Internal Medicine Coding Alert

You Be the Coder: 93458's Global Period Offers Coding Clues For Catheterization

Question: The cardiologist was called in to consult for an inpatient presenting with angina. The physician performs an E/M and decides to perform a left heart cath, which he does the next day. Should I report 99222 for day 1 and 93458 and 99231 for day 2? Should I use modifier 57 on 99222?

Codify Member

Answer: For a scenario in which the cardiologist performs an E/M on day 1 and performs the left heart catheterization on day 2, assuming the codes you list are the appropriate choices for the services provided, you should report:

- Day 1: 99222 -- Initial hospital care, per day, for the evaluation and management of a patient ...
- Day 2: 93458 -- Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed.

If your payer follows CMS rules, you should not use modifier 57 (Decision for surgery) with 99222, and you should not report 99231 (Subsequent hospital care, per day, for the evaluation and management of a patient ...) for an E/M on day 2, assuming it was related to the cath.

Here's why: The Medicare Physician Fee Schedule lists a "000" global period for 93458, which gives you two important clues for your question.

First, the 000 designation means that Medicare generally won't pay separately for E/M services performed on the same day as the procedure. Procedures with a 000 period have been priced to include the relative values of expected pre- and post-op services. Applying this rule, you see that you should not report 99231 for an E/M service related to and performed on the same date as the cath. (You'll find global periods defined in the "National Physician Fee Schedule Relative Value File Calendar Year 2011" available at www.cms.gov/PhysicianFeeSched/PFSRVF/list.asp)

Second, the 000 designation means you should not append modifier 57 to an E/M service that resulted in the decision for surgery. Medicare Claims Processing Manual, chapter 12, section 40.2.A.4, states that "The '-57' modifier is not used with minor surgeries because the global period for minor surgeries does not include the day prior to the surgery. Moreover, where the decision to perform the minor procedure is typically done immediately before the service, it is considered a routine preoperative service and a visit or consultation is not billed in addition to the procedure." (The manual is online at www.cms.gov/manuals/downloads/clm104c12.pdf.)