

Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Can You Code This Cardiac Cath Case?

We break the study down into four important questions so you can choose the right codes to report.

Coding a claim requires a big picture view encompassing not just the procedure, but the diagnoses and any modifiers, too.

To keep your skills sharp, determine the answers to these four questions based on a scenario from **Terry Fletcher, BS, CPC, CCC, CEMC, SCP-CA, ACS-CA, CCS-P, CCS, CMSCS, CMC**, in her Modifier Maze webinar from audioeducator.com. Then check the solutions for explanations of the answers.

Start with the basic scenario: A patient presents to the ER with substernal chest pain. The physician diagnoses the patient with unstable angina and then admits the patient for a cardiac catheterization with coronary injections, left ventriculography, and interpretations of the studies.

1: Calculate the Proper E/M Level

Question: Suppose documentation shows a comprehensive history, a comprehensive exam, and medical decision making of high complexity based on a Medicare patient's particular circumstances. Which E/M code should you report? Does it need any modifiers?

Solution: The applicable E/M code is 99223 (Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem[s] and the patient's and/or family's needs. Usually, the problem[s] requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.).

To indicate the physician is the admitting physician for this Medicare patient, append modifier AI (Principal physician of record), Fletcher advises.

Medicare introduced AI around the time it stopped accepting consult codes. The use of AI identifies the admitting or attending physician to avoid confusion because any consultants or other providers seeing the patient would bill an initial hospital care code, too.

Also append modifier 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service) to 99223, says Fletcher.

Use the modifier to indicate the E/M code is for a separately identifiable service on the same day as the procedure. Medicare includes the basic initial evaluation for a minor surgical procedure like this (0-day global) in the global surgical package. You need to indicate that the E/M documentation can stand alone beyond the usual same-day preoperative service.

2. Can You Properly Capture the Cath?

Question: Which CPT® code should you report for cardiac catheterization with coronary injections, left ventriculography, and interpretations of the studies performed in a facility? Do you need to add modifiers?

Solution: For the service, you should report 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), says Fletcher.

CPT® guidelines state that this code "includes introduction, positioning and repositioning, when necessary, of catheter(s), within the vascular system, recording of intracardiac and/or intravascular pressure(s), and final evaluation and report of procedure."

Because the service took place in a facility, you need to append modifier 26 (Professional component) to show you're reporting only the physician's work and not the technical component.

Support: The MPFS shows a PC/TC indicator of 1 for this code. The definition of indicator 1 states, in part, that "These codes have both a professional and technical component. Modifiers 26 and TC can be used with these codes."

3. Which ICD-9 and ICD-10 Codes Apply to Unstable Angina?

Question: Suppose the cardiac cath results do not reveal a new definitive diagnosis, and you link the cardiac cath to the diagnosis unstable angina. How should you report this diagnosis in ICD-9 and in ICD-10?

Solution: The ICD-9 code for unstable angina is 411.1 (Intermediate coronary syndrome), Fletcher says. Under ICD-10, the code is I20.0 (Unstable angina).

4. How Does Adding Arteriosclerosis Change Your Coding?

Question: Suppose the cath reveals the patient has coronary atherosclerosis of a native artery. How would you report the diagnoses of unstable angina with coronary atherosclerosis under ICD-9 and under ICD-10?

Solution: ICD-9 has 411.1 for unstable angina and separate code 414.01 (Coronary atherosclerosis of native coronary artery) for the atherosclerosis.

ICD-10 offers combination codes for angina and coronary artery disease. The appropriate ICD-10 code is I25.110 (Atherosclerotic heart disease of native coronary artery with unstable angina pectoris)