Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Can You Spot the Trouble Areas in These EP Study/Ablation Scenarios?

Plus, you'll get a hint of how the ICD-10 transition will affect coding for these services.

The codes that include both electrophysiology (EP) study and ablation prove that combo codes don't always equate to simpler coding. EP coders know there are still plenty of pitfalls to watch out for. Try your hand at these two scenarios to see if you capture every possible code.

Scenario 1: Start With a Slow Pathway Ablation

Take a look at this scenario provided by **Terry Fletcher, BS, CPC, CCC, CEMS, CCS-P, CCS, CMSCS, CMC**, of Terry Fletcher consulting, in her AudioEducator.com presentation, "Coding Electrophysiology/Diagnostics/Ablations." Choose the CPT®, ICD-9-CM, and ICD-10-CM codes you would report.

Scenario: The electrophysiologist performs:

- 1. A comprehensive EP study
- 2. 3D mapping
- 3. Ablation of a slow pathway for AV nodal re-entrant tachycardia.

Coding solution: You should report the following codes:

CPT® for 1 and 3: 93653, Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording (when necessary), and His bundle recording (when necessary) with intracardiac catheter ablation of arrhythmogenic focus; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry

- CPT® for 2: +93613, Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)
- ICD-9-CM: 427.89, Other specified cardiac dysrhythmias
- ICD-10-CM: I47.1, Supraventricular tachycardia.

Helpful hints: Keep two tips in mind to report this service correctly.

First, reporting 3D mapping using +93613 is appropriate in this case. Code 93653 does not include the +93613 service.

Forgetting to report +93613 is an easy mistake to make because a similar code for a comprehensive EP study/ablation DOES include the 3D mapping service: 93654, Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording (when necessary), and His bundle recording (when necessary) with intracardiac catheter ablation of arrhythmogenic focus; with treatment of ventricular tachycardia or focus of ventricular ectopy including intracardiac electrophysiologic **3D mapping**, when performed, and left ventricular pacing and recording, when performed.

Second, 93653 specifically refers to supraventricular tachycardia (SVT) treatment, so remember that AV nodal re-entrant tachycardia is a type of SVT. The AV (atrioventricular) node is located between the atria and ventricles, which makes the

AV node above (supra-) the ventricles.

Final note: Look again at the Coding Solution. Did you notice how ICD-10 changes your coding for this diagnosis? Instead of using an "other" code as you do under ICD-9, you'll have a code specific to SVT when ICD-10 becomes effective Oct. 1, 2014.

Scenario 2: Work Your Way Through 8 Steps

Now that you've warmed up using Scenario 1, try this second scenario based on a similar example from Fletcher.

Scenario: The electrophysiologist performs:

1. Comprehensive EP study
2. 3D mapping
3. Intracardiac echocardiography
4. Transseptal puncture
5. Left atrial pacing and recording
6. Ablation of right and left superior and inferior pulmonary veins
7. Additional EP testing
8. Ablation of an additional focus of atrial fibrillation in the right atrium.

Coding solution: You should report the following codes:

CPT® for 1, 4, 5, 6, and 7: 93656, Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia including left or right atrial pacing/recording when necessary, right ventricular pacing/recording when necessary, and His bundle recording when necessary with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation

CPT® for 2: +93613

CPT® for 3: +93662, Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)

CPT® for 8: +93657, Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation (List separately in addition to code for primary procedure)

ICD-9-CM: 427.31, Atrial fibrillation

ICD-10-CM: I48.91, Unspecified atrial fibrillation.

Helpful hints: Just like in our first scenario, you know to watch for whether you may report 3D mapping in addition to the primary 93656 service (yes, you can). But be sure you watch for these four additional problem areas.

First, the definition of 93656 specifically includes transseptal catheterization. This inclusion makes sense because the service typically requires a septal puncture. Consequently, you should not report that service separately using +93462 (Left heart catheterization by transseptal puncture through intact septum or by transapical puncture [List separately in addition to code for primary procedure]). Keeping track of this point is important because you may report +93462 in addition to EP study/ablation codes 93653 and 93654.

Second, 93656 is specific to pulmonary vein isolation (PVI). This treatment involves using a specialized catheter to apply energy (direct current, freezing, etc.) that creates scarring around where the pulmonary veins connect to the left atrium. The goal is to block irregular impulses.

Third, you may report a distinct code for intracardiac echocardiography (ICE) when 93656 is the primary code. EP reports

tend to be long, so be sure to watch for echocardiography performed with the service to support reporting +93662.

Fourth, you should report +93657 for additional ablation in conjunction with 93656 when the encounter meets these three requirements, Fletcher says:

- Successful PVI is achieved
- Attempts at re-induction of atrial fibrillation find another focus of A-fib
- Further ablation of the new mechanism is performed.

If the encounter doesn't meet those requirements, you could consider +93655 (Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia [List separately in addition to code for primary procedure]) for the additional ablation service. An example would be when the electrophysiologist goes through the steps of identifying, inducing, recording, pacing, and ablating atrial flutter, which would be distinct from the primary ablated mechanism.

While you want to be sure you capture +93657 when warranted, don't assume you're missing a second A-fib ablation service if you find only one in the documentation. Performing a second one during a single session isn't typical. Be especially careful not to report +93657 for the physician clean-up work of a successful PVI. The add-on code is for ablation of a discrete mechanism of arrhythmia that is distinct from the primary ablated mechanism.

Final note: The Coding Solution includes an ICD-10 code for unspecified atrial fibrillation, but you may be able to choose a more specific code if your electrophysiologist's documentation is up to snuff. Review these other possible ICD-10 A-fib codes:

- I48.0, Paroxysmal atrial fibrillation
- I48.1, Persistent atrial fibrillation
- I48.2, Chronic atrial fibrillation (aka, permanent A-fib)