Cardiology Coding Alert

The practical monthly adviser for ethically optimizing coding reimbursement and efficiency in cardiology practices

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Attack This Arteriogram, Angioplasty Scenario and Come Out Coding Both Services

▶ ***See which catheter placement code you should use based on access site***

Your cardiologist performed a diagnostic arteriogram followed by a balloon angioplasty of the right superficial femoral artery (SFA). Now you're wondering, should you report the arteriogram separately?

Solution: Yes, says **Yvette Hofmeister, CPC,** coding analyst at OSU Internal Medicine in Columbus, Ohio.

You may report the diagnostic arteriogram in this case, because the arteriogram determined the need for the angioplasty. Depending on how the cardiologist accessed the SFA, you should also report the appropriate catheter placement code, in addition to the related supervision and interpretation radiology code.

Keep in mind: Without the word "diagnostic" in the scenario above, you would not report the arteriogram as well. "If the physician knew about the blockage in the SFA from a previous session and only did the angiogram to scope out other things on the way to ballooning the SFA, or to find his way there (mapping), I wouldn't report it," says **Deb Ovall, CMA, CCS, CIC,** outpatient coder and interventional specialist at the University of Toledo Medical Center.

Follow this expert coding advice and rest assured that you're reporting the most accurate claim possible.

Punch Out the Correct Puncture Codes

First, let's look at your possible catheter code choices.

More commonly, cardiologists use an access site in the groin area with advancement of the catheter in an **antegrade fashion into the SFA**. For these cases, you should report 36245 (*Selective catheter placement, arterial system; each first-order abdominal, pelvic, or lower extremity artery branch, within a vascular family*) if the access site was in the common iliac or 36246 (... *initial second-order abdominal, pelvic, or lower extremity artery branch, within a vascular family*) if the access site was in the common femoral.

For a **contralateral puncture** (meaning vascular access in the opposite leg with catheter advancement through the distal abdominal aorta), choose 36247 (... *initial*

third-order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family).

If the cardiologist created the catheter puncture **ipsilateral to the SFA** (on the same side of the body), you could code for direct placement of the catheter into the superficial femoral artery (36140, *Introduction of needle or intracatheter; extremity artery*). However, this is an extremely rare access site.

Watch Modifiers With Radiology S&I

Second, when your case involves radiology supervision and interpretation (S&I), you need to report the radiology S&I for the diagnostic study with 75710-26-59 (*Angiography, extremity, unilateral, radiological supervision and interpretation; professional component; distinct procedural service*).

Modifiers explained: If the cardiologist performed these procedures in the facility setting, you should append modifier 26 to any radiology codes you claim. Also, you should append modifier 59 to 75710 to indicate that the cardiologist used the diagnostic arteriogram to make the decision to perform angioplasty. This will distinguish the diagnostic imaging reported with 75710 from the intervention imaging reported with 75962 (*Transluminal balloon angioplasty, peripheral artery, radiological supervision and interpretation*). Otherwise, a Correct Coding Initiative (CCI) edit would trigger denial of 75710.

You Be the Expert

Does Pacemaker Placement Route Matter?

Question: *I have an operative report for a dual pacemaker implant in which the cardiologist did not place the pacemaker through superior access as usually would occur. Instead, he placed the pacemaker abdominally. Should I still use 33208 and 71090?*

Florida Subscriber

Answer: See page 94 for the answer. ❑

Don't Forget the Angioplasty

You should report the femoral angioplasty with 35474 (*Transluminal balloon angioplasty, percutaneous; femoral-popliteal*) and 75962-26 for the S&I, says **Theresa Dix, CCS-P,** coder at East TN Heart Consultants in Knoxville.

Bonus: Did you know that you can report 35474 twice? If your cardiologist performs an angioplasty in the femoral and a second in the popliteal artery, you can report 35474 x 2, says **Jennifer Bankhead, RHIT, CPC-H, CIC,** specialized coding analyst for St. Joseph's Mercy Health Center in Hot Springs, Ark. Make sure you have documentation pointing out that the cardiologist performed the angioplasty in two different places. ❑

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Pay Attention to 5-Year Rule for Cardiovascular Screens

▶ *ABN protects you if patient forgets last screening date*

Medicare patients who report to your cardiologist for cardiovascular screenings are probably expecting the carrier to pay for the test. But the beneficiary or your office will be left footing the bill unless you correctly choose from four screening codes, use an approved V81.x code, and observe strict frequency guidelines.

In 2005, Medicare started covering cardiovascular screening blood tests (at proscribed intervals). Check out this information on cardiovascular screening test types and how to code for each of them.

Use Lipid Panel Code When Dr Performs 3 Screens

Patients who are at risk for certain types of heart disease — such as coronary artery disease or peripheral arterial disease — often require cardiovascular screenings, says **Mary Franklin,** coding/billing specialist at Virginia Medical Alliance in Springfield.

Four types of screenings are available to physicians, says **Sean M. Weiss, CPC, CPC-P, CMPE, CCA-P, CCP-P,** senior partner at The CMC Group LLC in Atlanta. The test the cardiologist performs (or orders) will depend on the patient:

- **Total cholesterol.** This test measures the patient's total cholesterol. Code these screenings with 82465 (*Cholesterol, serum or whole blood, total*).
- **Cholesterol test for high-density lipoproteins.** This test checks the patient's level of "good" cholesterol. Code these screenings with 83718 (*Lipoprotein, direct measurement; high-density cholesterol [HDL cholesterol]*).
- **Triglycerides.** This test checks the patient's triglyceride levels. Code these screenings with 84478 (*Triglycerides*).
- **Lipid panel.** Although your cardiologist might perform one of the above screens individually, he could also perform all three of the tests as a panel in the same session, Weiss says. When the cardiologist performs total cholesterol, cholesterol test for high-density lipoproteins and triglycerides in the same encounter, report 80061 (*Lipid panel*) for the service. *Note:* You should also include a cholesterol test for low-density lipoproteins (LDL) in lipid panels.

Newsletter Question or Comment?

If you have a question or comment about the contents of this publication, please contact the editor, Suzanne Leder, MPhil, CPC-A, at suzannel@eliresearch.com.

Verify CLIA Cert Before Testing

Suppose your cardiologist is part of a multi-specialty practice. Practices without a waived status Clinical Laboratory Improvement Amendments (CLIA) certification can forget about reporting the above cardiovascular screening codes. "If a provider's office does not have a CLIA certification or other lab certification, they are not able to provide the cardiovascular screening service or bill for it," Weiss says.

Only practices with CLIA-waived status should perform cardiovascular screening tests. If you code for a CLIA-waived practice, remember to attach modifier QW (*CLIA-waived test*) to cardiovascular test codes to indicate that you are billing for a waived test.

Example: A patient reports to a CLIA-waived multi-specialty practice. The physician conducts a total cholesterol test. You should report 82465-QW for the service.

Including V Code Is a Necessity

No matter which test the cardiologist runs on the patient, Medicare requires you to include one of these diagnosis codes on the claim. You are likely to receive a payer denial without one of these codes:

- V81.0 — *Special screening for ischemic heart disease*
- V81.1 — *Special screening for hypertension*
- V81.2 — *Special screening for other and unspecified cardiovascular conditions.*

Example: A Medicare patient reports to the cardiologist for a cardiovascular screening to check for hypertension. The physician performs a lipid panel. On the claim, report 80061 with V81.1 appended to prove medical necessity for the test.

Observe Frequency Guidelines or Face Denials

Cardiology practices that conduct cardiovascular screenings for Medicare patients also need to be aware of frequency guidelines for the tests, Franklin says.

The basics: Medicare will pay for one cardiovascular screening every five years for its patients, Weiss says.

Carriers will deny your screening claims if "there is already evidence of a paid claim within the prior 60 months with a diagnosis code of V81.0, V81.1 or V81.2, along with a procedure code of 80061, 82465, 83718, or 84478," he says.

So if a Medicare patient had a total cholesterol screen (82465) today, he would not be able to have any covered cardiovascular screens (82465, 83718, 84478, 80061) for five years. And you have to make sure it has been at least five years since the last screen, Weiss says.

This will give you a headache: If the physician performs the screening even one day prior to the expiration of the five-year "between test" period, Medicare will deny the service on the basis of frequency guidelines. Medicare payers are sticklers for dates, Weiss says.

For more information on determining a beneficiary's eligibility for Medicare preventive services, see www.cms.hhs.gov/MLNProducts/downloads/Preventive_Services_Eligibility.pdf.

Cover Your Bases With a Signed ABN

Experts recommend that you formulate an advance beneficiary notice (ABN) for patients who get cardiovascular screenings. That way, if the payer denies payment of the screening, you can make sure the patient will be responsible for the bill.

Otherwise, the office will have to pay whatever part of the bill Medicare won't cover. This is sound practice for cardiologists who perform screenings with frequency guidelines — just in case the patient has had a screening in the past five years that he forgot to tell you about.

Example: Your cardiologist sees an established patient and performs a lipid panel to check for cardiovascular disease. The patient reports that he has never had a lipid panel before. However, the patient's file indicates that another physician performed a Medicare-covered total cholesterol screen for him three years ago, making him ineligible for a covered lipid panel.

If you do not have a signed ABN from the patient, you will not be able to bill him for the lipid panel if Medicare decides not to pay. ❑

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Follow These 5 Routes to Modifier 22 Claim Success

▶ ***You decide which services warrant the effort associated with modifier 22***

Catch-22: If you're using modifier 22 on almost all of your cardiology cases, you are headed for an audit. But if you're not using modifier 22 at all, you could be passing by avenues for ethical reimbursement increases.

Did you know? In the past, some Medicare carriers have suggested that physicians should use modifier 22 (*Unusual procedural services*) with fewer than 5 percent of all cases. In other words, you should always apply modifier 22 sparingly — but that doesn't mean you should never use this modifier at all.

Key: When a procedure may require significant additional time or effort that falls outside the range of services described by a particular CPT code — and no other CPT code better describes the work involved in the procedure — modifier 22 is your best option, says **Marvel J. Hammer, RN, CPC, CCS-P, ACS-PM, CHCO,** owner of MJH Consulting in Denver.

Follow these expert tips, and you'll be stepping toward modifier 22 success.

1. Know When to Use Modifier 22

You should use modifier 22 "when the service(s) provided is greater than that usually required for the listed procedure," according to CPT. However, neither CPT nor Medicare provides guidelines about what type of service merits its use — that's up to you.

Example: If your cardiologist uses a telemetry-at-home device, which is not an event monitor but a live, real-time patient monitoring at home, some carriers do require 93799 (*Unlisted cardiovascular service or procedure*). Other payers will require the Holter monitor

codes (93224-93233) appended with modifier 22 because the technology is new.

2. Support the 'Unusual' Argument

CPT designed modifiers to represent the extra physician work involved in performing a procedure because of extenuating circumstances present in a patient encounter. Modifier 22 represents those extenuating circumstances that don't merit the use of an additional or alternative CPT code, but instead raise the reimbursement for a given procedure.

For example: If your cardiologist chooses a transseptal rather than a retrograde aortic approach to access the left side of the heart and performs a complex series of ablations to treat atrial fibrillation, you can append modifier 22 to 93651 (*Intracardiac catheter ablation of arrhythmogenic focus; for treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathways, accessory atrioventricular connections or other atrial foci, singly or in combination*).

Although such claims require documentation and may prompt automatic review, carriers will likely pay more for the service if the physician's procedure notes clearly indicate that he spent substantially more time performing the case and they illustrate the complexities involved.

Catch this: The key to collecting reimbursement for unusual procedures is all in the documentation. Sometimes a physician will tell you he did "x, y, and z," but when you look in the documentation, the support isn't there. Documentation is your chance to demonstrate the special circumstance that warrant modifier 22.

Also, don't forget to add on the additional dollar amount that you are asking for, says **Karen Green, CPC-H,** coding specialist in a physician's practice in Eau Clair, Wis. "Payers just don't pay you extra with this modifier; you need to say I am asking for ____ extra and this is why."

Some situations in which you might use modifier 22 include:

- morbid obesity
- significant scarring or adhesions during a pacemaker or defibrillator lead extraction
- extremely prolonged cases (such as, some left ventricular lead implantations)
- coronary interventions consisting of several interventions in the same vessel
- complex peripheral vascular cases involving several catheter exchanges and prolonged procedural time.

3. Count Time As a Vital Factor

Some experts suggest that you shouldn't use modifier 22 unless the procedure takes at least twice as long as usual. Several memorandums from Medicare carriers indicate that *time* is an important factor when deciding to use this modifier.

Tactic: Time is quantifiable, allowing a carrier to more easily convert the extra work into additional reimbursement. For example, your cardiologist performed and documented the following procedures:

- 93510-26-22
- 93543
- 93545
- 93555-26-59
- 93556-26-59
- 92980-59-22-LC

However, the physician had trouble advancing the cath through the iliacs. He made multiple attempts to engage the left main coronary, and after multiple attempts, he was finally able to engage. This meant that the procedure took 50 percent more time and effort than usual.

What to do: If your cardiologist had trouble with a series of procedures, you would append the modifier on the code with the highest relative value unit (RVU) — in this case, 92980, says **Sandy Fuller, CPC, MCS-P,** HIS supervisor and compliance officer for Cardiovascular Associates of East Texas. You must also have a letter in layman's terms that tells why this was a difficult study, and "it's always good to have the time in the letter along with the time of the normal case for this physician."

4. Use Unlisted-Procedure Code As a Last Resort

Avoid making the mistake of using an unlisted-procedure code when you could use modifier 22. Some coders go this route because they realize the payer must manually review such claims and the carrier's computer cannot automatically deny them. But you could be setting your practice up for missed reimbursement.

Rationale: Unlisted-procedure codes require the same amount of documentation as modifier 22. If you do not include an "accompanying narrative" with an unlisted-procedure code, the *Medicare Carriers Manual* (*MCM*), section 3005.4 (C.1.k), instructs carriers to return the claim as unprocessable.

(Continued on next page)

Because filing a claim with an unlisted-procedure code takes just as much time and effort and because the reimbursement rates don't appear to be higher, many coding experts recommend that you stick with modifier 22. If the modifier 22 claim gets denied, the cardiologist still gets paid for the base code. But if the carrier rejects the unlisted-procedure code, the physician may get nothing and may have to fight for reimbursement for the entire procedure.

5. If Possible, Use CPT Codes Instead of Modifier

Instead of attaching modifier 22 when a procedure is above and beyond its normal scope, you should consider reporting a CPT code that more specifically explains why the procedure was prolonged or unusual.

Example: Your cardiologist attempts to catheterize the aorta from a left femoral artery vascular access site but has difficulty advancing catheter. He performs a sheath injection to visualize the artery but then abandons the initial access site before obtaining a separate access from the right femoral artery.

In this case, you should report 36140 (*Introduction of needle or intracatheter; extremity artery*) and 75710 (*Angiography, extremity, unilateral, radiological supervision and interpretation*) in addition to the procedure codes that reflect the work performed from the second access site. Reporting these two codes, rather than applying modifier 22 to others, is more accurate and less of a hassle. ❑

You Be the Expert

Does Pacemaker Placement Route Matter?

Answer: You don't need to adjust your codes, because nothing in the code description says that the cardiologist *must* place the pacemaker in the chest through upper vessels.

You would report 33208 (*Insertion or replacement of permanent pacemaker with transvenous electrode[s]; atrial and ventricular*) for a generator with both right atrial and right ventricular leads.

Don't forget: You'll report the fluoroscopy using 71090-26 (*Insertion pacemaker, fluoroscopy and radiography, radiological supervision and interpretation; professional component*) only when your cardiologist documents it in the operative report. ❑

Reader Questions

Don't Let Runoff Studies Run Away With You

Question: *When coding for a right and left lower extremity arterial runoff, should I use supervision and interpretation codes 75630 and 75716, or should I use 75625 and 75716? The report says the cardiologist advanced the catheter into the descending aorta and runoffs way down to the foot.*

Virginia Subscriber

Answer: If the cardiologist performed the injection to view the bilateral extremities, you should *only* report 75716 (*Angiography, extremity, bilateral, radiological supervision and interpretation*). In other words, the cardiologist interprets information of the bilateral extremities when the runoff imaging is from the distal (above bifurcation) aorta.

You'll only report 75630 (*Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation*) when the cardiologist places the catheter at the level of the renals and provides one fluid injection. This is so he can view the abdominal through the femoral arteries bilaterally (at least to the common femoral).

Don't miss: Multiple injections versus one fluid injection will help you determine which runoff imaging code to use.

Remember: If the cardiologist provides only the professional component, be sure to include modifier 26 (*Professional component*).

❑

Examine Cause for AICD Code

Question: *An older male patient presented in our cardiology office complaining that his defibrillator was firing. What diagnosis code should I report for this?*

South Dakota Subscriber

Answer: Your diagnosis code for this patient will depend on the cause of the firing. If the firing resulted from an AICD (automatic implantable cardiac defibrillator) malfunction, you would describe the condition with 996.04 (*Mechanical complication of cardiac device, implant, and graft; due to automatic implantable cardiac defibrillator*).

If the patient had a dysrhythmia that caused the defibrillator to fire appropriately, you would use the heart condition as the primary diagnosis code, such as a code from the 427 series (*Cardiac dysrhythmias*). Then you would report V45.02 (*Cardiac device in situ; automatic implantable cardiac defibrillator*) to indicate that the patient has an AICD.

❑

Home In on Ultratag Kit HCPCS code

Question: *What is the HCPCS code for an Ultratag kit that a provider will use during a multi-gated acquisition (MUGA) scan?*

New York Subscriber

Answer: You should use A9560 (*Technetium TC-99m labeled red blood cells, diagnostic, per study dose, up to 30 millicuries*) for the Ultratag kit. You'll use this code for both the invivo/invitro methods of tagging red blood cells.

You should also use A9512 (*Technetium TC-99m pertechnetate, diagnostic, per microcurie*) for the tagging agent.

❑

Think You Can Report 2 E/Ms? Think Again

Question: *A patient who was not feeling well came into the office, and the physician performed an ECG that proved the patient was in a-fib. The cardiologist immediately sent the patient to the hospital. I reported 99214 and 93000 with diagnosis a-fib and was paid. Another cardiologist from our group saw the patient the same day in the hospital. How can I get paid for the services provided in the hospital by the second cardiologist, who is billing under the same tax ID number with the same diagnosis ?*

Arkansas Subscriber

Answer: Typically, you can bill only one E/M service per day per practice. You should charge 93000 (*Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report*) as well as your hospital charge, such as the appropriate level of initial hospital care (99221-99223).

In order to secure payment for two E/M services by physicians of the same specialty, you would have to prove the medical necessity for concurrent care. This is a hassle not commonly worth the additional reimbursement at stake.

❑

Multiple Procedures Don't Always Mean Multiple Codes

Question: *Our cardiologist's op report lists the following services:*

1. removal of atrial and ventricular pacemaker leads
2. removal of pulse generator
3. debridement of infected pocket and removal of necrotic tissue
4. closure of facial layers
5. Jackson-Pratt drain place via trocar

How should I code this?

New Jersey Subscriber

Answer: You'll code the removal of the generator and leads with 33233 (*Removal of permanent pacemaker pulse generator*) and 33235 (*Removal of transvenous pacemaker electrode[s]; dual lead system*). You should consider everything else you listed as included in these two codes.

❑

Get Your Lead Codes Straight

Question: *What code should I use for the removal of a CS lead? Code 33226 is for repositioning, right?*

Pennsylvania Subscriber

Answer: You won't find a specific code that accurately describes this service. However, many coders would report 33244 (*Removal of a single or dual chamber pacing cardioverter-defibrillator electrode[s]; by transvenous extraction*) for the lead(s) removal. Others may go the more conservative route and use the unlisted-procedure code 33999 (*Unlisted procedure, cardiac surgery*).

Yes, 33226 (*Repositioning of previously implanted cardiac venous system [left ventricular] electrode [including removal, insertion and/or replacement of generator]*) is for repositioning.

❑

Avoid Applying ICD-9 Codes Without Documentation

Question: *My cardiologist documented the patient's hypertension as "uncontrolled." Does that mean that I should use a malignant hypertension ICD-9 code? What if the doctor simply states "hypertension" or "history of hypertension"?*

Iowa Subscriber

Answer: "Uncontrolled" does not equal "malignant." To use a malignant hypertension diagnosis, your cardiologist has to specifically say that in his documentation.

The word "uncontrolled" does not affect code assignment. The type of hypertension is what drives your hypertension code selection. You should use 401.9 (*Essential hypertension; unspecified*) instead.

Unfortunately, physicians will use words that mean one thing in ICD-9 but something else to them. When your cardiologist is vague about the type of hypertension, you should ask the physician what he means, have him clarify it in the medical record, and then assign the ICD-9 code accordingly.

Keep in mind: Hypertension, commonly referred to as "high blood pressure" or "HTN," is a medical condition in which the blood pressure is chronically elevated. Malignant hypertension is a complication of hypertension characterized by very elevated blood pressure, and organ damage in the eyes, brain, lung and/or kidneys.

— You Be the Coder *and* Reader Questions *were prepared with the assistance of* ***Jim Collins, ACS-CA, CHCC, CPC,*** *CEO of the Cardiology Coalition and compliance manager for several cardiology groups around the country; and reviewed by* ***Jerome Williams Jr., MD, FACC,*** *a cardiologist with Mid Carolina Cardiology in Charlotte, N.C.* ❑

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