punctured and in 36406, a vein other than the femoral, jugular, or scalp vein is used. The needle is inserted into the vein and used for the withdrawal of blood 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 for venipuncture necessitating a physician’s skill, not when routine venipuncture is performed.

36410  
36410  Venipuncture, age 3 years or older, necessitating physician’s skill (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)

Explanation  
A needle is inserted through the skin to puncture a vein of a person 3 years of age or older. 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 for venipuncture necessitating a physician’s skill, not when routine venipuncture is performed.

36415-36416  
36415  Collection of venous blood by venipuncture  
36416  Collection of capillary blood specimen (eg, finger, heel, ear stick)

Explanation  
A needle is inserted into the skin over a vein to puncture the blood vessel and withdraw blood for venous collection in 36415. In 36416, a prick is made into the finger, heel, or ear and capillary blood that pools at the puncture site is collected in a pipette. In either case, the blood is used for diagnostic study and no catheter is placed.

36420-36425  
36420  Venipuncture, cutdown; younger than age 1 year  
36425  age 1 or over

Explanation  
The physician makes an incision in the skin directly over the vessel and dissects the area surrounding the vein. A needle is passed into the vein for the withdrawal of blood or for the infusion of intravenous medication of a patient under 12 months of age (in 36420) or over 12 months of age (in 36425). A catheter may be left behind. Once the procedure is complete, the incision is repaired with a layered closure.

36430  
36430  Transfusion, blood or blood components

Explanation  
The physician transfuses blood or blood components to a patient. The physician establishes venous access with a needle and catheter and transfuses the blood products.

36440  
36440  Push transfusion, blood, 2 years or younger

Explanation  
The physician performs a push transfusion on a child 2 years old and under. The physician calculates the amount of blood to be transfused and slowly injects it into the patient using a needle or existing catheter.

36450-36455  
36450  Exchange transfusion, blood; newborn  
36455  other than newborn

Explanation  
The physician performs an exchange transfusion on a newborn. The physician calculates the blood volume to be transfused. A needle is placed in an artery or in an existing arterial catheter. The patient’s blood is removed and replaced simultaneously to maintain blood pressure. Report 36455 if the child is other than a newborn.

36510  
36510  Catheterization of umbilical vein for diagnosis or therapy, newborn

Explanation  
The physician catheterizes the umbilical vein for diagnostic or therapeutic purposes. The physician cleanses the umbilical cord stump and locates the umbilical vein. A catheter is inserted in the vein for reasons including blood sampling or administering medication.

36660  
36660  Catheterization, umbilical artery, newborn, for diagnosis or therapy

Explanation  
The physician catheterizes an umbilical artery in a newborn for diagnostic or therapeutic purposes. The physician prepares the umbilical artery and passes a catheter sheath inside the lumen for arterial access. The catheter is attached to a pressure line that maintains patency of the arterial lumen. The access is used for diagnostic or therapeutic purposes, allowing the drawing of blood for tests or instillation of medication.

70373  
70373  Laryngography, contrast, radiological supervision and interpretation

Explanation  
A radiographic contrast study is performed of the larynx, or organ of voice. Iodized oil is given in conjunction with the examination via tubing, which allows oil to drip down the patient’s throat at the radiologist’s discretion. The radiologist, via x-ray fluoroscopy, simultaneously watches the image amplified and displayed on a TV monitor. Rapid film sequencing must be used to record the image, which may then be studied and interpreted by the radiologist.

70496-70498  
70496  Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing  
70498  Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing

Explanation  
Computed tomographic angiography (CTA) is a procedure used for the imaging of vessels to detect aneurysms, blood clots, and other vascular irregularities. Contrast medium is rapidly infused intravenously, at intervals, usually with an automatic injector, and the patient is scanned with thin section axial or spiral mode x-ray beams. The images obtained are acquired with narrower collimation.
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 $29 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 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.

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’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 within the past three years. An established patient is a patient who has received face-to-face professional services from the physician within the past three years. In the case of group practices, if a physician of the same specialty has seen the patient within three years, the patient is considered established.

If a physician is on call or covering for another physician, the patient’s encounter is classified as it would have been by the physician who is not available. Thus, a locum tenens physician who sees a patient on behalf of the patient’s attending physician may not bill a new patient code unless the attending physician has not seen the patient for any problem within three years.

Hospital observation services are E/M services provided to patients who are designated or admitted as “observation status” in a hospital.

Codes 99218-99220 are used to indicate initial observation care. These codes include the initiation of the observation status, supervision of patient care including writing orders, and the performance of periodic reassessments. These codes are used only by the physician “admitting” the patient for observation.

Codes 99224-99236 are used to indicate evaluation and management services to a patient who is admitted and discharged from observation status or hospital inpatient on the same day. If the patient is admitted as an inpatient from observation on the same day, use the appropriate level of Initial Hospital Care (99221-99223).

Code 99217 indicates discharge from observation status. It includes the final physical examination of the patient, instructions, and preparation of the discharge records. It should not be used when admission and discharge are on the same date of service. As mentioned above, report codes 99234-99236 to appropriately describe same day observation services.

If a patient is in observation longer than one day, subsequent observation care codes 99224-99226 should be reported. If the patient is discharged on the second day, observation discharge code 99217 should be reported. If the patient status is changed to inpatient on a subsequent date, the appropriate inpatient code, 99221-99223, should be reported.

Initial hospital care is defined as E/M services provided during the first hospital inpatient encounter with the patient by the admitting physician. (If a physician other than the admitting physician