Please see all code changes for 2013. However, pay particular attention to the following changes pertinent to Cardiovascular Medicine:

### Evaluation and Management Services:

**Eliminating “providers” and “physicians” from Evaluation and Management code descriptors**

Previous to the 2013 CPT Changes, Evaluation and Management codes had the following descriptions: “Counseling and/or coordination of care with providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.” This has now been changed to “Counseling and/or coordination of care with other physicians, qualified healthcare professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.” This provides a more definitive description of what constitutes a “provider” from a CPT standpoint.

The previous verbiage was also followed by a time threshold with the following language, “Physicians typically spend (amount of time) face-to-face with the patient and/or family.” This has now been changed to “Typically (amount of time) are spent face-to-face with the patient and/or family.”

**Defining the broad term “Counseling”**

Counseling is now defined as: “a discussion with a patient and/or family concerning one or more of the following: Diagnostic results, impressions, and/or recommended diagnostic studies, Prognosis, Risks and benefits of management (treatment) options, Instructions for management (treatment) and/or follow-up, Importance of compliance with chosen management (treatment) option, Risk factor reduction, and Patient and family education”. Again, more definition provided at what may take place in a counseling session. A discussion with a patient in which treatment options, etc and the risks/benefits of those options, would fall under the counseling definition.

### Transitional Care Management Services:

Codes 99495, 99496 require: –A **face-to-face visit** within the specified time frames;–**Interactive contact** with the patient or caregiver within 2 business days of discharge and may be direct (face-to-face), telephonic, or by electronic means; –**Medication reconciliation and management** no later than the date of the face-to-face visit

If another individual provides TCM services within the postoperative period of a surgical package, modifier S4 is not required.

The required contact with the patient or caregiver, as appropriate, may be by the physician or qualified health care professional or clinical staff. Within two business days of discharge is Monday through Friday except holidays without respect to normal practice hours or date of notification of discharge. The contact must include capacity for prompt interactive communication addressing patient status and needs beyond scheduling follow-up care. If two or more separate attempts are made in a timely manner, but are unsuccessful and other transitional care management criteria are met, the service may be reported.

99495 Transitional care management services with the following required elements: communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge medical decision making of at least moderate complexity during the service period face-to-face visit, within 14 calendar days of discharge

99496 Transitional care management services with the following required elements: communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge medical decision making of high complexity during the service period face-to-face visit, within 7 calendar days of discharge

### Physician Documentation of Face-to-Face visit for Durable Medical Equipment (DME)
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G0454 Physician documentation of face-to-face visit for Durable Medical Equipment determination performed by Nurse Practitioner, Physician Assistant or Clinical Nurse Specialist

Cardiovascular System:

2013 brings several changes to cardiovascular coding, including an emphasis on percutaneous coronary intervention (PCI), pacemaker and ablation codes. Additionally, new codes were created for transcatheter aortic valve replacement (TAVR), percutaneous ventricular assist devices (PVAD) and carotid angiography. Of particular interest are the changes in angioplasty, athrectomy and stenting. 6 codes have been replaced by 13 new codes that further define the number of vessels addressed, occlusion, native artery vs CABG, and of particular note - services provided during AMI.

The following are the new guidelines/clarifications pertinent to the cardiovascular system:

Codes 33361-33365, 0318T are used to report transcatheter aortic valve replacement (TAVR)/transcatheter aortic valve implantation (TAVI). TAVR/TAVI requires two physician operators and all components of the procedure are reported using modifier 62.

Codes 33361-33365, 0318T include the work, when performed, of percutaneous access, placing the access sheath, balloon aortic valvuloplasty, advancing the valve delivery system into position, repositioning the valve as needed, deploying the valve, temporary pacemaker insertion for rapid pacing (33210), and closure of the arteriotomy when performed. Codes 33361-33365, 0318T include open arterial or cardiac approach.

Angiography, radiological supervision, and interpretation performed to guide TAVR/TAVI (eg, guiding valve placement, documenting completion of the intervention, assessing the vascular access site for closure) are included in these codes. Diagnostic left heart catheterization codes (93452, 93453, 93458-93461) and the supravalvular aortography code (93567) should not be used with TAVR/TAVI services (33361-33365, 0318T) to report:
1. Contrast injections, angiography, roadmapping, and/or fluoroscopic guidance for the TAVR/TAVI
2. Aorta/left ventricular outflow tract measurement for the TAVR/TAVI, or
3. Post-TAVR/TAVI aortic or left ventricular angiography, as this work is captured in the TAVR/TAVI services codes (33361-33365, 0318T).

Diagnostic coronary angiography performed at the time of TAVR/TAVI may be separately reportable if:
No prior catheter-based coronary angiography study is available and a full diagnostic study is performed, or
A prior study is available, but as documented in the medical record:
   a. The patient’s condition with respect to the clinical indication has changed since the prior study, or
   b. There is inadequate visualization of the anatomy and/or pathology, or
   c. There is a clinical change during the procedure that requires new evaluation.
   a. For same session/same day diagnostic coronary angiography services, report the appropriate diagnostic cardiac catheterization code(s) appended with modifier 59 indicating separate and distinct procedural service from TAVR/TAVI.

Diagnostic coronary angiography performed at a separate session from an interventional procedure may be separately reportable.

Other cardiac catheterization services are reported separately when performed for diagnostic purposes not intrinsic to TAVR/TAVI.

When transcatheter ventricular support is required in conjunction with TAVR/TAVI, the appropriate code should be reported with the appropriate ventricular assist device (VAD) procedure code (33990-33993, 33975, 33976, 33999) or balloon pump insertion code (33967, 33970, 33973).
The TAVR/TAVI cardiovascular access and delivery procedures are reported with 33361-33365, 0318T. When cardiopulmonary bypass is performed in conjunction with TAVR/TAVI, codes 33361-33365, 0318T should be reported with the appropriate add-on code for percutaneous peripheral bypass (33367), open peripheral bypass (33368), or central bypass (33369).

Procurement of the saphenous vein graft is included in the description of the work for 33510-33516 and should not be reported as a separate service or co-surgery. To report harvesting of an upper extremity vein, use 35500 in addition to the bypass procedure. To report harvesting of a femoropopliteal vein segment, report 35572 in addition to the bypass procedure. When surgical assistant performs graft procurement, add modifier 80 to 33510-33516. For percutaneous ventricular assist device insertion, removal, repositioning, see 33990-33993.

Procurement of the saphenous vein graft is included in the description of the work for 33517-33523 and should not be reported as a separate service or co-surgery. Procurement of the artery for grafting is included in the description of the work for 33533-33536 and should not be reported as a separate service or co-surgery, except when an upper extremity artery (eg, radial artery) is procured. To report harvesting of an upper extremity artery, use 35600 in addition to the bypass procedure. To report harvesting of an upper extremity vein, use 35500 in addition to the bypass procedure. To report harvesting of a femoropopliteal vein segment, report 35572 in addition to the bypass procedure. When surgical assistant performs arterial and/or venous graft procurement, add modifier 80 to 33517-33523, 33533-33536, as appropriate. For percutaneous ventricular assist device insertion, removal, repositioning, see 33990-33993.

Patients receiving major cardiac procedures may require simultaneous cardiopulmonary bypass insertion of cannulae into the venous and arterial vasculatures with support of circulation and oxygenation by a heart-lung machine. Most services are described by codes in dyad arrangements to allow distinct reporting of procedures with or without cardiopulmonary bypass. Cardiopulmonary bypass is distinct from support of cardiac output using devices (eg, ventricular assist or intra-aortic balloon). For cardiac assist services see 33960-33983, 339XX1-33993.

The insertion of a ventricular assist device (VAD) can be performed via percutaneous (33990, 33991) or transthoracic (33975, 33976, 33979) approach. The location of the ventricular assist device may be intracorporeal or extracorporeal. For surgical insertion of cannula(s) for prolonged extracorporeal circulation for cardiopulmonary insufficiency (ECMO), use 36822.

Open arterial exposure when necessary to facilitate percutaneous ventricular assist device insertion (33990, 33991), may be reported separately (34812). Extensive repair or replacement of an artery may be additionally reported (eg, 35226 or 35286).

Removal of a ventricular assist device (33977, 33978, 33980, 33992) includes removal of the entire device, including the cannulas. Removal of a percutaneous ventricular assist device at the same session as insertion is not separately reportable. For removal of a percutaneous ventricular assist device at a separate and distinct session, but on the same day as insertion, report 33992 appended with modifier 59 indicating a distinct procedural service.

Repositioning of a percutaneous ventricular assist device at the same session as insertion is not separately reportable. Repositioning of percutaneous ventricular assist device not necessitating imaging guidance is not a reportable service.
For repositioning of a percutaneous ventricular assist device necessitating imaging guidance at a separate and distinct session, but on the same day as insertion, report 33993 with modifier 59 indicating a distinct procedural service.

Replacement of the entire implantable ventricular assist device system, ie, pump(s) and cannulas, is reported using the insertion codes (ie, 33975, 33976, 33979). Removal (ie, 33977, 33978, 33980) of the ventricular assist device system being replaced is not separately reported. Replacement of a percutaneous ventricular assist device is reported using implantation codes (ie, 33990, 33991). Removal (ie, 33992) is not reported separately.

33361 Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach

33362 Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach

33363 Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach

33364 Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach

33365 Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)

33367 Replace aortic valve w/byp

33368 Replace aortic valve w/byp

33369 Replace aortic valve w/byp

33990 Insert vad artery access

33991 Insert vad art&vein access

33992 Remove vad different session

33993 Reposition vad diff session

36221 Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed

36222 Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed

36223 Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed

36224 Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed
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36225 Selective catheter placement, subclavian or innominate artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed

36226 Selective catheter placement, vertebral artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed

36227 Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (list separately in addition to code for primary procedure)

36228 Place cath intracranial art

37197 Remove intrvas foreign body

37211 Thrombolytic art therapy

37212 Thrombolytic venous therapy

37213 Thromblytic art/ven therapy

37214 Cessj therapy cath removal

Medicine – Cardiovascular:

Ablation Code Guidelines

Deletion of intracardiac catheter ablation codes 93651 and 93652

5 new codes (93653-93657) differentiating ablation techniques for:
  – Supraventricular arrhythmias
  – Ventricular arrhythmias
  – Pulmonary vein isolation (for atrial fibrillation)
  – Ablation of discrete mechanism of arrhythmia separate from the primary ablated mechanism
  – Additional linear or focal ablation for mechanism of atrial fibrillation remaining after pulmonary vein isolation

Ablation codes (93653-93657) include the single site and comprehensive electrophysiology study services (93600-03603, 93619, 93620)

Atrial fibrillation ablation (93656) includes pacing and recording from the coronary sinus (93621) when performed.

Trans-septal puncture (93462) may be reported separately for ablations except for atrial fibrillation ablation (93656, 93657) which includes trans-septal puncture

93653, 93654, and 93656 are distinct primary services and may not be reported together

Mapping is a distinct procedure and may be reported separately with atrial ablation procedures

VT ablation (93654) includes mapping

Do not report standard mapping (93609) in addition to 3-D mapping (93613)—only one or the other
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Which add-on code (93655 or 93657) should be reported if a successful pulmonary vein isolation procedure for atrial fibrillation reveals a second, independent mechanism?

- Report +93655 when an additional non-atrial fibrillation tachycardia mechanism is identified after atrial fibr ablation
- Report +93657 when an additional left or right atrial focus for atrial fibrillation is identified after successful pulmonary vein isolation

PCI Guidelines
For PCI services, definition of “major” vessel now includes LAD, left circumflex, and right coronary plus left main and ramus intermedius

All interventions in a major vessel itself (including proximal, mid, and distal vessel) are reported with one PCI code (report the highest service level of intervention performed)

Interventions in up to 2 branches of each major vessel may be reported with add-on codes (LAD diagonals, circumflex marginals, etc.)

Reporting Guidelines for Multiple Target Lesion Procedures—Base Codes
Report only one base code for each major coronary artery approached (LAD, CFX, RCA, LM, ramus intermedius); that code reports all services in that major vessel (prox, mid, distal)

Report, as the base code, the most intensive service performed in that major vessel system

1. Acute total occlusion = chronic total occlusion higher than
2. Atherectomy + stent higher than
3. Atherectomy without stent higher than
4. Stent higher than
5. Any service through a bypass graft higher than
6. Balloon angioplasty alone (based upon CMS valuations)

Reporting Guidelines for Multiple Target Lesion Procedures—Add-on Codes
Report up to 2 add-on codes for services in branches of each major coronary artery approached; that code reports all services in that branch (prox, mid, distal)

Services performed in more than 2 branches are not separately reportable.

Report, as add-on code, the most intensive service(s) performed in that major vessel system

1. Chronic total occlusion = bypass graft service higher than
2. Atherectomy with stent higher than
3. Atherectomy without stent higher than
4. Stent higher than
5. Balloon angioplasty alone (based upon RUC valuations)

If a single lesion extends from one target vessel (major coronary artery, graft, or branch) into another target vessel but can be revascularized with a single intervention bridging the two vessels, report with a single code (eg, LAD into diagonal, LM into LAD)

For bifurcation lesions (when both treated), report for both vessels (eg, LAD and LAD diagonal)

Guidelines for Services Performed On or Through Bypass Grafts
Describes arterial and venous conduits, both direct (eg, LIMA) and free (eg, RIMA from aorta to RCA)
Each separate graft represents a major coronary artery

A sequential graft (more than one distal anastomosis) represents only one graft

A branching graft (Y graft) represents a major vessel for the main graft (aorta to distal anastomosis) and each branch off the main graft represents an additional coronary vessel

PCI performed on a major vessel through a graft is reported using the graft PCI codes

When a major artery is treated both through the native circulation and through a graft, report both base codes

**Reporting Diagnostic Angiography when Performed at Time of Intervention**

No prior catheter-based coronary angiography is available and a full diagnostic study is performed and decision to intervene is based upon the results OR

A prior study is available but, as documented in the medical record, either:

– The patient’s clinical condition (relating to the indication) has changed since the prior study); or
– Inadequate visualization of the anatomy in the prior study; or
– Clinical change during the procedure requiring new evaluation outside of the target area of PCI

**New Cardiac Catheterization Guidelines**

Do not report pharmacologic administration +93463 in conjunction with PCI (92920-92944) or with coronary thrombolyis (92975, 92977)

Injection for pulmonary angiography (+93568) may be reported with right heart catheterization codes 93451, 93453, 93456, 93457, 93460-93461, 93530-93533

When aortography is performed with other cardiac catheterization procedures, report +93567 for supravalvular aortography and the radiological supervision and interpretation code (36221, 75600-75630) for non-supravalvular thoracic or abdominal aortography

92920 Percutaneous transluminal coronary angioplasty; single major coronary artery or branch

92921 Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)

92924 Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch

92925 Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)

92928 Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch

92929 Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)

92933 Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch

92934 Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when
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performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)

92937 Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel

92938 Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (list separately in addition to code for primary procedure)

92941 Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel

92943 Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel

92944 Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (list separately in addition to code for primary procedure)

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, his recording 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

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, his recording 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

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)

93656 Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with atrial recording and pacing, when possible, right ventricular pacing and recording, his bundle recording with intracardiac catheter ablation of arrhythmogenic focus, with treatment of atrial fibrillation by ablation by pulmonary vein isolation

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)