Interventional Radiology, Cardiology and Endovascular CPT Coding Updates for 2016

Overview

• 2016 Interventional Radiology Updates
  • Urinary Intervention, Biliary Intervention, Fluid Collection Sclerosis, Soft Tissue Markers, Thoracic Parasympathetic Block, Neuro-Intervention (embolysis, vasospasm), IVUS,
  • Guideline changes over 2015 and regulatory updates

• 2016 Cardiology Updates
  • New codes: TPVI (Melody valve), Cardiac Contractility Modulation System
  • Guideline changes over 2015 and regulatory updates

GU Interventions: 2016

• There are 12 new codes for 2016 (in red)
• 50392, 50393, 50394, 50398, 74475, & 74480 deleted.
• All new urinary codes bundle S&I’s
• All codes include any and all imaging guidance (CT, MR, US, and fluoro) utilized throughout the procedure
• All new codes are billed once per side, unless two procedures done in a duplicated collecting system

GU Interventions: 2016

• New codes for:
  • Nephrostogram via new or existing access
  • PCN placement and PCN exchange
  • Initial placement of a nephroureteral catheter
  • Conversion of a PCN to a nephroureteral catheter
  • Placement of a ureteral stent via an existing access
  • Placement of a ureteral stent via a new access
  • Placement of a ureteral stent via a new access with additional placement of a new PCN
GU Interventions: 2016

• New add-on codes for:
  • percutaneous ureteroplasty (includes UPJ)
  • ureteral embolization
  • ureteral and/or calyceal biopsy
    • all add-ons may be via any approach (nephrostomy, ileal conduit, urethra, cystostomy, ureterostomy)
  • Nephrostogram/ureterogram is bundled with catheter placements, replacements, conversions and removals

Percutaneous Antegrade Pyelogram or Ureterogram via New Access

• **50430** (via new access)
  • The study can be performed with a needle or a catheter (that is removed at the end of the session)
  • Bundled if done at time of a new percutaneous nephrostomy, nephroureteral or ureteral catheter placement, even if diagnostic
  • Use **50430** with add-on codes **50606**, **50705** and **50706**
  • Use **50431** if nephrostogram is performed via an existing access

Percutaneous Antegrade Pyelogram or Ureterogram via Existing Access

• **50431** (via existing access)
  • Nephrostogram must be diagnostic in nature. **50431** is only billable with add-on codes **50606**, **50705**, **50706**, **50387** and **50389** (necessity must be well documented)
  • Do not use **50430** and **50431** at the same session for the same side.
  • Do not use **50431** when a nephrostomy, nephroureteral or ureteral catheter is replaced, converted or removed.
Nephrostomy Tube Procedures

- **50432**: nephrostomy tube placement via new access
- **50434**: conversion of nephrostomy to nephroureteral stent
- **50435**: nephrostomy tube change
  (The above codes include diagnostic nephrostogram)
- **50389**: nephrostomy tube removal (requires fluoroscopy),

**Percutaneous Nephrostomy (PCN)**

- **50432** (bundles 50430)
  - Placement of tube in renal collecting system via the flank that only drains externally
  - Code per collecting system that a PCN is placed. There are two collecting systems on one side when a duplicated ureter is present.
  - Dilation of the tract from skin to kidney is a normal component of a PCN placement. Do not use 50395.

**Percutaneous Nephrostomy (PCN)**

- **50432**
  - PCN placement bundles all imaging guidance (CT, MR, US, and fluoro) and diagnostic nephrostogram
  - PCN is bundled with ureteral stent placement code 50693 (via existing access) & 50695 (via new access)
  - Parentheticals state to not report 50430-50435 with 50693-50695 for the same collecting system/ureter
Nephrostomy Tube Change

- CPT code 50435 describes change of a nephrostomy tube. This includes imaging guidance and diagnostic nephrostogram.
- If the patient has new symptoms related to the tube, the diagnostic imaging is still bundled with a tube change.
- Nephrostomy tube change is bundled with codes for ureteral stent placements (50693-50695).

Nephroureteral Stent Procedures

50433: placement of a nephroureteral stent via a new access
50434: conversion of nephrostomy to nephroureteral stent
50435: remove nephroureteral stent & place nephrostomy
50387: nephroureteral stent change
50389: nephroureteral stent removal, (requires fluoro)
Ureteral Stent Placement

- **50693**: ureteral stent via existing nephrostomy access (appears PCN removal (50389) or replacement (50435), nephroureteral stent removal (50389), and nephroureteral stent removal and replacement with a PCN (50435) at the same session is bundled at the same session as the ureteral stent placement...see parentheticals).
- **50694** ureteral stent via new access **without** placement of PCN
- **50695** ureteral stent via new access **with** placement of new PCN
- **50382**: non-accessible ureteral stent exchange (PCN placement (50432) or exchange (50435) is coded in addition to 50382 or 50384
- **50384**: non-accessible ureteral stent removal

“Add-on” Percutaneous Urinary Procedures

- **+50606** - Biopsy of the Ureter or Renal Pelvis
- **+50705** - Ureteral Occlusion or Embolization
- **+50706** - Balloon Dilation of the Ureter
- These add-on codes can be reported when performed via nephrostomy, ureterostomy, urethra, and ileal conduit approaches

Procedures Through an Ileal Conduit

- **50684, 74425** Injection (no change in 2016)
- **50688, 75984** Externally accessible ureteral stent change via ileal conduit (usually a PNU via the ileal conduit). (No change in 2016)
- For combined flank and ileal conduit approaches to exchange a catheter, code the approach through which the new catheter is inserted.
- Biopsy, ureteroplasty and ureteral embolization can be performed via this access
Urological Catheter Removal Codes
(not externally accessible via percutaneous approach)

- **50382**  Removal and replacement of ureteral stent; this is used when the patient has a pre-existing ureteral stent that is not externally accessible. This can be via a newly placed sheath in the back or via a pre-existing PCN access. The stent is then snared and pulled out through the sheath, a wire placed into the bladder and a new double-pigtail stent or PNU stent is placed. The sheath is then removed.

- **50384**  Removal only of ureteral stent is the same procedure as above, but a new ureteral stent is not placed.

- Guidance, imaging, tract dilation, and sheath placement are included. These are unilateral codes. May use -50 modifier.

- Add code 50432 if PCN is left in place when via new access or 50435 if via a prior access the PCN or NPU is replaced with a new PCN at the end of the case.

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Urological Catheter Removal Codes
(externally accessible)

- **50387**  Removal of old nephroureteral stent and replacement with a new nephroureteral stent.

- **50389**  Removal only of a nephrostomy (or nephroureteral stent) requiring fluoroscopy (may be necessary when a double-pigtail ureteral stent and a nephrostomy are in place, and the nephrostomy is to be removed without entangling the ureteral stent in the string of the nephrostomy).

- Use an E&M code for removals not requiring fluoroscopy.

- Guidance, imaging, tract dilation, and sheath placement are included. These are unilateral codes. May use -50 modifier.

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**Nephrostomy Case 1:**

A. CT guided needle placement into right kidney. Contrast injection reveals high grade obstruction due to a stone in the distal ureter. Via separate access a sheath is placed along with buddy wire. A 26cm 8FR double pigtail ureteral stent is placed. A separate 8FR nephrostomy tube is placed over the buddy wire.

B. Ultrasound guided needle placement into dilated renal pelvis in patient with non-functioning ureteral stent. Contrast injection shows dilated system with fractured ureteral stent (from attempted cystoscopic removal). Sheath is placed, tract dilated, broken stent removed by snare technique and replacement of a new stent, leaving a separate external nephrostomy to drain due to bleeding.

C. Same patient as (B) required balloon dilation of the mid ureter for a stricture prior to ureteral stent placement.

D. Same patient as (B) returned for PCN removal w/ fluoroscopy.

E. Same patient as (B) returned for ureteral stent removal. The PCN is removed over a wire, the ureteral stent is snared and removed and a new PCN is placed.

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**Nephrostomy Case 1 Codes:**

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Biliary Interventions 2016

• There are 14 new bundled percutaneous biliary codes for 2016
• Codes 47500, 47505, 47510, 47511, 47525, 47530, 47630, 74305, 74320, 74327, 75980, and 75982 are deleted in 2016

PTC - Percutaneous Transhepatic Cholangiogram

• 47532
  • Initial diagnostic study performed to evaluate biliary ductal system
  • Performed via a new access by injecting contrast through a percutaneous needle placed in a bile duct or through a catheter if the catheter is placed and removed at end of session
  • These codes should not be used when contrast is injected to localize a duct for puncture (no code submitted for “guidance”) or when injection is into a pre-existing biliary drainage catheter for evaluation of the bile ducts. Use 47531 for study via an existing access (catheter)

Cholangiogram Through Existing Tube

• 47531
  • Used when contrast is injected into an existing biliary drainage catheter for evaluation of the biliary system, diagnostic in nature
  • Do NOT use when contrast is injected at the same time as a biliary catheter exchange, conversion or removal
External Biliary Drainage

- **47533**, includes dx study
  - Code 47533 describes the placement of an externally draining biliary catheter
  - Submit 47533 for each catheter placed. Use modifier -59.
  - An initial diagnostic study is bundled
  - Do NOT submit codes for diagnostic study (47531 or 47532) when a catheter is placed, replaced converted or removed

Internal/External Biliary Drainage

- **47534**: for placement of an internal/external catheter via a new access.
- **47535**: for conversion of prior external catheter to an internal/external catheter. Both include diagnostic PTHC (PTC).
  - Placement of a catheter that has crossed the common bile duct into the duodenum. Holes in the catheter allow it to drain internally (if external access port is capped off) or externally (if external access port is hooked to a drainage bag)
  - Diagnostic cholangiography (47531 or 47532) is bundled with catheter placement, replacement, conversion and removal.
  - Code for each catheter placed or converted (add modifier-59)
**Biliary Catheter Change**

- **47536**: includes external catheter change, internal/external catheter change OR conversion of internal/external to external
  - Code for each catheter changed (e.g., twice if a right and left biliary drainage tube are changed at the same session)
  - Cholangiocarcinoma, specifically a Klatskin tumor at the CHD bifurcation, may result in isolated systems requiring two drainage tubes. As these tumors grow outwards, they can occlude additional branches requiring additional drainage catheters. Sclerosing cholangitis may also require multiple catheters

**Revise/Reinsert Biliary Catheter**

- **47530, 75984 (DELETED IN 2016)**
  - Recommend biliary tube change code 47536
  - Use if a biliary tube falls out and is reinserted, for a T-tube change, or a cholecystostomy catheter change
  - Cholangiography and imaging guidance is bundled.

**Biliary Catheter Change**

- **47537**: Removal of biliary drainage catheter
  - Code for each catheter removed (e.g., twice if right and left biliary drainage tubes are removed at the same session)
  - If assisting an endoscopist via an existing access during “rendevous” procedure and at the end of the session the catheter is removed, use 47537 (not 47541)
  - Stent procedures include all catheter procedures, including removal.
Cholangioplasty of Common Bile Duct Stricture

Percutaneous Biliary Ductal Dilation (Cholangioplasty)

- **+47542**
  - Percutaneous cholangioplasty or sphincteroplasty is balloon dilation of a bile duct or the ampulla
  - Imaging guidance is bundled, however 47531 or 47532 is billable, unless bundled with other procedures at the same session
  - Use once for each bile duct dilation, however maximum is 2, regardless of how many additional ducts are dilated
  - Do not use code +47542 when the balloon is just used for clearing stones or debris from bile ducts (use +47544). Do use +47542 for sphincteroplasty
  - Balloon dilation is bundled with biliary stent placement in the same location. Do not submit +47542 with 47538-47540 in the same location.
  - Codes 47555 and 47556 are endoscopic codes, NOT percutaneous in 2016

Percutaneous Biliary Stent Placement

- **47538** Stent(s) placement, existing access, including catheter removal, replacement, or conversion
- **47539** Stent(s) placement, new access, w/o placement of a drainage catheter
- **47540** Stent(s) placement, new access, with placement of external or internal/external drainage catheter same session
  - All stent placement codes include imaging guidance, cholangiography, and cholangioplasty (of the same duct). Catheter placement, replacement, conversion and removal are bundled in one of the above listed codes.
  - Use code more than once with -59 if double barrel stents, two or more accesses with two or more stents, or if 2 or more ducts treated with stents
Biliary Biopsy Through Tract

+47543 - Endoluminal brush and/or needle biopsy.
- Use with codes 47531-47540
- Only submit code +47543 once per DOS

Biliary Stone Extraction

+47544
- May use “baskets”, balloons, snares, and/or sheaths to remove or destroy stones from bile ducts or gall bladder
- Dilation of the ampulla of the CBD with a balloon to allow the removal of a stone is considered a sphincteroplasty (+47542)
- Imaging guidance is bundled. Catheter placements or stent placements are separately billable (47531-47540)
- Do not use +47544 when no stones found, or when incidental sludge or debris is removed

Biliary Access for Endoscopist

• 47541
- ONLY when new access. NOT for wire via prior access.
- Includes leaving in a catheter for use in endoscopy
- If via an existing access, at the end of procedure, the catheter will either be removed, replaced or converted. Use 47535, 47536 or 47537 as appropriate, NOT 47541
- If a new external drain is placed at the end of the procedure, report code 47533, NOT 47541
Percutaneous Cholecystostomy

• Use code 47490 for placement (guidance is bundled).
• Code 47531 describes tube check of a cholecystostomy tube.
• Code 47536 describes cholecystostomy tube change *
• Code 47437 describes cholecystostomy tube removal
• Code 47544 describes stone extraction from gall bladder

Biliary Case 4:
A. Percutaneous access gained to liver with contrast injection. Diagnostic cholangiography reveals dilated ductal system with distal CBD obstruction. Via a separate access, an externally draining biliary tube is placed.
B. Patient returns 2 days later, diagnostic tube injection reveals less dilation but an irregular stenosis in the distal CBD. Brush biopsy followed by transcatheter biopsy with alligator forceps is done. Preliminary pathology is positive for malignancy. Balloon dilation followed by covered stent placement results in patent bile ducts. The sheath and drainage catheters are removed and the patient is left to drain internally through the covered metallic stent.
C. Same patient as A, but after initial access and diagnostic imaging is obtained, a metallic stent is placed across the malignancy in the distal common bile duct and an internal/external stent is left in place for drainage.

Biliary Case 4 Codes:

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<td>No difference even if a drainage catheter is left in place</td>
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Fluid

• **49185: Sclerotherapy includes dx study**
  • Fibrin glue closure of fistula (therapeutic)
  • Ablation of lymphocele, seroma, abscess, cyst with absolute alcohol or other sclerosing agent
  • Do code the drainage catheter placement separately
    • e.g., 10160, 49405, 49406
  • Imaging is bundled (diagnostic, monitoring, f/u)
Peritoneal Catheter Placements

- **49082**  Paracentesis; Dx or Tx, w/o imaging guidance
- **49083**  Paracentesis; Dx or Tx, with imaging guidance
- If does paracentesis and leaves catheter in place, use 49406 only. Do **not** code for the paracentesis.
- If places indwelling catheter, sends to floor for drainage, then pulls catheter on same DOS, use 49083

Percutaneous Abscess Drainage

- If two catheters are placed via separate punctures into two, non-communicating, separate abscess cavities, use the drainage code twice.
- If two catheters are placed via separate punctures into one large abscess cavity, only submit the drainage code once.

Vertebroplasty

- **22510**  Cervical or Thoracic
- **22511**  Lumbar or Sacral
- **22512**  Each additional C/T/L/S
- Code one initial level, ALL other levels are ADDITIONAL levels. **PER NCCI 22.0,** only code ONE initial vertebroplasty regardless of the levels treated
- Guidance and bone biopsy are bundled
- **Cervical vertebroplasty** is now included as appropriate with 22510
- **Sacral vertebroplasty** is now included as appropriate with 22511
Sacroplasty

- **0200T** Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, 1 or more needles
- **0201T** Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, 2 or more needles
- Augmentation is with kyphoplasty (balloon), arcuplasty (side-cutting or coring device) or other mechanical device
- Bone biopsy and imaging guidance is bundled with sacroplasty
- Needle injection of methylmethacrylate is L/S vertebroplasty

Breast Biopsy (19081-19086):

- Bundles imaging guidance/localization during biopsy
- Includes core needle and rotating vacuum assisted techniques
- Bundles specimen radiograph (even if different MD does Bx)
- Bundles clip placement at time of biopsy
- F/U mammogram allowed with procedures utilizing US, MRI and stereotactic guidance per ACR & NCCI 22.0

IVUS

- **37252** IVUS, non-coronary, initial vessel
- **37253** IVUS, non-coronary, each additional vessel
- Codes are per vessel imaged however only 1 code is reported for multiple contiguous vessel lesions (DVT evaluation from popliteal vein to IVC is reported as one IVUS)
- Different codes are used for coronary IVUS (92978, 92979)

Percutaneous Arterial Thrombectomy (non-coronary, non-AV-shunt)

- **37184** Primary arterial mechanical thrombectomy (any device, includes intraprocedural thrombolytics, guidance, and follow-up imaging)
- +**37185** Second and all subsequent vessels in the same vascular family
- +**37186** Secondary arterial thrombectomy, at time of another intervention (small emboli or short segment of clot either before or after another intervention)

DO NOT use for CNS arterial thrombus treatment in 2016
Percutaneous Venous Thrombectomy (non-coronary, non-AV-shunt)

- **37187** Venous thrombectomy includes intraprocedural thrombolytics
- **37188** Venous thrombectomy, repeat treatment on subsequent day during course of thrombolytic therapy
  - Do use these for cerebral venous therapy

Percutaneous Thrombectomy (Coronary and AV-shunt)

- **36870** Percutaneous dialysis graft thrombectomy (by any method)
- **92973** Percutaneous coronary artery thrombectomy (only with AngioJet device currently)
- **61645** Endovascular revascularization of cerebral vessels (per territory) for thrombus/embolus

Intracranial Revascularization

- **61645** Intracranial endovascular revascularization for thrombotic or embolic occlusion.
  - For arteries only (use 37187, 37188, 37212 for cerebral venous tx)
  - Bundles access and closure of access site, ipsilateral diagnostic, monitoring, & F/U angiography, catheter placements, thrombectomy by any method, thrombolysis, angioplasty, and stent placement
  - Submit once per territory (right brain, left brain, back of brain)
  - Do not submit 61630 or 61635 (angioplasty or stent) with 61645
  - Do not submit with new codes 61650 or 61651 (vasospasm infusion)

Thrombolytic Infusion with Thrombectomy Case 78:

43 year old patient presents with two hour history of left hemispheric stroke. Initial CT scan shows no intracranial bleed. Via a right femoral approach, arch, bilateral selective common carotid catheter placement with imaging of the cervical and cerebral vessels is performed. This demonstrates normal carotid bifurcations and normal left cerebral vessels. Right cerebral angiogram shows thrombus and occlusion of the M1 and M2 segments of the MCA with some clot seen in two branches. Selective M1 and A1 catheterization and imaging is performed to detail the intracranial circulation. Intracranial thrombolysis is initiated for 30 minutes (after balloon maceration) with follow-up angiography showing some improvement, however the Solitaire device (or MERCI, Trevo, Penumbra) is necessary to remove clot in the M1 segment and two M2 branches. Follow-up shows improvement. Thrombolysis is continued for 20 minutes with 8mg TPA. M1 and M2 superior and inferior branches are selected during this treatment. Symptoms are significantly improved as is intracranial flow on follow-up imaging. The sheath is removed and hemostasis obtained. Cardiology is consulted to evaluate for PFO. 22mm PFO is seen on TEE and 1 week later the PFO is closed.
Thrombolytic Infusion with Thrombectomy Case 78 Codes:

36223-59  LCCA cath placement and cerebral angiography
61645  Solitaire thrombectomy in superior and inferior M2 segment branches and thrombolysis

- The PFO closure would be reported with code 93580.
- Code 61645 covers the ipsilateral catheter placement, imaging, thrombolysis and/or thrombectomy of the right brain territory

Non-Thrombolytic Infusion Therapy

- Code 61650/+61651 for treatment of vasospasm with Verapamil, Nicardipine, Nimodipine and Milrinone. Can also use for cerebral chemoinfusion therapy!
- Infusion may be continuous or intermittent for at least 10 minutes duration.
- Ipsilateral cath placement, imaging & f/u are bundled
- Code each cerebral territory (RT, LT, & Posterior fossa)
- Do not use for treatment of iatrogenic vasospasm
- Do not use for injections of drugs (heparin, nitro, saline)
- Do not use w/61640-61642, (vasospasm balloon dilation)
**Non-Thrombolytic Infusion Therapy**

- CPT codes 37202 & 75896 are deleted in 2016
- No code for Vasopressin infusion for GI bleed
- No code for Nitroglycerin (even as a continuous overnight infusion for limb salvage).
- Consider unlisted code 37799 if a true infusion is done.
- No code for injection of drugs (such as nitroglycerin, heparin or priscoline) into vessel.
- No code for chemoinfusion into liver (via hepatic artery)
- No code for direct injection of drugs into the wall of an artery utilizing specialized balloon technology

**Vasospasm Infusion Case 79:****

23 year old presents with a ruptured aneurysm and intracranial bleed treated with surgical clipping. He now has decreased level of consciousness suggesting vasospasm. Arch angiography demonstrates bovine configuration. No FMD or proximal vessel disease. Bilateral selective internal carotid and left vertebral catheter placement with imaging demonstrates severe narrowing of the carotid cerebral and vertebral cervical and cerebral arteries. Selective Verapamil (Milrinone, Nicardipine, Nimodipine) infusion is performed for 30 minutes in all three cerebral territories due to diffuse vasospasm. Follow-up angiography after each infusion shows improved perfusion.

**Reimbursable Devices**

- HCPCS Level 2: Hospital only device codes
  - **C2623** Drug Eluting Balloon device code (e.g., Lutonix, IN.PACT Admiral, effective date for Hospital billing is 4/1/15)
  - **C2624** Wireless Pulmonary Artery Sensor Implantation (Cardiomems) device code
Percutaneous Left Atrial Appendage Closure

- Left atrial appendage closure with implant, includes fluoroscopy, transseptal puncture, catheter placement, left atrial angiography, left atrial appendage angiography, including S&I 0281T
- Do NOT code for transseptal approach (93462)
- Do code for left/right heart cath/pediatric heart cath, ventriculography, etc, but ONLY if done for indications unrelated to the LAA closure (unlikely)
- Inpatient only C-status indicator procedure
- Watchman Device (FDA approved...3/13/2015)

Percutaneous Valve Intervention

- **33418** Transseptal mitral valve repair (MitraClip, NOT paravalvular leak)
  - **+33419** additional clip(s)
  - Bundles heart catheterization related to procedure
  - Bundles coronary angiography, unless for CAD
  - Bundles transseptal approach. 93462 may be used if transapical approach utilized
  - Bundles US and echo guidance (however 93355 is billable)
- **0345T** Mitral Contour System (cinching device in coronary sinus)
- **33999** Percutaneous closure of para-prosthetic heart valve leak
Percutaneous Pulmonary Valve Replacement

- **33477** Implantation of catheter-delivered prosthetic pulmonary valve, endovascular approach (Melody Valve). Only submit once per session.
  - Includes all congenital cardiac catheterization(s), intraprocedural contrast injection(s), fluoroscopic radiological supervision and interpretation, and imaging guidance performed to complete the pulmonary valve procedure (including 93662).
  - Do not report 33477 in conjunction with 93451, 93453, 93456, 93563.
  - 33477 includes percutaneous balloon angioplasty/stent placement of the pulmonary valve/conduit within the prosthetic valve delivery site.
  - Do not report 33477 in conjunction with valvuloplasty code 92990.
  - Report coronary or pulmonary artery stent placement (e.g., 92928, 92929, 37236) when performed at a site separate from the prosthetic valve delivery site.
  - Report pulmonary artery angioplasty 92997, 92998 separately when performed at a site separate from the prosthetic valve delivery site.
  - Report percutaneous VAD, Balloon Pump, ECMO, ECLS or CP-Bypass separately with 33477.
  - Inpatient only C-status indicator.

Cardiac Contractility Modulation System

- **Insertion**
  - Insertion of generator and leads (total system) – 0408T
  - Insertion of generator only – 0409T
  - Insertion of atrial lead only – 0410T
    - Reported per lead inserted
  - Insertion of ventricular lead only – 0411T
    - Reported per lead inserted

Cardiac Contractility Modulation System

- **Removal**
  - Generator removal only – 0412T
  - Lead removal – 0413T
    - Reported per lead removed
    - Reported in addition to placement of a lead (0410T and/or 0411T) if a lead is replaced
  - Removal and replacement of pulse generator – 0414T
  - If generator and leads are all replaced, report 0408T for placement of the generator and leads, and report 0413T for each lead removed
    - The removal of the generator is not reported separately

Cardiac Contractility Modulation System

- Repositioning of lead – 0415T
  - Do not report in addition to insertion of a new lead unless it is a different lead
  - Do not report in addition to cardiac catheterization codes
- Relocation of skin pocket – 0416T
- Programming device evaluation (in person) – 0417T
- Interrogation device evaluation (in person) – 0418T
  - Do not report at time of insertion or replacement of generator and/or leads
  - Do not report at time of repositioning a lead
### Key NCDs for Cardiology

- **20.4:** Implantable Automatic Defibrillators (DOJ audits)
- **20.8:** Pacemakers
- **20.7:** Carotid Stents (and other vessel angioplasty/stent)
- **20.32:** Transcatheter Aortic Valve Replacement (TAVR)
- **20.33:** Transcatheter Mitral Valve Repair (TMVR)
- **Pending:** Left Atrial Appendage Closure (LAAC)

### Defibrillator

- **NCD 20.4** (long-standing NCD)
- Focus of DOJ reviews (simple data mining)
  - Reviewing all cases with ICDs placed with:
    - MI within 40 days
    - Stent, CABG, or PTCA (revascularization) within 90 days
- DOJ Resolution Model available over internet
- Requested cases back to after 10/1/03
  - Recouping for overpayments for AICDs not meeting CMS NCD 20.4 guidelines (as of 2/23/16, $273,000,000 from 510 hospitals)

### Pacemaker

- Implantation of pacemaker requires medical necessity of irreversible symptomatic bradycardia (for single or dual chamber)
  - **NCD 20.8** final implementation date of Nov. 2015
  - Does not pertain to resynchronization therapy
  - Requires **KX modifier** for payment (This modifier is the attestation that the requirements in the NCD for placement of this pacemaker are met, documented and available for review in the medical record)

### Transcatheter Aortic Valve Replacement (TAVR/TAVI)

- **NCD 20.32** (Implementation 1/7/2013)
- CMS covers when the following are met
  - Furnished according to an FDA approved indication
  - Two cardiac surgeons independently examined the patient, face to face, for suitability for open AVR
  - The patient is under care of a “Heart Team”
Transcatheter Aortic Valve Replacement (TAVR/TAVI)

- The heart team’s interventional cardiologist and cardiac surgeon must **jointly participate** in the intra-operative technical aspects of TAVR
- Both hospital and heart team must participate in a prospective, national audited registry
- Recent CERT review showed 1/3 of TAVR cases did not have adequate documentation of face to face evaluations available in the chart for the heart team to review

Transcatheter Mitral Valve Repair (TMVR)

- **NCD 20.33** (Implementation 4/6/2015)
- CMS covers when the following are met
  - Furnished according to an FDA approved indication
  - One Cardiac Surgeon and one Interventional Cardiologist experienced in Mitral Valve Surgery/Disease have independently examined the patient, face to face, for suitability of open MVR and TMVR and these evaluations must be available to the Heart Team
  - The patient is under care of a “Heart Team”

Transcatheter Mitral Valve Repair (TMVR)

- The heart team’s interventional cardiologist and cardiac surgeon **MAY jointly participate** in the intra-operative technical aspects of TAVR
- Both hospital and heart team must participate in a prospective, national audited registry

Left Atrial Appendage Closure (LAAC)

- Coverage by Medicare is Effective Feb. 8, 2016. **NCD pending.**
- CMS covers when the following are met
  - Non-valvular atrial fibrillation, <=Chad 2, unable to take long term warfarin
  - Formal shared decision making between the interventional cardiologist and an independent non-interventional MD with the findings documented in the medical record
  - The patient is under care of a “Multidisciplinary Team”
- Hospital and physicians must participate in a prospective, national audited registry
**Angioplasty and Stent Placements**

- **NCD 20.7** (below are rules for carotid artery stents)
  - Symptomatic and High risk for CEA
  - ≥ 70% stenosis not in a clinical trial (CREST II 50%, Asymptomatic)
  - FDA-approved stent
  - FDA-approved embolic protection device (EPD)
    - If EPD can’t be placed, procedure will be non-covered for Medicare patients (use 37216)
  - Stenosis must be confirmed angiographically at time of procedure. **DO NOT use EYEBALL TECHNIQUE!**
  - History must be in chart prior to performing the procedure (including documentation of high risk and symptoms)