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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: CPT® 2020: Use New Pericardium and Aortic Graft Options Effectively

Hint: Don't report 99473 more than once per device.

In less than a month, CPT® 2020 becomes effective. You'll have many new cardiology-related codes to choose from, but new codes mean new guidelines. That's why it's a good idea to understand the options ahead of time and alleviate claims issues down the line.

Read on to dig into these guidelines to ensure you submit clean claims starting Jan. 1.

Discover New Pericardium Guidelines

CPT® 2020 will add several new codes to the "Pericardium” section in the CPT® code book. They are as follows:

- 33016 (Pericardiocentesis, including imaging guidance, when performed). **Note:** You should not report 33016 in conjunction with ultrasonic guidance code 76942, fluoroscopic guidance code +77002, CT guidance code 77012, or magnetic resonance imaging code 77021.
- 33017 (Pericardial drainage with insertion of indwelling catheter, percutaneous, including fluoroscopy and/or ultrasound guidance, when performed; 6 years and older without congenital cardiac anomaly) and 33018 (…birth through 5 years of age or any age with congenital cardiac anomaly). **Note:** You should not report 33017 or 33018 in conjunction with radiological guidance codes 75989, 76942, +77002, 77012, or 77021.
- 33019 (Pericardial drainage with insertion of indwelling catheter, percutaneous, including CT guidance). As the descriptor for 33019 suggests, you will report 33019 for CT-guided pericardial drainage. **Note:** You should not report 33019 in conjunction with 75989, 76942, +77002, 77012, or 77021.

When you report new codes 33017-33019, the catheter must remain in place after the procedure is completed, according to CPT® guidelines. So, you should not report 33017-33019 when the physician places a catheter to aspirate fluid and then removes the catheter when the procedure is over.

Code 33018: When you look at the descriptor for 33018, you will see the words "with congenital cardiac anomaly.”

When reporting percutaneous pericardial drainage with insertion of indwelling catheter, the guidelines define a congenital cardiac anomaly as, "as abnormal situs (heterotaxy, dextrocardia, mesocardiac), single ventricle anomaly/physiology, or any patient in the first 90-day postoperative period after repair of a congenital cardiac anomaly.”

Caution: You should not report 33016-33018 in conjunction with 93303-93325 when the cardiologist performs echocardiography "solely for the purpose of pericardiocentesis guidance,” according to CPT®.

We have known for a long time that complete component CPT® codes were in our near future, so it is no surprise that procedure standards to successfully perform a diagnostic or surgical procedure have become bundled within the primary procedure CPT® code(s), says **Christina Neighbors, MA, CPC, CCC**, Coding Quality Auditor for Conifer Health Solutions, Coding Quality & Education Department, and member of AAPC's Certified Cardiology Coder steering committee.

"Thankfully, the total RVU reimbursement is also being reevaluated,” Neighbors adds. "Where it is going to be tricky is when multiple departments or physicians perform the specific diagnostic or surgical procedure(s).”

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Catch New Aortic Graft Instructions

CPT® will also introduce the following aortic graft codes to the "Thoracic Aortic Aneurysm" section:

- 33858 (Ascending aorta graft, with cardiopulmonary bypass, includes valve suspension, when performed; for aortic dissection) and 33859 (… for aortic disease other than dissection (eg, aneurysm)).
- 33871 (Transverse aortic arch graft, with cardiopulmonary bypass, with profound hypothermia, total circulatory arrest and isolated cerebral perfusion with reimplantation of arch vessel(s) (eg, island pedicle or individual arch vessel reimplantation)

Aortic hemiarch grafts: If a patient has ascending aortic disease that involves the aortic arch and the cardiologist has to perform an aortic hemiarch graft along with the ascending aortic graft, then you should report add-on aortic hemiarch graft code +33866 in conjunction with the appropriate ascending aortic graft code - 33858, 33859, or 33864, according to CPT®.

Aortic hemiarch grafts require the following three components, per CPT®.

- **Component 1:** Total circulatory arrest or isolated cerebral perfusion. The cerebral perfusion can be retrograde or antegrade;
- **Component 2:** An incision into the transverse arch that extends under one or more of the arch vessels;
- **Component 3:** "Extension of the ascending aortic graft under the aortic arch by construction of a beveled anastomosis to the distal ascending aorta and aortic arch without a cross-clamp (an open anastomosis)."

Caution: Component three above specifies that the ascending aortic repair with a beveled anastomosis into the arch does not use a cross-clamp. In fact, the guidelines reiterate this point further on: "An ascending aortic repair with a beveled anastomosis into the arch with a cross-clamp cannot be reported separately as a hemiarch graft using +33866."

Code 33871: You should not report 33871 for an aortic hemiarch graft, according to the guidelines. Instead, 33871 describes a complete transverse arch graft placement. Also, you should never report 33871 in conjunction with +33866.

Get Ready for 99473 and 99474

CPT® 2020 will add 99473 (Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration) and 99474 (… separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient) to the E/M section of the CPT® manual.

You must heed the following rules when reporting 99473 and 99474:

- **Rule 1:** You should not report 99473 more than once per device.
- **Rule 2:** You should not report 99474 more than once per calendar month.
- **Rule 3:** Never report 99473 or 99474 in the same calendar month as ambulatory blood pressure monitoring codes 93784-93790; digitally stored data and remote physiologic monitoring codes 99091, 99453, and 99454; remote physiologic monitoring treatment management code 99457; and complex chronic care E/M codes 99487-99491.

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