Part B Insider (Multispecialty) Coding Alert

CARDIOLOGY REVENUE BOOSTER: Earn An Extra $400 With Unlisted Code For Transseptal Puncture

2 right ways and 1 wrong way to capture this extra reimbursement

It's a source of frustration for cardiology coders: CPT has no code for ablation with transseptal puncture. This approach requires a lot more work than the standard ablation (CPT code 93651), and yet it's a challenge to obtain any reimbursement for the extra trouble.

Solution: Coding experts have found two different ways to code for transseptal puncture. This procedure involves the physician puncturing the atrial wall from the right side of the heart, to get the catheter to the left side for the ablation.

Wrong way: The **North American Society of Pacing and Electrophysiology** (NASPE) advised coders to bill for the transseptal ablation by coding both 93651 and combined right heart/left heart catheterization code 93527. But many coding experts warn that transseptal puncture does not meet the definition of 93527, so this combination amounts to incorrect coding.

-We-re not doing a transseptal heart catheterization, we-re doing a transseptal puncture,- warns **Nikki Vendegna**, a cardiology coding consultant in Overland Park, KS. Both procedures use a catheter, but in the case of transseptal puncture, the physician is only using the catheter for the ablation. CPT code 93527 is close to the correct code, but it's not actually correct, she warns.

Jim Collins with the **Cardiology Coalition** also advises providers not to use 93527 for transseptal puncture in the Coalition's March 2007 newsletter. Collins cites the definition of 93527, as well as some carriers- local coverage determinations.

Luckily, there are two right ways to receive your rightful payment for transseptal puncture. Unfortunately, your reimbursement amount will depend on your carrier.

Right way #1: You can code just 93651, but attach the 22 modifier (Unusual procedural services) for the extra work. Vendegna says carriers will pay anywhere from an extra 5 percent to an extra 30 percent. Medicare pays between $800 and $900 for 93651, depending on geographic area.

Spokane Cardiology receives 100 percent of the allowable for 93651 instead of 80 percent, when it uses the 22 modifier, according to coder **Jennifer Crowell**. The modifier adds an extra $170 to the practice's reimbursement. But the extra amount is hardly enough to cover the transseptal puncture, plus the extra time required for the atrial fibrillation (afib) ablation.

Right way #2: St. Paul Heart Clinic has been billing 93651, plus unlisted code 93799, since the start of this year. Payors generally reimburse around $300 to $400 for the unlisted code, on top of the payment for 95651, according to Coding & Compliance Specialist **Anne Karl.**

Medical College of Virginia Physicians in Richmond has been billing the unlisted code since last fall and has only receive denials for three out of 30 instances, says coder **Staci Dougherty.**

Write a letter: Either the 22 modifier or the unlisted code requires you to write a letter to your carrier explaining why the transseptal approach deserves more pay. Your extra reimbursement depends on how good your letters are, says

Vendegna.

Your doctor's cover letter should explain what a transseptal puncture is, why it's difficult and high-risk, and how it adds complexity to the case, Vendegna advises. You should attach it to the actual operative report.

To use the 22 modifier, you must document the time involved and list the procedural details of the transseptal puncture, says Crowell. -Our physicians have also dictated a standard letter explaining the differences for a afib ablation including the transeptal puncture, and the high risk involved for the patient,- she says. She often has to appeal denials for the extra reimbursement.

When submitting the unlisted code, St. Paul sends a cover letter explaining the procedure and notes that it's not included in the standard ablation codes, says Karl. -We compare it to the difference in pricing between a transeptal catheterization (93527) and a right and left heart cath performed through an existing septal opening (93529),- she explains.

The difference between the two RVUs should reflect the extra work of crossing the septum, she adds.

Bottom line: Don't bill 93527 just to obtain extra reimbursement, because you won't be able to prove later that your physician performed a heart catheterization.