

Coding for Interventional Cardiology Procedures

An overview of the complex coding for various cardiology procedures.

BY ROSEANNE R. WHOLEY

When coding and billing for coronary interventions, it is important to know that Medicare only recognizes three major coronary arteries. These are the left anterior descending artery, the right coronary artery, and the circumflex artery. Branch vessels are considered an integral part of these three major arteries. Interventions in these vessels are reported with the appropriate coronary artery modifiers: LAD (left anterior descending), RCA (right coronary artery), and LC (left circumflex).

COMPLETE PROCEDURAL TERMINOLOGY

The Complete Procedural Terminology (CPT) codes for interventions in each of these vessels include an initial vessel code and each additional vessel code. This is true for:

- 92982 Percutaneous transluminal coronary angioplasty (PTCA), single vessel
- 92984 PTCA, each additional vessel
- and
- 92995 Percutaneous transluminal coronary atherectomy, with or without balloon angioplasty, initial vessel
- 92996 Percutaneous transluminal coronary atherectomy, each additional vessel
- and
- 92980 Transcatheter placement of an intracoronary stent(s) percutaneous, with or without other therapeutic intervention, initial vessel
- 92981 Transcatheter placement of an intracoronary stent(s) percutaneous, each additional vessel.

Before 1995, multiple-vessel procedures were performed with the initial vessel codes and a -51 multiple surgical modifier added to the lower-valued procedure.

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On January 1, 1995, the regulation was changed to the current method. Only the most highly valued procedure would be reported with the initial vessel code in the first vessel. Any other therapeutic coronary artery procedures in different vessels are reported using the “each additional vessel” code for the same procedure, which is reimbursed significantly less than the initial vessel code.

If a single intervention is utilized in more than one of these three vessels, the first vessel is to be identified using the respective “single vessel” code. Each additional major coronary artery treated is identified by using the “each additional vessel” code. Interventions in the branch vessels are considered a part of the intervention in the major vessel and are not reported separately. Anatomic variants should be reported as closely as possible to a corresponding major vessel and not separately coded.

MEDICARE CORRECT CODING INITIATIVE

The Medicare Correct Coding Initiative (CCI) defines a hierarchical schema in technical complexity that exists when multiple coronary interventions are performed in a single session. This means that certain services supersede other services and the other services are not reported separately. Generally, stent placement supersedes atherectomy, which supersedes angioplasty. When

multiple interventions are combined during a single session on multiple vessels, the most complex intervention is to be reported by using that intervention's "single vessel" code and additional interventions using the appropriate "each additional vessel" code. Only one interventional procedure code per session is applied to each of the three major coronary arteries. Therefore, stent placement, angioplasty, and/or atherectomy may not be paid on the same vessel. Additional major-vessel interventions may be reported using the "each additional vessel" codes, including the appropriate coronary artery modifier.

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For example, if PTCA is performed in the LAD artery and the vessel is subsequently stented, the PTCA is bundled into the stent placement code, which is the highest paying service. This means that when a stent is placed because of an abrupt closure of a vessel during PTCA, or as a scheduled event, the PTCA in that same vessel is not reported separately. The only CPT code that would be used to report this service is 92980-LD.

Note that there are three modifiers used to identify the three major coronary arteries:

- -LD Left anterior descending
- -RD Right coronary artery
- -LC Left circumflex.

If PTCA is performed in the LAD artery and also in the RCA, and a stent is placed in the circumflex, the coding of the procedure would be:

- 92980-LC Stent, initial LC
- 92982-LD PTCA LAD
- 92984-RC PTCA, each additional vessel, RCA.

Note that if multiple stents were placed side by side in a single vessel, the stent code would be reported only once.

Codes 92973 (percutaneous transluminal coronary thrombectomy), 92974 (coronary brachytherapy), 92978, and 92979 (intravascular ultrasound) are add-on codes for reporting procedures performed in addition to coronary stenting, atherectomy, and angioplasty, and are not included in the therapeutic interventions.

It is not appropriate to report imaging supervision and interpretation (S&I) services for therapeutic coronary artery procedures. The placement of all catheters, as well as angiography performed during the course of

the therapeutic procedure, and the S&I, are included in the therapeutic procedure code.

However, if a diagnostic catheterization is performed before any therapeutic intervention, it is coded separately, along with the intervention. When a diagnostic cardiac catheterization is performed and immediately followed by a therapeutic procedure, such as PTCA, all of the appropriate cardiac catheterization codes should be reported in addition to the code for the therapeutic procedure.

The cardiac catheterization codes are split into three main categories: cardiac catheterization procedure codes, injection codes, and imaging S&I codes.

DIAGNOSTIC CARDIAC CATHETERIZATION CODES

The diagnostic cardiac catheterization codes (the physician professional component is reported with a -26 modifier) are:

- 93501 Right heart catheterization
- 93508 Catheter placement in coronary artery(s) arterial coronary conduit(s), and/or venous coronary bypass graft(s) for coronary angiography without concomitant left heart catheterization
- 93510 Left heart catheterization, retrograde, from the brachial artery, axillary artery, or femoral artery: percutaneous
- 93511 Left heart catheterization, retrograde, from the brachial artery, axillary artery, or femoral artery: by cutdown
- 93514 Left heart catheterization by left ventricular puncture
- 93524 Combined transseptal and retrograde left heart catheterization
- 93526 Combined right heart catheterization and retrograde left heart catheterization
- 93527 Combined right heart catheterization and transseptal left heart catheterization through intact septum (with or without retrograde left heart catheterization)
- 93528 Combined right heart catheterization with left ventricular puncture (with or without retrograde left heart catheterization)
- 93529 Combined right heart catheterization and left heart catheterization through existing septal opening (with or without retrograde left heart catheterization)
- 93530 Right heart catheterization, for congenital cardiac anomalies
- 93531 Combined right heart catheterization and retrograde left heart catheterization, for congenital cardiac anomalies

- 93532 Combined right heart catheterization and transeptal left heart catheterization through intact septum with or without retrograde left heart catheterization, for congenital cardiac anomalies
- 93533 Combined right heart catheterization and transeptal left heart catheterization through existing septal opening, with or without retrograde left heart catheterization, for congenital cardiac anomalies.

INJECTION CODES

The possible injection codes for procedures performed during cardiac catheterization are:

- 93539 Injection procedure during cardiac catheterization for selective opacification of arterial conduits, whether native or used for bypass
- 93540 Injection procedure during cardiac catheterization for selective opacification of aortocoronary venous bypass grafts, one or more coronary arteries
- 93541 Injection procedure during cardiac catheterization for pulmonary angiography
- 93542 Injection procedure during cardiac catheterization for selective right ventricular or right atrial angiography
- 93543 Injection procedure during cardiac catheterization for selective left ventricular or left atrial angiography
- 93544 Injection procedure during cardiac catheterization for aortography
- 93545 Injection procedure during cardiac catheterization for selective coronary angiography.

RADIOLOGICAL S&I CODES

The radiological S&I codes (reported with a -26 modifier for the professional component) used with diagnostic cardiac catheterization procedures are:

- 93555 Imaging S&I and report for injection procedure(s) during cardiac catheterization; ventricular and/or atrial angiography
- 93556 Imaging S&I and report for injection procedure(s); pulmonary angiography, aortography, and/or selective coronary angiography including venous bypass grafts and arterial conduits.

CORONARY CATHETERIZATION CODES

If a left heart catheterization were performed along with a left ventriculography and coronary angiography, the following codes would be used to describe the procedure:

- 93510-26 Left heart catheterization
- 93543 Injection for selective left ventricular angiography

- 93545 Injection for selective coronary angiography
- 93555-26 S&I for left ventriculography
- 93556-26 S&I for coronary angiography.

Note that if a -26 modifier is used to describe only the professional component when the physician component is reported separate from the technical component.

CONCLUSION

The heart catheterization procedure must be correctly defined (left heart, right heart, right and left heart catheterization). It is important to remember that, if during a cardiac catheterization procedure, an injection is also performed, the correct injection(s) code should be submitted along with the accompanying S&I code. No matter how many injection procedures are performed, the S&I codes can only be listed one time each. Each type of injection performed may be reported separately.

If a history and physical or consultation is performed on the same day of a procedure, the service is billable as long as the performing physician is providing an initial evaluation or consult in which the decision to operate is made. In this case, a modifier -25 (for minor procedures) or -57 (for major procedures) would be appended to the evaluation and management code (not the procedure code). If the modifier is not used, the carrier will consider the history and physical or consult to be included in the surgical package payment for the procedure.

Finally, if a therapeutic intervention is performed at the same time as the diagnostic heart catheterization, it is important to include the code(s) for the intervention along with the heart catheterization codes. If a therapeutic service is not performed at the same time as a heart catheterization, but rescheduled for a few days later, the diagnostic procedure would not be rebilled at the time of the diagnostic service. ■

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