Coding Companion for Cardiology/Cardiothoracic/Vascular Surgery

A comprehensive illustrated guide to coding and reimbursement

2014
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Heart transplantation involves three distinct components. Code 33945 includes only transplant of the cadaver donor heart with or without recipient cardectomy and care of the recipient. Cardectomy (33940) is reported separately. Backbench work (33944), which involves preparation of the cadaver donor heart allograft prior to transplant, is also reported separately. Any additional repair or resection procedures on the donor heart are also reported separately, see 33300, 33310, 33320, 33400, 33463, 33464, 33510, 33641, 35216, 35276, or 35685. Donor cardectomy and any backbench work, repair, or resection procedures on the donor heart are usually the financial responsibility of the recipient.

**ICD-9-CM Procedural**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00.93</td>
<td>Transplant from cadaver</td>
</tr>
<tr>
<td>37.51</td>
<td>Heart transplantation</td>
</tr>
<tr>
<td>39.61</td>
<td>Extracorporeal circulation auxiliary to open heart surgery</td>
</tr>
</tbody>
</table>

**Anesthesia**

33945 00580

**ICD-9-CM Diagnostic**

398.0   Rheumatic myocarditis

412     Old myocardial infarction — (Use additional code to identify presence of hypertension: 401.0-405.9)

414.00  Coronary atherosclerosis of unspecified type of vessel, native or graft — (Use additional code to identify presence of hypertension: 401.0-405.9)

414.01  Coronary atherosclerosis of native coronary artery — (Use additional code to identify presence of hypertension: 401.0-405.9)

414.02  Coronary atherosclerosis of autologous vein bypass graft — (Use additional code to identify presence of hypertension: 401.0-405.9)

414.04  Coronary atherosclerosis of artery bypass graft — (Use additional code to identify presence of hypertension: 401.0-405.9)

414.8   Other specified forms of chronic ischemic heart disease — (Use additional code to identify presence of hypertension: 401.0-405.9)

422.91  Idiopathic myocarditis

422.92  Septic myocarditis — (Use additional code to identify infectious organism)

422.93  Toxic myocarditis

425.0   Endomyocardial fibrosis

425.3   Endocardial fibroelastosis

425.4   Other primary cardiomyopathies

428.0   Congestive heart failure, unspecified — (Code, if applicable, heart failure due to hypertension first: 402.0-402.9, with fifth-digit 1 or 404.0-404.9 with fifth digit 1 or 3)

428.22  Chronic systolic heart failure — (Code, if applicable, heart failure due to hypertension first: 402.0-402.9, with fifth-digit 1 or 404.0-404.9 with fifth digit 1 or 3)

428.32  Chronic diastolic heart failure — (Code, if applicable, heart failure due to hypertension first: 402.0-402.9, with fifth-digit 1 or 404.0-404.9 with fifth digit 1 or 3)

428.42  Chronic combined systolic and diastolic heart failure — (Code, if applicable, heart failure due to hypertension first: 402.0-402.9, with fifth-digit 1 or 404.0-404.9 with fifth digit 1 or 3)

429.0   Unspecified myocarditis — (Use additional code to identify presence of arteriosclerosis)

429.1   Myocardial degeneration — (Use additional code to identify presence of arteriosclerosis)

429.2   Unspecified cardiovascular disease — (Use additional code to identify presence of arteriosclerosis)

746.9   Unspecified congenital anomaly of heart

**CCI Version 18.3**


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

**Medicare Edits**

<table>
<thead>
<tr>
<th>Fac</th>
<th>Non-Fac</th>
<th>FUD</th>
<th>Status</th>
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</thead>
<tbody>
<tr>
<td>33945</td>
<td>145.58</td>
<td>145.58</td>
<td>R</td>
</tr>
</tbody>
</table>

MUE 62* 80

* with documentation

**Medicare References:** 100-2,15,50.5; 100-2,15,60.3; 100-3,260.9; 100-4,3,90.2.1
### Appendix

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Explanation</th>
<th>Coding Tips</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>36400</td>
<td>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</td>
<td>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 when the venipuncture necessitates the skills of a physician or other qualified health care professional. Do not use this code when routine venipuncture is performed.</td>
<td>This code has been revised for 2013 in the official CPT description.</td>
<td></td>
</tr>
<tr>
<td>36405-36406</td>
<td>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; scalp vein</td>
<td>A needle is inserted through the skin to puncture a vein of a child younger than age 3. 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 these codes when venipuncture necessitates the skill of a physician or other qualified health care professional. Do not use these codes when routine venipuncture is performed.</td>
<td>This code has been revised for 2013 in the official CPT description.</td>
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<tr>
<td>36410</td>
<td>Venipuncture, age 3 years or older, necessitating the skill of a physician or other qualified health care professional (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)</td>
<td>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 when the venipuncture necessitates the skills of a physician or other qualified health care professional. Do not use this code when routine venipuncture is performed.</td>
<td>This code has been revised for 2013 in the official CPT description.</td>
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<tr>
<td>36440</td>
<td>Push transfusion, blood, 2 years or younger</td>
<td>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.</td>
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<td>364400</td>
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<tr>
<td>36450</td>
<td>Exchange transfusion, blood; newborn</td>
<td>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.</td>
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<td>36450-36455</td>
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<tr>
<td>365010</td>
<td>Catheterization of umbilical vein for diagnosis or therapy, newborn</td>
<td>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.</td>
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<tr>
<td>36660</td>
<td>Catheterization, umbilical artery, newborn, for diagnosis or therapy</td>
<td>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.</td>
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<tr>
<td>70373</td>
<td>Laryngography, contrast, radiological supervision and interpretation</td>
<td>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 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.</td>
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Coding Companion for Cardiology/Cardiothoracic Surgery/Vascular Surgery
Evaluation and Management

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 $32 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 x 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” (OQHCP) 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 privilege (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 professionals 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 by 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 may not bill a new