

CARDIOLOGY CODING ALERT

Your practical adviser for ethically optimizing coding, reimbursement, and efficiency in cardiology practices

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Perform AICD Services? Don't Miss This All New V12.53 Rule

► **Check your files for claims denied since Oct. 1, 2007, and collect your fees.**

You can add one more ICD-9 code to the short list that supports implantable cardioverter defibrillator services for Medicare patients outside of a clinical trial and not enrolled in a CMS-specified data registry. Here's the scoop on applying the change and perhaps recouping payment for past services rendered.

Background: An automatic implantable cardioverter defibrillator (AICD) has a pulse generator (battery) and electrodes that detect and treat life-threatening tachyarrhythmias (fast heart rhythms). Medicare covers AICD services in very specific cases, described in the *National Coverage Determinations Manual* (NCD Manual), Chapter 1, Part 1, Section 20.4.

Through various transmittals, CMS has posted a handful of ICD-9 codes that support coverage without the patient needing to be enrolled in a clinical trial or CMS-specified data registry. But there are numerous other indications that Medicare covers only if the patient is in a trial, and you signify enrollment by appending modifier Q0 (*Investigational clinical service provided in a clinical research study that is in an approved clinical research study*) to the AICD service's CPT code. (Note that the modifier is Q-zero.)

What's new: CMS announced you should add V12.53 (*Personal history of sudden cardiac arrest*) to the short list of diagnoses that don't require modifier Q0 for AICD procedure coverage (Transmittal 663, CR 6867).

Keep Track of Q0 Requirement

The news about not needing modifier Q0 on claims that include V12.53 makes sense, says **Sandy Fuller, CPC, MCS-P**, HIS supervisor and compliance officer for Cardiovascular Associates of East Texas. You use modifier Q0 to indicate that the cardiologist implanted the device for the primary preventative reasons studied in the trials (MADIT I, MADIT II, and SCD-HeFT), she explains. You can't assume a personal history of sudden cardiac arrest moves the patient into the "primary prevention" category. In fact, the NCD Manual indicates that one of the covered indications not considered "primary prevention of sudden cardiac death" is a documented episode of cardiac arrest caused "by ventricular fibrillation (VF), not due to a transient or reversible cause."

Term tip: Primary prevention means the patient has "no history of induced or spontaneous arrhythmias," according to Transmittal 819, CR 4273. Look specifically

for no spontaneous sustained ventricular arrhythmias, experts say.

Post Acceptable Diagnoses Nearby

Now that V12.53 is on CMS's list of codes that support AICD service coverage without the use of modifier Q0, be sure to update your job aids. The current list includes the following codes:

- 427.1 — *Paroxysmal ventricular tachycardia*
- 427.41 — *Ventricular fibrillation*
- 427.42 — *Ventricular flutter*
- 427.5 — *Cardiac arrest*
- 427.9 — *Cardiac dysrhythmia, unspecified*
- V12.53 — *Personal history of sudden cardiac arrest*
- 996.04 — *Mechanical complication of cardiac device, implant, and graft; due to automatic implantable cardiac defibrillator*
- V53.32 — *Fitting and adjustment of other device; automatic implantable cardiac defibrillator.*

Application: Based on the list, if a patient has v-tach (427.1), for example, you haven't had to — and still don't have to — append Q0 to the AICD procedure code, such as 33249 (*Insertion or repositioning of electrode lead[s] for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator*), to receive payment, explains **Sarah Tupper, CMC**, billing manager for Central

New York Cardiology in Utica, N.Y. And this rule now applies for V12.53.

For those indications that the NCD Manual lists under "primary prevention," such as heart failure and cardiomyopathy (see the manual for specific clinical indications), you must append modifier Q0 for payment, she warns. And the facility must enroll the patient in the American College of Cardiology data registry.

Helpful history: In Transmittal 819, retroactive to April 1, 2005, CMS added the last two codes on the list, 996.04 and V53.32, to allow payment for services such as replacing the AICD due to a recall, a complication, or the end of battery-life.

Look Back for Unpaid V12.53 Claims

The V12.53 change is retroactive, so check your files for AICD claims with dates of service on or after Oct. 1, 2007, that Medicare denied because the diagnosis code was V12.53 and the claim did not include the clinical trial modifier. Transmittal 663 refers to modifier Q0 for dates on or after Jan. 1, 2008, and modifier QR (*Item or service provided in a Medicare specified study*) for dates before Jan. 1, 2008. This is because modifier Q0 essentially replaced now deleted modifier QR in 2008.

Action plan: If any of these claims remain unpaid, you can bring them to your contractor's attention for payment, Transmittal 663 reveals. The implementation date

Cardiology Coding Alert (print ISSN 1522-7472; online ISSN 1947-6892) (USPS # 019-177) is published monthly by The Coding Institute, a subsidiary of Eli Research, 2222 Sedwick Road, Durham, NC 27713. © 2010 The Coding Institute. All Rights Reserved. Subscription price is \$297. Periodicals postage is paid at Durham, NC, 27705 and additional entry offices. POSTMASTER: Send address changes to *Cardiology Coding Alert*, PO Box 413006, Naples, FL 34101-3006. **Web:** www.codinginstitute.com **Customer Service:** service@medville.com **Discussion Group:** www.coding911.com

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for this transmittal is July 6, 2010, so payers have until that date to change their systems to recognize the new rule.

Round Up the AICD Resources

If you want to learn more about AICD coding, CMS has various resources available:

- The NCD Manual, Chapter 1, Part 1, Section 20.4, explains coverage requirements in detail: www.cms.gov/manuals/downloads/ncd103c1_Part1.pdf.
- Transmittal 819, CR 4273 (2006), explains the appropriate use of 996.04 and V53.32: www.cms.gov/Transmittals/downloads/R819CP.pdf
- The recent V12.53 update is in Transmittal 663, CR 6867: www.cms.gov/transmittals/downloads/R663OTN.pdf. □

Advance Your Angio Skills With This Carotid Scenario

► **Knowing right from left can bring a \$105 reward.**

How do you handle a case with a common carotid placement but both common and internal carotid imaging?

That's what one coder wanted to know when she sent in the following scenario: Using femoral access and common carotid placement, the physician images the right common carotid and right internal carotid. The physician documents normal anatomy and states there are no

(Continued on next page)

Take a Sneak Peek at ICD-10 Codes for AICD Diagnoses

► **Is your documentation up to the seven-character challenge?**

If you've got the 2013 transition to ICD-10 on the brain, chances are you looked at "Perform AICD Services? Don't Miss This All New V12.53 Rule" and wondered what your AICD coding might look like after the big diagnosis coding change.

Your final ICD-10 code choice will depend on the codes and guidelines in effect for the relevant date of service, as well as the physician's specific documentation. But this rundown, based on the ICD-10-CM 2010 files posted at www.cdc.gov/nchs/icd/icd10cm.htm#10update, will help give you an idea of what to expect. Many of the code definitions look much the same. But items such as cardiac arrest and mechanical complications may require you to dig a little deeper into documentation to choose among codes that have greater specificity.

ICD-9-CM 2010	ICD-10-CM 2010
• 427.1 — <i>Paroxysmal ventricular tachycardia</i>	• I47.2 — <i>Ventricular tachycardia</i>
• 427.41 — <i>Ventricular fibrillation</i>	• I49.01 — <i>Ventricular fibrillation</i>
• 427.42 — <i>Ventricular flutter</i>	• I49.02 — <i>Ventricular flutter</i>
• 427.5 — <i>Cardiac arrest</i>	• I46.2 — <i>Cardiac arrest due to underlying cardiac condition</i> • I46.8 — <i>Cardiac arrest due to other underlying condition</i> • I46.9 — <i>Cardiac arrest, cause unspecified</i>
• 427.9 — <i>Cardiac dysrhythmia, unspecified</i>	• I49.9 — <i>Cardiac arrhythmia, unspecified</i>
• V12.53 — <i>Personal history of sudden cardiac arrest</i>	• Z86.74 — <i>Personal history of sudden cardiac arrest</i>
• 996.04 — <i>Mechanical complication of cardiac device, implant, and graft; due to automatic implantable cardiac defibrillator</i>	• T82.110x — <i>Breakdown (mechanical) of cardiac electrode (seventh character indicates initial encounter, subsequent, or sequela)</i>
• V53.32 — <i>Fitting and adjustment of other device; automatic implantable cardiac defibrillator</i>	• Z45.02 — <i>Encounter for adjustment and management of automatic implantable cardiac defibrillator</i>

Keep in mind: "The transition date for ICD-10 codes is Oct 1, 2013," stressed CMS's **Stewart Streimer** during a CMS-sponsored Open Door Forum. "But there are a lot of things that must happen before then, and I expect many of the payers may even require ICD-10 codes before then so a sufficient amount of testing can take place," he said. □

abnormalities in the common carotid, but she finds stenosis in the internal carotid.

Determine your answer, and then see if your solution matches the experts’.

Image 2 Vessels From Same Placement?

The scenario indicates catheter placement terminated in the common carotid, but the cardiologist imaged both the common and internal carotid arteries. Assuming your documentation supports it, you will be able to report imaging for both the common and internal carotid arteries.

This imaging of both vessels is possible because the contrast flows upward, says **Michele Midkiff, CPC-I, PCS, RCC**, executive director of Coding Affiliates Inc., an interventional coding service based in Mountain View, Calif. As a result, physicians can inject contrast at the common carotid artery and “render the interpretation of not only the common carotid bifurcation, specifying what is seen ([for example,] the common carotid bifurcation was clean and free of disease),” but also intracranial segments of the internal carotid artery, Midkiff explains.

The codes: For the unilateral common (cervical) carotid artery angiography, you should report 75676 (*Angiography, carotid, cervical, unilateral, radiological supervision and interpretation*), says Midkiff. You should apply 75665 (*Angiography, carotid, cerebral, unilateral, radiological supervision and interpretation*) for unilateral intracranial (cerebral) carotid artery angiography, she says.

Remember to verify that the physician’s documentation for the scenario above supports reporting the cerebral code (based on what she performed and the recorded findings) in addition to the cervical code, says **Jeff Fulkerson, BA, CPC, CIRCC**, senior certified coder with Emory Healthcare in Atlanta.

Rake in Rightful Right Carotid Fee

In addition to imaging, you need to choose the proper catheter placement code. One important factor is whether the cardiologist worked in the left or right carotid arteries. In the scenario above, the cardiologist placed the catheter in the patient’s right common carotid.

Impact: The right common carotid originates from the innominate artery which branches from the aorta. Therefore, from a femoral approach, the innominate is the first-order catheterization, and the right common carotid is a second-order catheterization. On the other hand, the patient’s left common carotid originates from the aorta in a typical patient and is therefore a first-order catheterization. (See Figure 1.)

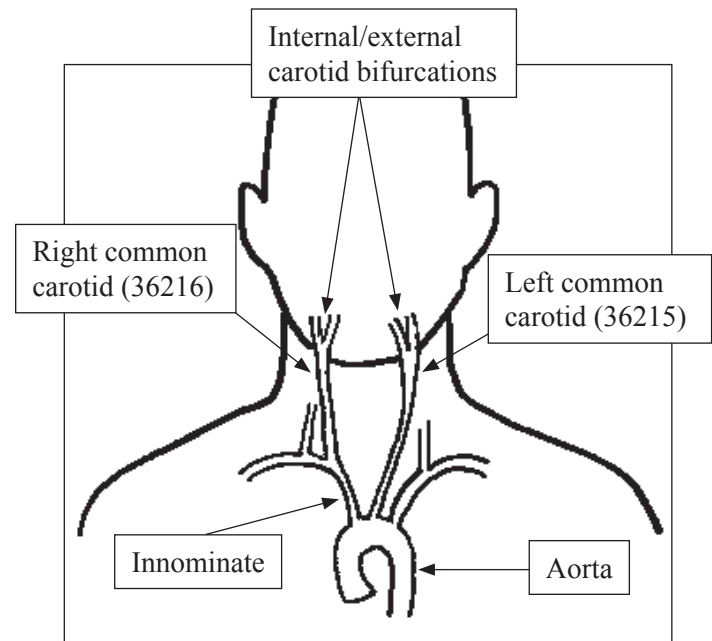


Figure 1. Patient with normal anatomy

Because of these anatomical differences, the appropriate code for a right common carotid cath placement, as described in the above scenario, is second order code 36216 (*Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family*), says Midkiff.

On the other hand, for a left common carotid cath placement, you would report first-order code 36215 (*... each first order thoracic or brachiocephalic branch, within a vascular family*) for a patient with a normal anatomy, Midkiff says.

Payoff: If you correctly identify the need to code right carotid placement rather than left, you’re in for some good news. Medicare’s national nonfacility rate for 36216 (\$1,212) is \$105 more than the rate for 36215 (\$1,107), using a conversion factor of 36.0846. Or if you’re coding a service performed in a facility, 36216 will earn you \$32 more than 36215.

Choose ‘0’ If ‘Cerebral Infarction’ Is Absent

Depending on the documentation, the appropriate ICD-9 code for stenosis in the internal carotid alone is 433.1x (*Occlusion and stenosis of precerebral arteries; carotid artery*), says Fulkerson. You must add a fifth digit to the code, basing that digit on whether the physician documents cerebral infarction.

You’ll choose from the following options:

- 0 — *without mention of cerebral infarction*
- 1 — *with cerebral infarction.*

If the physician's dictation doesn't specifically state cerebral infarction is present, you should report 433.10, says Fulkerson. Inform your clinicians that being "as specific as possible in identifying the location of a stenosis, embolism, thrombosis, or occlusion" will aid you in selecting the proper code, such as choosing between 433.1x and 434.xx (*Occlusion of cerebral arteries ...*), Fulkerson adds. □

News You Can Use:

Make Up for Lost Time: EP Edit Deletion Is Official

► ***If you've been holding study claims, the time to send them in is here.***

Correct Coding Initiative (CCI) version 16.1 has the news you've been waiting for.

The latest version, effective April 1, deletes 142 edit pairs, **Frank D. Cohen, MPA, MBB**, senior analyst with MIT Solutions Inc. in Clearwater, Fla., reported in a March 22 announcement.

Most importantly: As expected, CCI deleted the edits mistakenly added Jan. 1 that blocked payment for recording, pacing, and electrophysiology (EP) studies performed on the same date of service as an intracardiac catheter ablation procedure (see chart). Adding potentially delayed EP payments to Medicare's 2010 fee cuts did not equal good news, as **Jennifer Crowell, CPC, CCC, CEMC**, lead hospital coordinator for Spokane Cardiology in Washington, pointed out. And the edits had a modifier indicator of "0," so there was no way to override them to receive payment. (See *Cardiology Coding Alert*, Vol. 13,

No. 1, "Red Alert: Expect EP Study + Ablation Denials Until April 1," for more information.)

Stake Your Claim for EP Pay

Act now: CCI lists the deletions with a modifier indicator of "9" and shows Jan. 1, 2010, as both the effective and deletion dates, both of which indicate the deletion is retroactive to the effective date. That means if you've been holding your claims or have gotten denials because of the erroneous edits, you may now submit the claims for payment.

Edits Deleted by CCI Version 16.1	
Col. 1	Col. 2
<ul style="list-style-type: none"> • 93650, <i>Intracardiac catheter ablation of atrioventricular node ...</i> 	<ul style="list-style-type: none"> • 93602-93603, ... <i>recording</i> • 93610, 93612, 93618, ... <i>pacing</i> • 93619-93622, <i>Comprehensive electrophysiologic evaluation ...</i> • 93623, <i>Programmed stimulation and pacing ...</i>
<ul style="list-style-type: none"> • 93651, <i>Intracardiac catheter ablation of arrhythmogenic focus; for treatment of supraventricular tachycardia ...</i> 	<ul style="list-style-type: none"> • 93610, 93612
<ul style="list-style-type: none"> • 93652, ... <i>for treatment of ventricular tachycardia</i> 	<ul style="list-style-type: none"> • 93600, <i>Bundle of his recording</i> • 93602-93603 • 93610, 93612, 93618 □

READER QUESTIONS

Watch Global Period for 33215 Service

Question: *If the cardiologist repositions and reconnects a dislodged transvenous, right ventricular lead of a dual-chamber pacemaker or defibrillator device for one of her patients during the postoperative period, how should I report this?*

Pennsylvania Subscriber

Answer: The appropriate code for repositioning is 33215 (*Repositioning of previously implanted transvenous*)
(Continued on next page)

You Be the Coder

Consider Congenital Echo Codes

Question: *A pediatrician sent a patient to us because he suspected a congenital heart defect. The cardiologist performed an echo but did not find an anomaly. Should I report a congenital echo code for this service?*

Hawaii Subscriber

Answer: See page 31. □

pacemaker or pacing cardioverter-defibrillator [right atrial or right ventricular] electrode).

Modifier must: Because you mention that the service was during the postoperative period, you should consider appending modifier 78 (*Unplanned return to the operating procedure room by the same physician following initial procedure for a related procedure during the postoperative period*). Be sure the service meets four requirements before you append this modifier:

1. The same physician performed the original procedure (such as 33208, *Insertion or replacement of permanent pacemaker with transvenous electrode[s]; atrial and ventricular*) and subsequent procedure (33215, repositioning)
2. The subsequent procedure occurs within the global period of the initial procedure (for example, 33208 has a 90-day global period).
3. The subsequent procedure is a complication of the initial procedure.
4. The subsequent procedure requires a return to the operating room (OR) or procedure room.

FYI: Medicare includes cardiac cath suites in its OR definition, as indicated in *Medicare Claims Processing Manual*, Chapter 12, Section 40.1.B: "Treatment for

postoperative complications which requires a return trip to the operating room (OR). An OR for this purpose is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient's condition was so critical there would be insufficient time for transportation to an OR)" (www.cms.gov/manuals/downloads/clm104c12.pdf).

Land On 0126T for IMT Screen

Question: Which CPT code describes carotid IMT screening?

Washington Subscriber

Answer: The code describing this service is 0126T (*Common carotid intima-media thickness [IMT] study for evaluation of atherosclerotic burden or coronary heart disease risk factor assessment*). A note following 93882 (*Duplex scan of extracranial arteries; unilateral or limited study*) supports this use: "To report common carotid intima-media thickness (IMT) study for evaluation of atherosclerotic burden or coronary heart disease risk factor assessment, use 0126T."

The procedure involves using ultrasound to measure carotid IMT. The intima and media are the carotid artery wall's two innermost layers. One argument is that monitoring IMT allows physicians to keep an eye on atherosclerosis, intervening earlier than they might otherwise.

Coverage: Be sure to check your policies for coverage as many payers consider the service investigational. For example, Premera Blue Cross, headquartered in Washington, states ultrasonic carotid IMT measurement is investigational, but notes physicians may perform the service as a part of some clinical trials (www.premera.com/stellent/groups/public/documents/medicalpolicy/cmi_009710.pdf).

Similarly, Cigna's policy states that it considers carotid IMT testing investigational and therefore doesn't cover it, specifically listing 0126T (www.cigna.com/customer_care/healthcare_professional/coverage_positions/medical/mm_0475_coveragepositioncriteria_carotid_intima_media_thickness.pdf).

Remember: You shouldn't report an unlisted code or other Category I CPT code in an attempt to garner payment if there is a more appropriate Category III code

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available. CPT guidelines instruct, “Category III codes allow data collection for these services/procedures. Use of unlisted codes does not offer the opportunity for the collection of specific data. If a Category III code is available, this code must be reported instead of a Category I unlisted code.”

Avoid Multiplying Bilateral 36245 Claims

Question: *One of the coders in our office is reporting two units of 36245-50 for bilateral services. I always thought you should use a single unit with modifier 50. Which method is correct?*

Utah Subscriber

Answer: Reporting two units of a code and appending modifier 50 (*Bilateral procedure*) will equal reporting four services, which is incorrect. The correct method of coding bilateral 36245 (*Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family*) services will depend on your payer’s preference.

Some payers prefer that you report your procedure code only once, one unit, with modifier 50 appended (36245-50). Other payers want the code reported using two line items, one unit each, with modifier LT (*Left side*) attached to one and modifier RT (*Right side*) attached to the other (36245-LT, 36245-RT), or payers may have another preference.

Fee facts: The Medicare Physician Fee Schedule lists a “1” indicator in the bilateral surgery column for 36245. That means if you report two of the services on the same day (whether with two units, modifier 50, or some other way), the contractor will pay either the actual total charge for both sides or 150 percent of the fee schedule amount for a single code, whichever is lower, according to the “National Physician Fee Schedule Relative Value File Calendar Year 2010.”

Add PFSH to Determine History

Question: *The cardiologist performed a comprehensive exam and high complexity medical decision making for a new patient who presented with fever and chest pain. He suffered a myocardial infarction (MI) several weeks ago. The cardiologist documented a diagnosis of Dressler’s syndrome. If the cardiologist addressed five history of present illness (HPI)*

elements and reviewed 10 systems (ROS), what is the history level?

California Subscriber

Answer: CPT bases the history level on HPI, ROS, and personal past, family, and social history (PFSH), so you’ll have to review the notes to determine the PFSH level before deciding on a history level. During a “complete” PFSH for a new patient, the physician asks the patient direct questions about all three PFSH elements. If she only asks a new patient about one or two PFSH elements, it is a “pertinent PFSH.” You may need to hunt for the PFSH within the body of the HPI or ROS because the information may not be marked separately.

HPI, ROS levels: The 1995 and 1997 E/M documentation guidelines both indicate that four HPI elements (and therefore the five in your example) qualify as extended HPI and 10 systems equal a complete ROS (guidelines available for download at www.cms.gov/MLNEdweb/Guide/25_EMDOC.asp).

(Continued on next page)

You Be the Coder

Consider Congenital Echo Codes

(Question on page 29)

Answer: When the cardiologist performs echocardiography for a suspected congenital anomaly, but does not find one, you should not report a congenital echo code.

Support: *CPT Assistant* (December 1997) explains that you should not use the congenital echo codes “when a congenital heart disease is *suspected, but is not found* on echocardiography evaluation. In this case, the noncongenital echocardiography codes should be used.”

So instead of 93303-93304 (*Transthoracic echocardiography for congenital cardiac anomalies ...*) or 93315-93317 (*Transesophageal echocardiography for congenital cardiac anomalies ...*), you should report a code such as 93306-93308 (*Echocardiography, transthoracic ...*) or 93312-93314 (*Echocardiography, transesophageal ...*).

Tip: Don’t let clinical significance of the anomaly affect your code. If the cardiologist does find an anomaly, but notes that it doesn’t require treatment or that it may heal itself, you still should report the congenital echo code. □

Once you've determined the HPI, ROS, and PFSH levels, you can determine the history level. You must meet all three requirements for a given history level. Following are the requirements for a comprehensive history:

HPI	Extended
ROS	Complete
PFSH	Complete

If you meet the following requirements, you instead have a detailed history:

HPI	Extended
ROS	Extended
PFSH	Pertinent

Result: Based on your case, if your documentation shows extended HPI, complete ROS, and complete PFSH, this qualifies as a comprehensive history.

If instead the case you describe supports extended HPI, complete ROS, and pertinent PFSH, this is a detailed history (because you must meet all three requirements of a given level).

ICD-9: ICD-9 indexes Dressler's syndrome to 411.0 (*Postmyocardial infarction syndrome*). Interestingly, ICD-10-CM 2010 also uses the same code for Dressler's and postmyocardial infarction syndrome, but the definition puts Dressler's in the spotlight: I24.1 (*Dressler's syndrome*). You can find out more about ICD-10-CM, expected to replace ICD-9-CM in the U.S. in 2013, at www.cdc.gov/nchs/icd/icd10cm.htm.

— You Be the Coder *and* Reader Questions prepared with the assistance of **Jim Collins, CCC, CPC, CHCC**, president of *CardiologyCoder.Com*. □

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