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Part B Insider (Multispecialty) Coding Alert

Minimally Invasive CABG Maximally Noncovered - ButYou Can Bill 33510-33523 for New Techniques

When it comes to new surgical techniques, it's often hard to figure out what Medicare will cover.

The carriers often don't make it easy for coders either, with their confusing and apparently contradictory local medical review policies. A case in point: coronary artery bypass graft (CABG), a surgery which new techniques have simplified. Instead of cutting the entire rib cage down the middle, surgeons can now make a small incision over the heart.

But many insurers don't cover such minimally invasive CABG procedures, and it's unclear whether Medicare does. Hardly any carriers have addressed this issue, says Mesa, Ariz., coder **Jennifer Stinely**. But the Regence Group, the Medicare carrier for Utah, came out with a heart-breakingly obscure article on coverage of minimally invasive CABG in its July 1999 bulletin.

On the one hand, Regence says flat-out that you shouldn't use standard CABG codes (33510-33523, and 33533-33536) for minimally invasive CABG. Instead, you should use unlisted-procedure code 33999, and then hold the patient or other insurer financially liable after Medicare denies it.

But then Regence goes on to say that some "technical refinements" to CABG will be covered after all. These include such minimally invasive techniques as alternate incisions instead of the traditional "full median sternotomy," such as anterior tho-racotomy incisions, parasternal incisions or limited median sternotomy incisions. Also covered will be alternative means of creating a cardiopulmonary bypass, such as peripheral instead of central bypass.

Regence will even cover CABG if you avoid a cardiopulmonary bypass entirely and instead use a mechanical device, such as the Starfish or the Octopus, to limit the heart's motion and allow the surgeon to perform CABG.

The crucial part of the Regence article is the insistence that "the hallmark of an acceptable, non-investigational procedure" is the use of hand-sewn anastomoses between the coronary vessel and the bypass conduit, says consultant **George Alex** with Iatro in Baltimore. As long as you use this technique, you can bill for all sorts of refinements. Some coders have reported success using modifier -52 (Reduced services) with these claims, he adds.

Alex says the clinical literature does show that procedures with hand-sewn anastomoses have a lower complication rate than procedure without.

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