Getting to the Heart of the Errors

CARDIAC CATHETERIZATION CODING

By Jackie Miller, RHIA, CPC

When it comes to billing for heart catheterization, many cardiology practices are tripped up by the same coding errors. Some of these errors can result in missed reimbursement, while others pose the risk of overpayment and billing compliance issues.

Here is a brief description of some errors that are commonly seen on cardiology coding audits.

INJECTION CODES

CPT® contains a series of codes (93539-93545) that are used to report contrast injection for diagnostic imaging. Each of these codes can be reported only once per encounter, regardless of how many different structures are injected. For example, code 93543 is used to report injection of the left ventricle and/or left atrium. Only one unit of 93543 can be reported even if both the atrium and the ventricle are injected. Reporting multiple units can result in an overpayment and/or compliance risk.

There are two CPT® codes for injections of grafts. Code 93539 is used to report injection of arterial grafts or conduits—for example, injection of the left internal mammary artery (whether grafted or non-grafted), or injection of a free radial artery graft. Code 93540 is used to report injection of a vein graft. If the medical record reflects injection of both an arterial graft or conduit *and* a vein graft, both 93539 and 93540 should be reported. Failure to assign both codes will result in lost reimbursement. Remember, however, that only one unit of each code can be assigned regardless of how many grafts were injected.

IMAGING CODES

CPT® contains two codes that are used to report diagnostic imaging during cardiac catheterization. Code 93555 is used to report imaging of one or more heart chambers (left or right atrium or ventricle). Code 93556 is used to report imaging of blood vessels, including the coronary arteries, bypass grafts, pulmonary arteries, etc. Like the injection codes, the imaging codes can be reported only once per encounter, even if multiple areas are imaged.

Codes 93555-93556 should be reported only for imaging related to *diagnostic* cardiac catheterization. If the patient undergoes a diagnostic heart catheterization, a coronary lesion is found, and the physician performs an intervention during the same session, both the diagnostic heart cath and the intervention (e.g., stenting) should be coded. On the other hand, if the patient has had a prior heart cath and returns at this time for treatment of a known lesion, only the intervention should be reported. Injection codes (93539-93545) and imaging codes (93555-93556) should *not* be reported unless a full initial diagnostic cardiac catheterization is performed.

CORONARY ARTERY CATHETERIZATION

CPT® code 93508 should be assigned when diagnostic coronary artery catheterization is performed without left heart catheterization (i.e., when the catheter does not cross the aortic valve). Physicians frequently refer to this procedure as a left heart cath, but unless the catheter is advanced into the left ventricle, the left heart catheterization code (93510) should not be assigned.

INTERVENTIONS

If a diagnostic heart catheterization procedure is followed by a coronary intervention during the same encounter, modifier 59 must be applied to the diagnostic imaging codes (93555 and/or 93556) to show that they represent an initial diagnostic exam rather than the imaging related to the intervention. If modifier 59 is not applied, codes 93555-93556 will be bundled under the Correct Coding edits into the intervention (for example, 92980 for coronary artery stenting). This will result in lost reimbursement for the imaging.

Stent placement, angioplasty, and atherectomy are considered "major" coronary interventions. Only one of these interventions can be reported per coronary artery. Stent placement includes any angioplasty or atherectomy that is performed in the same vessel, and atherectomy includes any angioplasty in the same vessel.

Unlike the other coronary interventions, coronary thrombectomy (CPT® code 92973) can be reported together with other therapeutic procedures in the same coronary artery. For example, if the physician places a stent and performs a thrombectomy in the left anterior descending coronary artery, codes 92980 (stent placement) and 92973 (thrombectomy) should both be reported. Failure to assign 92973 will result in lost reimbursement.

Billing companies can do their cardiology clients a great service by helping them to ensure that their claims do not include any of these common coding errors. ▲

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