Optum

Coding Companion

Cardiology/ Cardiothoracic/ Vascular Surgery

A comprehensive illustrated guide to coding and reimbursement

2024

optumcoding.com

Contents

Getting Started with Coding Companion

Coding Companion for Cardiology/Cardiothoracic/Vascular Surgery is designed to be a guide to the specialty procedures classified in the CPT® book. It is structured to help coders understand procedures and translate physician narrative into correct CPT codes by combining many clinical resources into one, easy-to-use source book.

The book also allows coders to validate the intended code selection by providing an easy-to-understand explanation of the procedure and associated conditions or indications for performing the various procedures. As a result, data quality and reimbursement will be improved by providing code-specific clinical information and helpful tips regarding the coding of procedures.

CPT/HCPCS Codes

For ease of use, evaluation and management codes related to cardiology/cardiothoracic/vascular surgery are listed first in the *Coding Companion*. All other CPT codes in *Coding Companion* are listed in ascending numeric order. Included in the code set are all surgery, radiology, laboratory, and medicine codes pertinent to the specialty. Each CPT/HCPCS code is followed by its official CPT code description.

Resequencing of CPT Codes

The American Medical Association (AMA) employs a resequenced numbering methodology. According to the AMA, there are instances where a new code is needed within an existing grouping of codes, but an unused code number is not available to keep the range sequential. In the instance where the existing codes were not changed or had only minimal changes, the AMA assigned a code out of numeric sequence with the other related codes being grouped together. The resequenced codes and their descriptions have been placed with their related codes, out of numeric sequence.

CPT codes within the Optum *Coding Companion* series display in their resequenced order. **Resequenced codes are enclosed in brackets [ ] for easy identification.**

ICD-10-CM

The most current ICD-10-CM codes are provided, each listed with their full official description. Refer to the ICD-10-CM book for more ICD-10-CM coding information.

Detailed Code Information

One or more columns are dedicated to each procedure or service or to a series of similar procedures/services. Following the specific CPT code and its narrative, is a combination of features.

Appendix Codes and Descriptions

Some CPT/HCPCS codes are presented in a less comprehensive format in the appendix. The CPT/HCPCS codes appropriate to the specialty are included in the appendix with the official CPT code description, followed by an easy-to-understand explanation.

The codes in the appendix are presented in the following order:

- HCPCS
- Surgery
- Radiology
- Pathology and Laboratory
- Medicine Services
- Category III

Category II codes are not published in this book. Refer to the CPT book for code descriptions.

CCI Edits, RVUs, HCPCS, and Other Coding Updates

The *Coding Companion* includes the list of codes from the official Centers for Medicare and Medicaid Services' National Correct Coding Policy Manual for Part B Medicare Contractors that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version 28.3, the most current version available at press time. CCI edits are updated quarterly and will be posted on the product updates page listed below. The website address is http://www.optumcoding.com/ProductUpdates/. The 2024 edition password is: **XXXX.** Log in frequently to ensure you receive the most current updates.

Index

A comprehensive index is provided for easy access to the codes. The index entries have several axes. A code can be looked up by its procedural name or by the diagnoses commonly associated with it. Codes are also indexed anatomically. For example:

32800 Repair lung hernia through chest wall

could be found in the index under the following main terms:

Hernia
Repair
Lung, 32800

or **Repair**
Lung
Hernia, 32800

General Guidelines

Providers

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, it is not limited to use only by that specialty group (see paragraphs two and three under "Instructions for Use of the CPT Codebook" on page xiv of the CPT Book). Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies). Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Supplies

Some payers may allow physicians to separately report drugs and other supplies when reporting the place of service as office or other nonfacility setting. Drugs and supplies are to be reported by the facility only when performed in a facility setting.

Professional and Technical Component

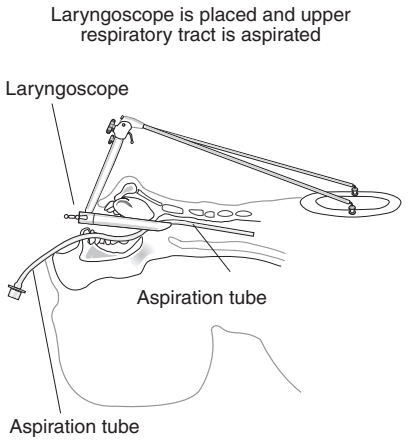
Radiology and some pathology codes often have a technical and a professional component. When physicians do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

Sample Page and Key

The following pages provide a sample page from the book displaying the format of *Coding Companion* with each element identified and explained.

31515

31515 Laryngoscopy direct, with or without tracheoscopy; for aspiration



Explanation

The physician uses an aspirator to remove excess saliva or semi-solid foreign material from the larynx. After applying topical anesthesia to the oral cavity and pharynx, the physician inserts the laryngoscope through the patient's mouth. An aspirator is fed through the laryngoscope and the larynx is cleared of saliva and semi-solid foreign material. If a tracheoscopy is performed, a bronchoscope is inserted through the laryngoscope for microscopic visualization of the trachea and bronchi. No other procedure is performed.

Coding Tips

Laryngoscopy code selection is dependent on two variables. Laryngoscopy procedures may be either direct or indirect, and they may be performed with either a rigid or flexible scope. A direct laryngoscopy allows the physician to see the larynx through a scope in the throat. In contrast, when an indirect laryngoscopy is performed, the physician uses mirrors to visualize the larynx. Code 31515 refers to direct visualization with a rigid laryngoscope. Report the appropriate endoscopy for each anatomic site examined. Surgical endoscopy includes a diagnostic endoscopy; however, diagnostic endoscopy can be identified separately when performed at the same surgical session as an open procedure.

ICD-10-CM Diagnostic Codes

J04.0	Acute laryngitis
J05.0	Acute obstructive laryngitis [croup]
J38.3	Other diseases of vocal cords
J38.7	Other diseases of larynx
J39.0	Retropharyngeal and parapharyngeal abscess
J39.8	Other specified diseases of upper respiratory tract
J69.0	Pneumonitis due to inhalation of food and vomit
J69.1	Pneumonitis due to inhalation of oils and essences
J69.8	Pneumonitis due to inhalation of other solids and liquids
J95.01	Hemorrhage from tracheostomy stoma
J95.02	Infection of tracheostomy stoma
J95.09	Other tracheostomy complication
J95.859	Other complication of respirator [ventilator]
J95.88	Other intraoperative complications of respiratory system, not elsewhere classified
J95.89	Other postprocedural complications and disorders of respiratory system, not elsewhere classified
O89.01	Aspiration pneumonitis due to anesthesia during the puerperium M ♀
P24.01	Meconium aspiration with respiratory symptoms N
P24.11	Neonatal aspiration of (clear) amniotic fluid and mucus with respiratory symptoms N
P24.21	Neonatal aspiration of blood with respiratory symptoms N
P24.31	Neonatal aspiration of milk and regurgitated food with respiratory symptoms N
P24.81	Other neonatal aspiration with respiratory symptoms N
R04.1	Hemorrhage from throat
R04.2	Hemoptysis
R04.81	Acute idiopathic pulmonary hemorrhage in infants P
R04.89	Hemorrhage from other sites in respiratory passages
R09.3	Abnormal sputum
T81.41XA	Infection following a procedure, superficial incisional surgical site, initial encounter
T81.42XA	Infection following a procedure, deep incisional surgical site, initial encounter
T81.43XA	Infection following a procedure, organ and space surgical site, initial encounter
T81.44XA	Sepsis following a procedure, initial encounter
T81.49XA	Infection following a procedure, other surgical site, initial encounter

Associated HCPCS Codes

A4305	Disposable drug delivery system, flow rate of 50 ml or greater per hour

AMA: **31515** 2020,Dec; 2019,Sep

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
31515	1.8	4.36	0.25	6.41
Facility RVU	**Work**	**PE**	**MP**	**Total**
31515	1.8	1.22	0.25	3.27

	FUD	Status	MUE	Modifiers				IOM Reference
31515	0	A	1(3)	51	N/A	N/A	N/A	None

* with documentation

Terms To Know

direct laryngoscopy. Endoscopic instrument, such as a flexible or rigid fiberoptic scope, inserted into the larynx for direct viewing capabilities of the voice box and vocal cords.

larynx. Musculocartilaginous structure between the trachea and the pharynx that functions as the valve preventing food and other particles from entering the respiratory tract, as well as the voice mechanism. Also called the voicebox, the larynx is composed of three single cartilages: cricoid, epiglottis, and thyroid; and three paired cartilages: arytenoid, corniculate, and cuneiform.

trachea. Tube descending from the larynx and branching into the right and left main bronchi.

1. CPT/HCPCS Codes and Descriptions

This edition of *Coding Companion* is updated with CPT and HCPCS codes for year 2023.

The following icons are used in *Coding Companion:*

- ● This CPT code is new for 2023.
- ▲ This CPT code description is revised for 2023.
- ✚ This CPT code is an add-on code.

Add-on codes are not subject to bilateral or multiple procedure rules, reimbursement reduction, or appending modifier 50 or 51. Add-on codes describe additional intraservice work associated with the primary procedure performed by the same physician on the same date of service and are not reported as stand-alone procedures. Add-on codes for procedures performed on bilateral structures are reported by listing the add-on code twice.

- ★ This CPT code is identified by CPT as appropriate for audio-visual telemedicine services.

The Centers for Medicare and Medicaid Services (CMS) have identified additional services that may be performed via telehealth. Due to the COVID-19 public health emergency (PHE), some services have been designated as temporarily appropriate for telehealth. These CMS approved services are identified in the coding tips where appropriate. Payers may require telehealth/telemedicine to be reported with place of service 02 Telehealth Provided Other than the Patient's Home or 10 Telehealth Provided in Patient's Home and modifier 93 or 95 appended. If specialized equipment is used at the originating site, HCPCS Level II code Q3014 may be reported. Individual payers should be contacted for additional or different guidelines regarding telehealth/telemedicine services. Documentation should include the type of technology used for the treatment in addition to the patient evaluation, treatment, and consents.

According to CPT guidelines, the codes listed below may be used for reporting audio-only telemedicine services, when modifier 93 Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System, is appended. These procedures involve electronic communication using interactive telecommunications equipment that at a minimum includes audio.

90785	90791	90792	90832	90833	90834	90836
90837	90838	90839	90840	90845	90846	90847
92507	92508	92521	92522	92523	92524	96040
96110	96116	96160	96161	97802	97803	97804
99406	99407	99408	99409	99497	99498	

2. Illustrations

The illustrations that accompany the *Coding Companion* series provide coders a better understanding of the medical procedures referenced by the codes and data. The graphics offer coders a visual link between the technical language of the operative report and the cryptic descriptions accompanying the codes. Although most pages will have an illustration, there will be some pages that do not.

3. Explanation

Every CPT code or series of similar codes is presented with its official CPT code description. However, sometimes these descriptions do not provide the coder with sufficient information to make a proper code selection. In *Coding Companion*, an easy-to-understand step-by-step clinical description of the procedure is provided. Technical language that might be used by the physician is included and defined. *Coding Companion* describes the most common method of performing each procedure.

4. Coding Tips

Coding tips provide information on how the code should be used, provides related CPT codes, and offers help concerning common billing errors, modifier usage, and anesthesia. This information comes from consultants and subject matter experts at Optum and from the coding guidelines provided in the CPT book and by the Centers for Medicare and Medicaid Services (CMS).

5. ICD-10-CM Diagnostic Codes

ICD-10-CM diagnostic codes listed are common diagnoses or reasons the procedure may be necessary. This list in most cases is inclusive to the specialty. Some ICD-10-CM codes are further identified with the following icons:

- N Newborn: 0
- P Pediatric: 0-17
- M Maternity: 9-64
- A Adult: 15-124
- ♂ Male only
- ♀ Female Only
- ☑ Laterality

Please note that in some instances the ICD-10-CM codes for only one side of the body (right) have been listed with the CPT code. The associated ICD-10-CM codes for the other side and/or bilateral may also be appropriate. Codes that refer to the right or left are identified with the ☑ icon to alert the user to check for laterality. In some cases, not every possible code is listed and the ICD-10-CM book should be referenced for other valid codes.

6. Associated HCPCS Codes

Medicare and some other payers require the use of HCPCS Level II codes and not CPT codes when reporting certain services. The HCPCS codes and their description are displayed in this field. If there is not a HCPCS code for this service, this field will not be displayed.

7. AMA References

The AMA references for *CPT Assistant* are listed by CPT code, with the most recent reference listed first. Generally only the last six years of references are listed.

8. Relative Value Units/Medicare Edits

Medicare edits are provided for most codes. These Medicare edits were current as of November 2022.

The 2023 Medicare edits were not available at the time this book went to press. Updated 2023 values will be posted at https://www.optumcoding.com/ProductUpdates/. The 2023 edition password is **23SPECIALTY**.

Relative Value Units

In a resource based relative value scale (RBRVS), services are ranked based on the relative costs of the resources required to provide those services as opposed to the average fee for the service, or average prevailing Medicare charge. The Medicare RBRVS defines three distinct components affecting the value of each service or procedure:

- Physician work component, reflecting the physician's time and skill
- Practice expense (PE) component, reflecting the physician's rent, staff, supplies, equipment, and other overhead
- Malpractice (MP) component, reflecting the relative risk or liability associated with the service
- Total RVUs are a sum of the work, PE, and MP RVUs

There are two groups of RVUs listed for each CPT code. The first RVU group is for facilities (Facility RVU), which includes provider services performed in hospitals, ambulatory surgical centers, or skilled

Evaluation and Management (E/M) Services Guidelines

E/M Guidelines Overview

▶The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter with the patient and/or family/caregiver. (For 99211 and 99281, the face-to-face services may be performed by clinical staff.)

In the **Evaluation and Management** section (99202-99499), there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home or Residence Services
- Prolonged Service With or Without Direct Patient Contact on the Date of an Evaluation and Management Service◀

Classification of Evaluation and Management (E/M) Services

▶The E/M section is divided into broad categories, such as office visits, hospital inpatient or observation care visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital inpatient and observation care visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified (eg, office or other outpatient visit). Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided in the Guidelines for Selecting Level of Service Based on Time.)

The place of service and service type are defined by the location where the face-to-face encounter with the patient and/or family/caregiver occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.◀

New and Established Patients

▶Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

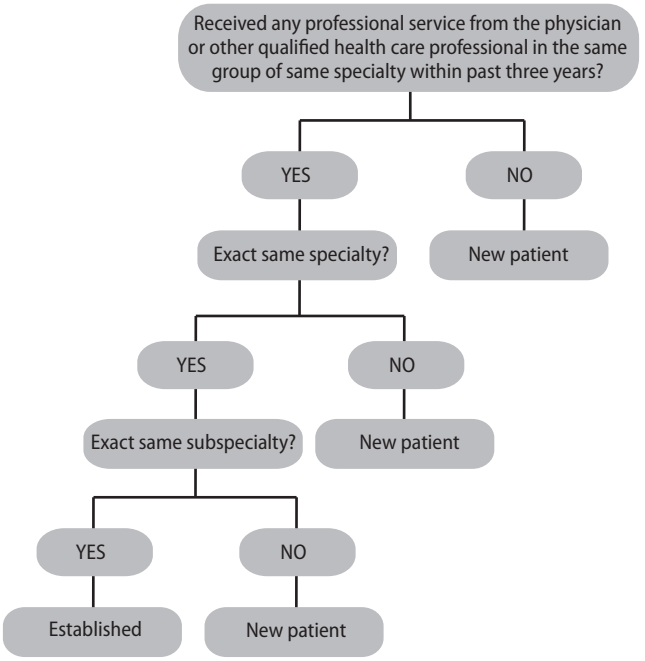
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the **exact** same specialty **and subspecialty** as the physician.◀

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The Decision Tree for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Decision Tree for New vs Established Patients



AMA CPT® Evaluation and Management (E/M) Services Guidelines reproduced with permission of the American Medical Association.

99202-99205

★**99202** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

★**99203** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

★**99204** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

★**99205** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

Explanation

Providers report these codes for new patients being seen in the doctor's office, a multispecialty group clinic, or other outpatient environment. All require a medically appropriate history and/or examination. Code selection is based on the level of medical decision making (MDM) or total time personally spent by the physician and/or other qualified health care professional(s) on the date of the encounter. Factors to be considered in MDM include the number and complexity of problems addressed during the encounter, amount and complexity of data requiring review and analysis, and the risk of complications and/or morbidity or mortality associated with patient management. The most basic service is represented by 99202, which entails straightforward MDM. If time is used for code selection, 15 to 29 minutes of total time is spent on the day of encounter. Report 99203 for a visit requiring a low level of MDM or 30 to 44 minutes of total time; 99204 for a visit requiring a moderate level of MDM or 45 to 59 minutes of total time; and 99205 for a visit requiring a high level of MDM or 60 to 74 minutes of total time.

Coding Tips

These codes are used to report office or other outpatient services for a new patient. A medically appropriate history and physical examination, as determined by the treating provider, should be documented. The level of history and physical examination are not considered when determining the level of service. Codes should be selected based upon the current CPT Medical Decision Making table. Alternately, time alone may be used to select the appropriate level of service. Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the date of the encounter. For office or other outpatient services for an established patient, see 99211-99215. For patients admitted and discharged from inpatient or observation care on the same date, see 99234-99236. For prolonged services with 99205, see 99417; for Medicare, see G2212. Medicare has identified these codes as telehealth/telemedicine services. Commercial payers should be contacted regarding their coverage guidelines. Telemedicine services may be reported by the performing provider by adding modifier 95 to these procedure codes and using the appropriate place of service. Services at the origination site are reported with HCPCS Level II code Q3014.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

AMA: **99202** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99203** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99204** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99205** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.12	0.09	2.14
99203	1.6	1.52	0.17	3.29
99204	2.6	2.06	0.24	4.9
99205	3.5	2.66	0.32	6.48
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.41	0.09	1.43
99203	1.6	0.67	0.17	2.44
99204	2.6	1.11	0.24	3.95
99205	3.5	1.54	0.32	5.36

	FUD	Status	MUE	Modifiers				IOM Reference
99202	N/A	A	1(2)	N/A	N/A	N/A	80*	None
99203	N/A	A	1(2)	N/A	N/A	N/A	80*	
99204	N/A	A	1(2)	N/A	N/A	N/A	80*	
99205	N/A	A	1(2)	N/A	N/A	N/A	80*	

* with documentation

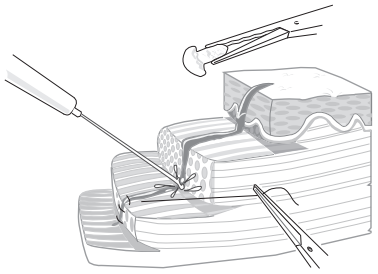
Terms To Know

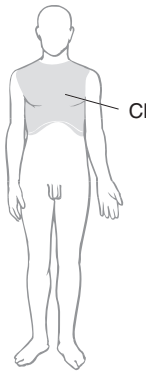
new patient. Patient who is receiving face-to-face care from a physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice for the first time in three years. For OPPS hospitals, a patient who has not been registered as an inpatient or outpatient, including off-campus provider-based clinic or emergency department, within the past three years.

outpatient visit. Encounter in a recognized outpatient facility.

20101

20101 Exploration of penetrating wound (separate procedure); chest





A penetrating wound of the chest is explored. The depth of the wound is assessed and the tissues debrided of fragments. Repairs and closures are made as needed

Explanation

The physician explores a penetrating wound of the chest in the operating room, such as a gunshot or stab wound, to help identify damaged structures. Nerve, organ, and blood vessel integrity is assessed. The wound may be enlarged to help assess the damage. Debridement, removal of foreign bodies, and ligation or coagulation of minor blood vessels in the subcutaneous tissues, fascia, and muscle are also included in this code. Damaged tissues are debrided and repaired when possible. The wound is closed (if clean) or packed open if contaminated by the penetrating body.

Coding Tips

This separate procedure by definition is usually a component of a more complex service and is not identified separately. When performed alone or with other unrelated procedures/services, it may be reported. If performed alone, list the code; if performed with other procedures/services, list the code and append modifier 59 or an X{EPSU} modifier. This code includes debridement, enlargement of the wound (to determine penetration), removal of foreign body, and minor blood vessel ligation or coagulation. If major repair is performed on a major structure or major blood vessel, requiring thoracotomy, then 20101 is not reported separately. For simple, intermediate, or complex repair that does not require enlargement of the wound, report the specific codes for repair instead of 20101. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

S21.111A Laceration without foreign body of right front wall of thorax without penetration into thoracic cavity, initial encounter

S21.112A Laceration without foreign body of left front wall of thorax without penetration into thoracic cavity, initial encounter

S21.121A Laceration with foreign body of right front wall of thorax without penetration into thoracic cavity, initial encounter

S21.122A Laceration with foreign body of left front wall of thorax without penetration into thoracic cavity, initial encounter

S21.131A Puncture wound without foreign body of right front wall of thorax without penetration into thoracic cavity, initial encounter

S21.132A Puncture wound without foreign body of left front wall of thorax without penetration into thoracic cavity, initial encounter

S21.141A Puncture wound with foreign body of right front wall of thorax without penetration into thoracic cavity, initial encounter

S21.142A Puncture wound with foreign body of left front wall of thorax without penetration into thoracic cavity, initial encounter

S21.151A Open bite of right front wall of thorax without penetration into thoracic cavity, initial encounter

S21.152A Open bite of left front wall of thorax without penetration into thoracic cavity, initial encounter

S21.211A Laceration without foreign body of right back wall of thorax without penetration into thoracic cavity, initial encounter

S21.212A Laceration without foreign body of left back wall of thorax without penetration into thoracic cavity, initial encounter

S21.221A Laceration with foreign body of right back wall of thorax without penetration into thoracic cavity, initial encounter

S21.222A Laceration with foreign body of left back wall of thorax without penetration into thoracic cavity, initial encounter

S21.231A Puncture wound without foreign body of right back wall of thorax without penetration into thoracic cavity, initial encounter

S21.232A Puncture wound without foreign body of left back wall of thorax without penetration into thoracic cavity, initial encounter

S21.241A Puncture wound with foreign body of right back wall of thorax without penetration into thoracic cavity, initial encounter

S21.242A Puncture wound with foreign body of left back wall of thorax without penetration into thoracic cavity, initial encounter

S21.251A Open bite of right back wall of thorax without penetration into thoracic cavity, initial encounter

S21.252A Open bite of left back wall of thorax without penetration into thoracic cavity, initial encounter

S29.021A Laceration of muscle and tendon of front wall of thorax, initial encounter

S29.022A Laceration of muscle and tendon of back wall of thorax, initial encounter

S29.091A Other injury of muscle and tendon of front wall of thorax, initial encounter

S29.092A Other injury of muscle and tendon of back wall of thorax, initial encounter

S29.8XXA Other specified injuries of thorax, initial encounter

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
20101	3.23	14.0	0.83	18.06
Facility RVU	**Work**	**PE**	**MP**	**Total**
20101	3.23	2.23	0.83	6.29

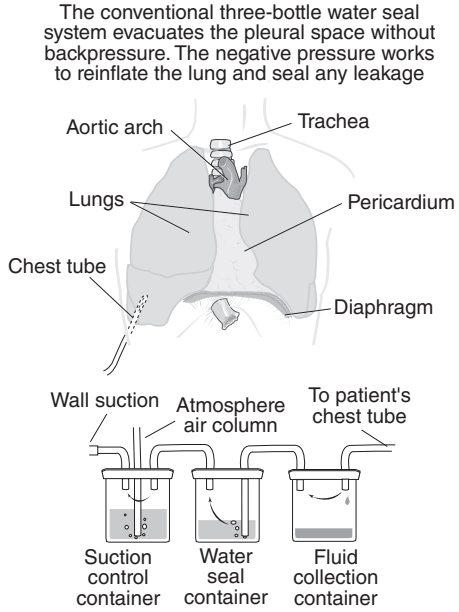
	FUD	Status	MUE	Modifiers				IOM Reference
20101	10	A	2(3)	51	N/A	N/A	N/A	None

* with documentation

 N Newborn: 0 **P** Pediatric: 0-17 **M** Maternity: 9-64 **A** Adult: 15-124 ♂ Male Only ♀ Female Only

32551

32551 Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open (separate procedure)



Explanation

The physician removes fluid and/or air from the chest cavity by puncturing through the space between the ribs. To enter the chest cavity, the physician passes a trocar over the top of a rib, punctures through the chest tissues between the ribs, and enters the pleural cavity. Separately reportable imaging guidance may be used. With the end of the trocar in the chest cavity, the physician advances the plastic tube into the chest cavity. The sharp trocar is removed leaving one end of the plastic catheter in place within the chest cavity. A large syringe is attached to the outside end of the catheter and the fluid (blood or pus) is removed from the chest cavity by pulling back on the plunger of the syringe. The outside end of the tube may be connected to a drainage system, such as a water seal, to prevent air from being sucked into the chest cavity and to allow continuous or intermittent removal of air or fluid.

Coding Tips

When medically necessary, report moderate (conscious) sedation provided by the performing physician with 99151-99153. When provided by another physician, report 99155-99157. Do not report 32551 with 33020 or 33025 if a pleural drain is placed on the same side. For pleural drainage, percutaneous, with insertion of an indwelling catheter, see 32556–32557. Do not report 32551 with 43287 or 43288. For radiological supervision and interpretation, see 75989.

ICD-10-CM Diagnostic Codes

J86.0	Pyothorax with fistula
J86.9	Pyothorax without fistula
J90	Pleural effusion, not elsewhere classified
J91.0	Malignant pleural effusion
J91.8	Pleural effusion in other conditions classified elsewhere
J93.0	Spontaneous tension pneumothorax
J93.11	Primary spontaneous pneumothorax
J93.12	Secondary spontaneous pneumothorax
J93.81	Chronic pneumothorax
J93.82	Other air leak
J93.83	Other pneumothorax
J94.0	Chylous effusion
J94.2	Hemothorax
J94.8	Other specified pleural conditions
J95.811	Postprocedural pneumothorax
P26.0	Tracheobronchial hemorrhage originating in the perinatal period N
P26.1	Massive pulmonary hemorrhage originating in the perinatal period N
P26.8	Other pulmonary hemorrhages originating in the perinatal period N
S27.0XXA	Traumatic pneumothorax, initial encounter
S27.1XXA	Traumatic hemothorax, initial encounter
S27.2XXA	Traumatic hemopneumothorax, initial encounter

AMA: 32551 2021,Nov; 2019,Dec; 2018,Jul; 2017,Jun

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
32551	3.04	1.02	0.55	4.61
Facility RVU	**Work**	**PE**	**MP**	**Total**
32551	3.04	1.02	0.55	4.61

	FUD	Status	MUE	Modifiers				IOM Reference
32551	0	A	2(3)	51	50	N/A	N/A	None

* with documentation

Terms To Know

hemothorax. Blood collecting in the pleural cavity.

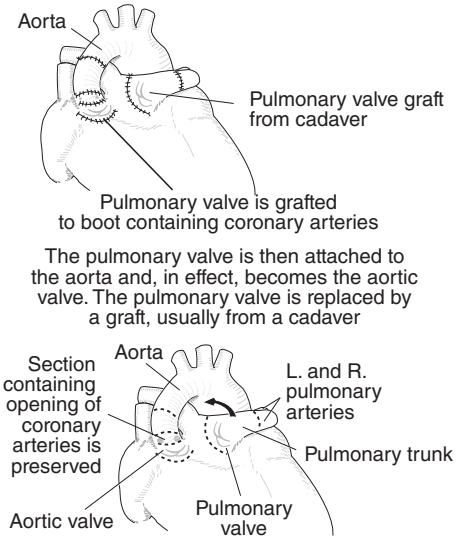
pneumothorax. Collapsed lung due to air or gas trapped in the pleural space formed by the membrane that encloses the lungs and lines the thoracic cavity.

thoracostomy. Creation of an opening in the chest wall for drainage.

trocar. Cannula or a sharp pointed instrument used to puncture and aspirate fluid from cavities.

33413

33413 Replacement, aortic valve; by translocation of autologous pulmonary valve with allograft replacement of pulmonary valve (Ross procedure)



Explanation

Cardiopulmonary bypass is initiated. The aorta and pulmonary artery are separated and the main pulmonary trunk is completely cleaned off. After the heart is stopped, the pulmonary trunk is detached from the branching point of the left and right pulmonary arteries. It is taken off the heart with a small lip of heart muscle. Care is taken when the muscle of interventricular septum is cut. It is possible to damage a large branch of the left anterior descending coronary artery when this muscle is cut. The aorta is opened above the valve. The coronary arteries are detached from the aorta with a surrounding "button" of aortic wall. Next, the aortic valve and its annulus are removed from the heart. A length of the ascending aorta is also removed. The pulmonary artery is sewn to the heart in the aortic position. The commissures and cusps of the pulmonary valve are lined up to be in the same positions as their aortic counterparts were before the aortic valve was removed. The open end of the pulmonary artery is sewn to the ascending aorta. The coronary arteries are re-implanted on the pulmonary artery in positions similar to their positions on the aorta. The pulmonary valve and artery from an organ donor are sewn into the pulmonary position.

Coding Tips

For reoperation on the aortic valve more than one month after the original procedure, report 33530 in addition to the code for the primary procedure. When more than one valve (aortic, mitral, tricuspid, pulmonary) is being repaired or replaced, report each procedure separately and append modifier 51 to the secondary valve procedures. Do not report 33413 with 33412 or 33440. For valvuloplasty of the aortic valve, see 33390–33391. For construction of the apical aortic conduit, see 33404. For the Ross-Konno procedure, see 33440.

ICD-10-CM Diagnostic Codes

I06.0	Rheumatic aortic stenosis
I06.1	Rheumatic aortic insufficiency
I06.2	Rheumatic aortic stenosis with insufficiency
I06.8	Other rheumatic aortic valve diseases
I08.0	Rheumatic disorders of both mitral and aortic valves
I08.8	Other rheumatic multiple valve diseases
I35.0	Nonrheumatic aortic (valve) stenosis
I35.1	Nonrheumatic aortic (valve) insufficiency
I35.2	Nonrheumatic aortic (valve) stenosis with insufficiency
I35.8	Other nonrheumatic aortic valve disorders
Q23.0	Congenital stenosis of aortic valve
Q25.21	Interruption of aortic arch
Q25.29	Other atresia of aorta
Q25.3	Supravalvular aortic stenosis
T82.01XA	Breakdown (mechanical) of heart valve prosthesis, initial encounter
T82.02XA	Displacement of heart valve prosthesis, initial encounter
T82.03XA	Leakage of heart valve prosthesis, initial encounter
T82.09XA	Other mechanical complication of heart valve prosthesis, initial encounter
T82.6XXA	Infection and inflammatory reaction due to cardiac valve prosthesis, initial encounter
T82.817A	Embolism due to cardiac prosthetic devices, implants and grafts, initial encounter
T82.827A	Fibrosis due to cardiac prosthetic devices, implants and grafts, initial encounter
T82.837A	Hemorrhage due to cardiac prosthetic devices, implants and grafts, initial encounter
T82.847A	Pain due to cardiac prosthetic devices, implants and grafts, initial encounter
T82.855A	Stenosis of coronary artery stent, initial encounter
T82.857A	Stenosis of other cardiac prosthetic devices, implants and grafts, initial encounter
T82.867A	Thrombosis due to cardiac prosthetic devices, implants and grafts, initial encounter
T82.897A	Other specified complication of cardiac prosthetic devices, implants and grafts, initial encounter

AMA: **33413** 2019,Nov; 2019,Apr; 2017,Dec

Relative Value Units/Medicare Edits

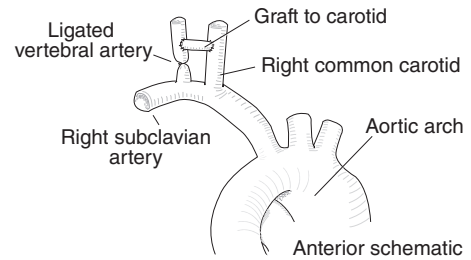
Non-Facility RVU	Work	PE	MP	Total
33413	59.87	20.68	14.02	94.57
Facility RVU	**Work**	**PE**	**MP**	**Total**
33413	59.87	20.68	14.02	94.57

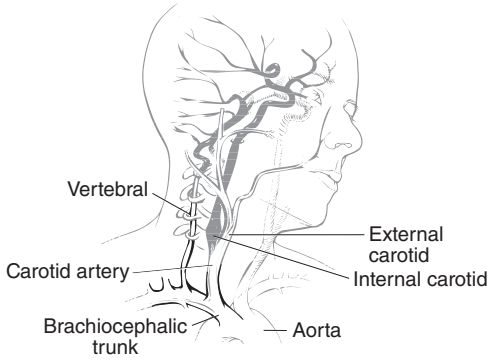
	FUD	Status	MUE	Modifiers				IOM Reference
33413	90	A	1(2)	51	N/A	62*	80	None

* with documentation

35691

35691 Transposition and/or reimplantation; vertebral to carotid artery





Explanation

The physician performs a supraclavicular incision and exposes the vertebral and carotid arteries by careful dissection. The adventitia of the chosen translocation site in the posterolateral wall of the common carotid artery is cleared. The physician anticoagulates the patient with heparin and divides the vertebral artery above the stenotic area. The proximal vertebral stump is ligated with sutures and a small arteriotomy in the common carotid arterial wall with an aortic punch is performed. The vertebral artery is attached using an end-to-side anastomosis to the carotid artery. The physician may perform arteriography or use a Doppler probe to establish patency of the graft. The supraclavicular wound is closed, leaving a drain in place.

Coding Tips

Establishing both inflow and outflow by any method is included. That portion of the operative arteriogram performed by the surgeon is also included. Angioscopy performed during therapeutic intervention should be reported in addition to the code for the primary procedure, see 35400.

ICD-10-CM Diagnostic Codes

G45.0	Vertebro-basilar artery syndrome
I63.011	Cerebral infarction due to thrombosis of right vertebral artery ☑
I63.012	Cerebral infarction due to thrombosis of left vertebral artery ☑
I63.013	Cerebral infarction due to thrombosis of bilateral vertebral arteries ☑
I63.033	Cerebral infarction due to thrombosis of bilateral carotid arteries ☑
I63.111	Cerebral infarction due to embolism of right vertebral artery ☑
I63.112	Cerebral infarction due to embolism of left vertebral artery ☑
I63.113	Cerebral infarction due to embolism of bilateral vertebral arteries ☑
I65.01	Occlusion and stenosis of right vertebral artery ☑
I65.02	Occlusion and stenosis of left vertebral artery ☑
I65.03	Occlusion and stenosis of bilateral vertebral arteries ☑
I76	Septic arterial embolism
I77.1	Stricture of artery
I77.2	Rupture of artery
I77.74	Dissection of vertebral artery
I77.89	Other specified disorders of arteries and arterioles
S15.111A	Minor laceration of right vertebral artery, initial encounter ☑
S15.112A	Minor laceration of left vertebral artery, initial encounter ☑
S15.121A	Major laceration of right vertebral artery, initial encounter ☑
S15.122A	Major laceration of left vertebral artery, initial encounter ☑
S15.191A	Other specified injury of right vertebral artery, initial encounter ☑
S15.192A	Other specified injury of left vertebral artery, initial encounter ☑

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
35691	18.41	4.74	4.6	27.75
Facility RVU	**Work**	**PE**	**MP**	**Total**
35691	18.41	4.74	4.6	27.75

	FUD	Status	MUE	Modifiers				IOM Reference
35691	90	A	1(3)	51	50	62*	80	None

* with documentation

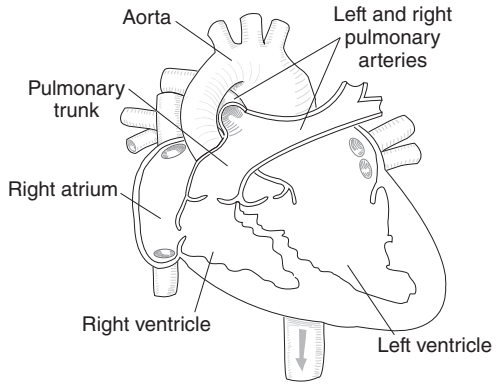
Terms To Know

adventitia. Outermost layer of connective tissue covering an organ or other tissue.

 ● New ▲ Revised + Add On ★ Telemedicine AMA: CPT Assist [Resequenced] ☑ Laterality

92960-92961

92960 Cardioversion, elective, electrical conversion of arrhythmia; external
92961 internal (separate procedure)



Explanation

The physician may administer an electronic shock to the patient's chest to regulate heartbeats considered dangerously irregular. The physician uses a defibrillator machine and places two paddles on the patient's chest and/or back. A measured electric shock is delivered through the chest to the heart to convert the heartbeat to a regular rhythm. Report 92960 for external cardioversion and 92961 when the procedure is performed internally.

Coding Tips

When medically necessary, report moderate (conscious) sedation provided by the performing physician with 99151-99153. When provided by another physician report 99155-99157. Note that 92961, a separate procedure by definition, is usually a component of a more complex service and is not identified separately. When performed alone or with other unrelated procedures/services, it may be reported. If performed alone, list the code; if performed with other procedures/services, list the code and append modifier 59 or an X{EPSU} modifier. Do not report 92961 with 93282-93284, 93287, 93289, 93295, 93296, 93618-93624, 93631, 93640-96342, 93650, 93653-93657, or 93662.

ICD-10-CM Diagnostic Codes

I44.0	Atrioventricular block, first degree
I44.1	Atrioventricular block, second degree
I44.2	Atrioventricular block, complete
I44.30	Unspecified atrioventricular block
I44.39	Other atrioventricular block
I44.4	Left anterior fascicular block
I44.5	Left posterior fascicular block
I44.69	Other fascicular block
I45.0	Right fascicular block
I45.19	Other right bundle-branch block
I45.2	Bifascicular block
I45.3	Trifascicular block
I45.4	Nonspecific intraventricular block
I45.5	Other specified heart block
I45.6	Pre-excitation syndrome
I45.81	Long QT syndrome
I45.89	Other specified conduction disorders
I47.0	Re-entry ventricular arrhythmia
I47.1	Supraventricular tachycardia
I47.21	Torsades de pointes
I47.29	Other ventricular tachycardia
I48.0	Paroxysmal atrial fibrillation
I48.11	Longstanding persistent atrial fibrillation
I48.19	Other persistent atrial fibrillation
I48.21	Permanent atrial fibrillation
I48.3	Typical atrial flutter
I48.4	Atypical atrial flutter
I49.01	Ventricular fibrillation
I49.02	Ventricular flutter
I49.1	Atrial premature depolarization
I49.2	Junctional premature depolarization
I49.3	Ventricular premature depolarization
I49.49	Other premature depolarization
I49.5	Sick sinus syndrome
I49.8	Other specified cardiac arrhythmias

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
92960	2.0	2.46	0.14	4.6
92961	4.34	1.91	0.96	7.21
Facility RVU	**Work**	**PE**	**MP**	**Total**
92960	2.0	1.02	0.14	3.16
92961	4.34	1.91	0.96	7.21

	FUD	Status	MUE	Modifiers				IOM Reference
92960	0	A	2(3)	N/A	N/A	N/A	80*	None
92961	0	A	1(3)	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

anomalous atrioventricular excitation. Pre-excitation associated with paroxysmal tachycardia or atrial fibrillation with a short P-R interval on EKG and an early delta wave. The normal conduction pathway is bypassed.

arrhythmias. Heart disorder of rhythm or rate, due to an electrical conduction system malfunction.

atrioventricular block. Condition in which there is a disturbance of electrical conduction, such as a delay, intermittence, or absence in the transmission of an impulse from the atria to the ventricles and categorized according to degree of severity.

supraventricular tachycardia. Rapid beating of the heart, usually pertains to more than 100 beats per minute and can be as high as 250 beats per minute. SVT is caused by abnormal electrical impulses originating at the AV node or above it in the atria (upper chambers) of the heart.

93268-93272

★**93268** External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; includes transmission, review and interpretation by a physician or other qualified health care professional

★**93270** recording (includes connection, recording, and disconnection)

★**93271** transmission and analysis

★**93272** review and interpretation by a physician or other qualified health care professional

Explanation

The purpose of this study is to evaluate the patient's ambient heart rhythm during symptoms. The physician or other qualified health care professional instructs the patient in the use of an external rhythm monitor. A technician places ECG leads on the patient's chest, and the monitor uses a symptom-related memory loop mechanism with remote download capability up to 30 days to record the patient's rhythm. During symptoms, the patient activates the monitor by pressing a button. The resulting recording includes ECG activity prior to and during symptoms. The patient uses the device to transmit the recording over the telephone line, allowing a rhythm printout to be generated. The provider reviews and interprets this rhythm strip. Code 93268 reports transmission and provider review and interpretation. Code 93270 reports the recording only (including connection, recording, and disconnection). Code 93271 reports transmission download and analysis. Code 93272 reports only the provider review and interpretation.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
93268	0.52	4.91	0.04	5.47
93270	0.0	0.24	0.01	0.25
93271	0.0	4.49	0.01	4.5
93272	0.52	0.18	0.02	0.72
Facility RVU	**Work**	**PE**	**MP**	**Total**
93268	0.52	4.91	0.04	5.47
93270	0.0	0.24	0.01	0.25
93271	0.0	4.49	0.01	4.5
93272	0.52	0.18	0.02	0.72

93278

93278 Signal-averaged electrocardiography (SAECG), with or without ECG

Explanation

Electrodes placed on a patient's chest record the heart's electrical activity. This technique uses signal-averaged electrocardiography (SAECG) and may include a standard electrocardiogram.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
93278	0.25	0.58	0.02	0.85
Facility RVU	**Work**	**PE**	**MP**	**Total**
93278	0.25	0.58	0.02	0.85

[93264]

93264 Remote monitoring of a wireless pulmonary artery pressure sensor for up to 30 days, including at least weekly downloads of pulmonary artery pressure recordings, interpretation(s), trend analysis, and report(s) by a physician or other qualified health care professional

Explanation

A pulmonary pressure monitoring system, a device comprised of a battery-free sensor such as the CardioMEMS™, permits ongoing monitoring and measurement of a patient's heartrate as well as systolic, diastolic, and mean pressures in a patient diagnosed with non-rhythm related cardiac conditions (i.e., heart failure). Pulmonary arterial pressure (PAP) readings transmitted from an internally implanted sensor to a wireless electronic unit are subsequently transmitted to an internet-based file server or monitored by a surveillance technician with results sent to an online portal that can be accessed by the patient's treating health care provider. Through accurate monitoring of patients diagnosed with heart failure (HF) for exacerbations, it is possible to minimize the need for additional hospitalizations and the associated complications and allow for early pharmacological intervention.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
93264	0.7	0.71	0.05	1.46
Facility RVU	**Work**	**PE**	**MP**	**Total**
93264	0.7	0.28	0.05	1.03

93279-93281

93279 Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead pacemaker system or leadless pacemaker system in one cardiac chamber

93280 dual lead pacemaker system

93281 multiple lead pacemaker system

Explanation

A programming device evaluation is performed in person in order to test the device's function and select the most favorable permanent programmed values. Patients with previously implanted pacemakers require periodic programming device evaluations. This diagnostic procedure includes a face-to-face assessment of all device functions. Components that must be evaluated in order to assign a code from this range include the battery, leads, capture and sensing function, heart rhythm, and programmed parameters. Stored and measured data regarding these components are retrieved using an office, hospital, or emergency room instrument. This information is assessed to discern battery voltage, lead impedance, and settings for rhythm treatment and tachycardia detection, as well as to determine the pacemaker's current programming. If necessary, the sensing value and rate response, upper and lower heart rates, AV intervals, pacing voltage and pulse duration, and diagnostics are adjusted. These codes include physician or other qualified health care professional review, interpretation, and report, and are assigned per procedure. Report 93279 for evaluation of a single-lead pacemaker or leadless system (one in which there is pacing and sensing function in only one chamber of the heart). Report 93280 for evaluation of a dual-lead device (one with pacing and sensing function in only two chambers). Report 93281 for evaluation of a multiple-lead device (one with pacing and sensing function in three or more chambers).

Correct Coding Initiative Update 28.3

❖Indicates Mutually Exclusive Edit

0234T 01924-01926, 0213T, 0216T, 0596T-0597T, 11000-11006, 11042-11047, 34713-34716, 34812, 34820, 34833-34834, 35201-35206, 35226-35236, 35256-35266, 35286, 36000, 36002-36005, 36400-36410, 36420-36430, 36440, 36500, 36591-36592, 36600-36640, 37184, 43752, 49000-49002, 51701-51703, 61645-61650, 62320-62327, 64400, 64405-64408, 64415-64435, 64445-64454, 64461, 64463, 64479, 64483, 64486-64490, 64493, 64505, 64510-64530, 69990, 75893, 76000, 76942, 76998, 77002, 93000-93010, 93040-93042, 93050, 93318, 93355, 94002, 94200, 94680-94690, 95812-95816, 95819, 95822, 95829, 95955, 96360, 96365, 96372, 96374-96377, 96523, 97597-97598, 97602, 99155, 99156, 99157, 99446-99449, 99451-99452, G0471

0235T 01924-01926, 0213T, 0216T, 0596T-0597T, 11000-11006, 11042-11047, 34713-34716, 34812, 34820, 34833-34834, 35201-35206, 35226-35236, 35256-35266, 35286, 36000, 36002-36005, 36400-36410, 36420-36430, 36440, 36500, 36591-36592, 36600-36640, 37184, 43752, 49000-49002, 51701-51703, 61645-61650, 62320-62327, 64400, 64405-64408, 64415-64435, 64445-64454, 64461, 64463, 64479, 64483, 64486-64490, 64493, 64505, 64510-64530, 69990, 75726, 75736, 75774, 75893, 76000, 76942, 76998, 77002, 93000-93010, 93040-93042, 93050, 93318, 93355, 94002, 94200, 94680-94690, 95812-95816, 95819, 95822, 95829, 95955, 96360, 96365, 96372, 96374-96377, 96523, 97597-97598, 97602, 99155, 99156, 99157, 99446-99449, 99451-99452, G0471

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