

Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Nail Down Your Cardiac Cath Coding With This Updated Advice

Read this op report and figure out how you would code it.

Coding medical charts is always a difficult task, but when it comes to cardiac catheterizations, the year-to-year code changes and detailed instructions can confuse even a veteran medical staff member.

The sample case below, based on a real-life report, offers a chance to look at the nitty gritty details involved in choosing which codes to assign to your claim.

Navigate Your Way Through the Report

PROCEDURES:

Left heart catheterization.

Bilateral selective coronary artery angiography.

Left ventriculogram.

Ascending aorta angiography.

Right common femoral artery angiography.

Perclose ProGlide closure device to achieve hemostasis.

INDICATIONS: There is a 67-year-old male with history of diabetes type 2 who presented with complaint of chest pain. The patient underwent exercise treadmill test and developed shortness of breath and chest pain during the procedure. The patient also noted to have some apical ischemia. The patient was subsequently brought to the cardiac catheterization lab for left heart catheterization due to the patient's diabetes (high risk for coronary artery disease) and abnormal stress test.

DESCRIPTION OF PROCEDURE: ... A Cook needle was used to obtain access to the right common femoral artery. Access obtained via modified Seldinger technique.

A 6 French standard sheath was inserted into the right common femoral artery. A JL4.0 and JR4.0 catheter was used to perform the bilateral selective coronary artery angiography. The pigtail catheter and power injector were used to perform the left ventriculogram and ascending aorta angiography with positioning and injection in each. Then the right common femoral artery angiography was performed. The needle insertion above bifurcation and below the inferior epigastric artery, which is suitable for closure device. A Perclose ProGlide closure device was used to achieve hemostasis ...

FINDINGS:

HEMODYNAMICS:

The LV pressure was 140/10. The left ventricular end-diastolic pressure was 24 mmHg. The aorta pressure was 140/70. There was no gradient noted across the aortic valve.

LEFT VENTRICULOGRAM:

The left ventricle is small in size. There is evidence of hypertrophy. The left ventricular fraction is hyperdynamic with left ventricular end-diastolic function more than 65%. There was no evidence of mitral regurgitation.

ASCENDING AORTA ANGIOGRAPHY:

The ascending aorta is normal in size. Aortic valve is trileaflet. There is no evidence of dissection or aneurysm. There is no evidence of aortic regurgitation.

BILATERAL SELECTIVE CORONARY ANGIOGRAPHY:

Left main is normal in size. It bifurcates into left anterior descending artery and left circumflex artery. There was no significant stenosis noted.

Left anterior descending artery: The left anterior descending artery is a normal size and tortuous vessel. It gives rise to 1 diagonal branch and multiple septal perforators. Distally it travels toward apex and wraps around the apex. There is evidence of 40% stenosis with some calcification noted at the proximal left anterior descending artery right at the bifurcation to the diagonal 1 branch. There is also 20% stenosis at the ostium of diagonal 1 branch.

Left circumflex artery: The left circumflex artery is a very large vessel. It is the dominant vessel. It is also tortuous in nature. It gives rise to 1 large obtuse marginal branch which further bifurcates and distally gives rise to branches traveling toward the posterolateral wall. There is no significant disease in the left circumflex artery.

Right coronary artery: The right coronary artery is a small size caliber vessel. It is nondominant. It gives rise to the conus branch, RV marginal branch. There is some mild luminal irregularity in the proximal to mid right coronary artery.

There is evidence of rapid filling from the left coronary artery system to the left ventricle suggestive of coronary artery to a left ventricle fistula.

RIGHT COMMON FEMORAL ARTERY ANGIOGRAPHY:

The right common femoral artery is a regular size caliber vessel. It bifurcates into superficial femoral and deep profunda artery. The needle insertion is above the bifurcation and below the inferior epigastric artery, which is suitable for closure device. There is no evidence of any stenosis noted.

IMPRESSION:

1. The patient has nonobstructive coronary artery disease with 40% stenosis in the proximal left anterior descending right at the bifurcation of the diagonal branch. There is also evidence of 20% stenosis in the ostium of the diagonal branch.
2. There is evidence of coronary artery to left ventricle fistula with a rapid filling from the coronary artery to the left ventricle.
3. Diastolic dysfunction with left ventricular end-diastolic pressure at 24 mmHg.
4. Hyperdynamic left ventricle with small left ventricular cavity. The left ventricular ejection fraction is more than 65%.

RECOMMENDATION:

To continue medical management for the nonobstructive coronary artery disease including aspirin, statins, ACE inhibitor and would add a beta-blocker, Toprol 25 mg daily to his regimen.

Start Your Cath Coding Here

The report gives a description and findings for selective coronary angiography, left heart measurements, and left

ventriculogram (LVgram). CPT® includes all of these services in 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 **Robin Stuart, CPC**, a coder for PeaceHealth Heart and Vascular Cardiology Clinic and President of her local Vancouver, Wash., AAPC Chapter.

Don't miss: Remember that for hospital procedures, the physician should append modifier 26 (Professional component) to 93458, says **Jessica Carriveau, CPC, CCC**, a coder for Prevea Health in Wisconsin.

LHC tip: In this case, the physician clearly crossed the aortic valve and performed a left heart catheterization (LHC), says Carriveau. There are LV pressures documented and the LVgram clinches it. You "can't go into the left ventricle unless you cross the aortic valve," she emphasizes.

Add-On Depends on Intent

After the coronary angiography, LHC, and LVgram, the physician describes ascending aortography. The code for this service is +93567 (Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for supra-avalvular aortography [List separately in addition to code for primary procedure]), says Carriveau.

Reality check: Many payers may deny +93567 because the findings of the aortogram in this case were normal, says **Christina Neighbors, MA, CPC, CCC, ACS-CA**, charge capture reconciliation specialist and coder at St. Joseph Heart & Vascular Center in Tacoma, Wash. Be sure to check your payer's local coverage determination (LCD) for covered diagnoses, she says. You must code only those diagnoses supported by the documentation, but checking the policy will give you a heads up about coverage. Also remember that ICD-9 guidelines instruct you not to report "rule out" or similarly uncertain diagnoses.

Beware: Understanding the intention behind a service is a key aspect of determining whether you may code it separately. For instance, before you code ascending aortography, remember that +93567 is "appropriate only for diagnostic purposes to determine competency of the ascending aorta," says Neighbors. Examples include looking for "aortic root disease, valvular heart disease, or congenital heart disease," she explains.

You should not report +93567 if the physician injects contrast because he needs help locating the patient's grafts, says Carriveau. That imaging is included in the payment for the graft studies, she adds.

Similarly, if the cardiologist injects contrast to help visualize the coronary ostia as part of coronary angiography, you should include that service in the coronary angiography, Neighbors says.

Focus on Reason for Femoral Angiography

The final services the physician describes are femoral angiography and closure.

Again, documentation of the intent of the imaging is important. "The right common femoral artery angiography is not billable as it was done strictly for the closure device," says Stuart.

Support: Carriveau cites the following quote from Medicare's National Correct Coding Initiative manual, Chapter XI: "19. Placement of an occlusive device such as an angio seal or vascular plug into an arterial or venous access site after cardiac catheterization or other diagnostic or interventional procedure should be reported with HCPCS code G0269 [Placement of occlusive device into either a venous or arterial access site, post surgical or interventional procedure (e.g. angioseal plug, vascular plug)]. A physician should not separately report an associated imaging code such as CPT® code 75710 [Angiography, extremity ...] or HCPCS code G0278 [Iliac and/or femoral artery angiography, non-selective ...]."

Keep in mind that physicians won't be paid for G0269, so reporting this code would be for statistical purposes only.

Dig Into Your Diagnosis Options

To complete your claim, you need to assign diagnosis codes to support medical necessity

Documentation of coronary artery disease points to 414.01 (Coronary atherosclerosis of native coronary artery), says Stuart. Code 414.01 may be sufficient to demonstrate medical necessity for the service.

The impression section also documents diastolic dysfunction, which falls under the unspecified code 429.9 (Heart disease unspecified). Payers may or may not cover the services for this unspecified code on its own.

If your payer requires further support or if there had been no definitive diagnosis, you also should look at the indications that led to the test. Code 794.39 (Other nonspecific abnormal function study of cardiovascular system) applies for the abnormal stress test, says Carriveau. Another reason for the cardiac cath was the patient's diabetes (250.00, Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled). Code 786.50 (Unspecified chest pain) describes the patient's chest pain.