New Cardiothoracic Surgery CPT Codes for 2013

There were several changes to the cardiothoracic surgery CPT codes for 2013. There are five new codes in the general thoracic surgery section, with one revised code and three deleted codes. For cardiac surgery, there are 13 new codes, and one revised code and four deleted Category III codes.

**General Thoracic CPT Coding Changes**

**Deleted Codes:**
- 32420 – Pneumoncentesis, puncture of lung for aspiration (To report, use 32405)
- 32421 – Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent (To report, see 32554, 32555)
- 32422 – Thoracentesis with insertion of tube, includes water seal (eg, for pneumothorax), when performed (separate procedure) (To report, see 32554, 32555)

**Revised Code:**
- 32551 – Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open (separate procedure) (If imaging guidance is performed, use 75989)

**New Codes**
- 32554 – Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance
- 32555 – with imaging guidance
- 32556 – Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance
- 32557 – with imaging guidance
- 32701 – Thoracic target(s) delineation for stereotactic body radiation therapy (SRS/SBRT), (photon or particle beam), entire course of treatment (Do not report 32701 in conjunction with 77261 – 77799) (For placement of fiducial markers, see 31626, 32553)

**2013 Global Period, Relative Value Units (RVU), and Payments**

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Based on 2013 CF: $34.0230

Pleural Drainage Procedures

The first series of codes—the deletion of codes 32421 and 32442, the revision to code 32551 (i.e., chest tube), and new codes 32554 – 32557 (i.e., thoracentesis and catheters)—represent changes to clarify coding for chest tube insertion, thoracentesis, and percutaneous catheter procedures. These codes were identified through the AMA Relative Value Update Committee (RUC) screen for codes that were frequently reported together. The ultrasound guidance code 76942 was reported combined with the thoracentesis codes more than 75% of the time.

Additionally, the major provider for code 32551 (chest tube) had shifted from cardiothoracic and general surgery to interventional radiologists. As a result, a new set of codes and clarification of the existing codes was undertaken in a multi-specialty effort to ensure correct coding for these procedures.

In selecting the correct code, it is important to focus on the procedural technique (open cutdown vs. percutaneous) used to perform the procedure since the size and types of tubes, catheters, or drains can be similar regardless of the technique.

Code 32551 was revised to emphasize that this is an open procedure requiring a surgical cutdown and exploration using blunt and sharp dissection to access the pleural space for chest tube insertion. The reference to specific diagnosis for the code was also removed since code 32551 can apply to a variety of different diagnoses. When reporting 32551, the following issues should be considered:

- 32551 should not be reported in addition to thoracic or cardiac procedures where the tubes are inserted intraoperatively for drainage since this is considered inherent to procedures where a thoracic or mediastinal approach is used.
- Moderate sedation is inherent to the procedure and should not be separately reported if used.
- 32551 has a 000 day global period, and when it is performed independent of another cardiac or thoracic surgical procedure, services provided after the day of the procedure may be separately reported using the appropriate evaluation and management (E&M) code with supporting documentation.
- There is no corresponding removal code for a thoracostomy tube (32551).
- For removal of this type of tube, the appropriate level of E&M code based on supporting documentation can be reported.
- If 32551 is performed bilaterally, append modifier -50 to the code.

Codes 32421 – 32422 were deleted and replaced with codes 32554 – 32555, which were created to identify percutaneous needle or catheter pleural fluid aspiration with or without imaging guidance,
and codes 32556 – 32557 for percutaneous pleural drainage by placement of an indwelling catheter (e.g., pigtail) with or without imaging guidance. For this series of codes, it is important to consider the following:

- Percutaneous insertion techniques for codes 32554 – 32557 do not require extensive dissection, tunneling, or local exploration.
- Imaging guidance codes 76942, 77002, 77012, 77021 and 75989 should not be reported in addition to these codes. If imaging guidance is used, then code 32555 or 32557 should be reported as appropriate.
- Moderate sedation is not inherent to these procedures, and if used, the appropriate moderate sedation code (99143 – 99150 as appropriate) can also be reported.
- These codes all have a 000 day global period, so services provided after the day of the procedure may be separately reported with the appropriate E&M code with supporting documentation.
- Code 32552 should not be reported for the removal of these catheters. 32552 should only be used for removal of an indwelling tunneled pleural catheter with a cuff.
- There is no corresponding removal code for indwelling noncuffed pleural catheters or non-indwelling pleural catheters (32556, 32557).
- For removal of this type of catheter, the appropriate level of E&M code based on supporting documentation should be reported.
- If 32554 – 32557 are performed bilaterally, append modifier -50 to the code.

**Thoracic Stereotactic Radiation Surgery (SRS) / Stereotactic Body Radiation Therapy (SBRT)**

For SRS/SBRT services that are provided as a collaborative effort between the surgeon and the radiation oncologist, there are now codes that can be reported by each physician. The thoracic surgeon would report code 32701, which describes the work of drawing the contours around the tumor and planning the dosage and fractionation. The radiation oncologist would report the appropriate code(s) from the Radiation Oncology section (77295, 77331, 77370, 77373, 77345) for clinical treatment planning, physics and dosimetry, treatment delivery, and management. The same physician should not report code 32701 with the radiation treatment and management codes (77247 – 77499).

Target delineation involves the determination of specific tumor borders, the identification of tumor volume and the relationship with adjacent structures, and fiducial markers if present. Delineation can also be provided if a fiducial-less tracking system is utilized. If fiducial placement is provided by the same physician who provides the target delineation, it should be separately reported using the appropriate code (31626, 32553).

Code 32701 should be reported only once for the entire course of treatment if the treatment requires more than one session. The global period is XXX for this procedure, which means that the global concept does not apply—so if the surgeon provides other services related to the SRS/SBRT treatment outside of the target delineation, they should be reported with the appropriate CPT code (eg, E&M) beginning the day of the service.
Deleted Codes:

0256T – Implantation of catheter-delivered prosthetic aortic heart valve; endovascular approach (To report, see 33361 – 33364)
0257T – open thoracic approach (eg, transapical, transventricular) (To report, see 33365, 0318T)
0258T – Transthoracic cardiac exposure (eg, sternotomy, thoracotomy, subxiphoid) for catheter-delivered aortic valve replacement; without cardiopulmonary bypass (To report, see 33365, 0318T)
0259T – with cardiopulmonary bypass (To report, see 33365 – 33369)

Revised Code:

33225 – Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator (eg, for upgrade to dual chamber system) (List separately in addition to code for primary procedure)
(Use 33225 in conjunction with 33206, 33207, 33208, 33212, 33213, 33214, 33216, 33217, 33221, 33228, 33229, 33230, 33231, 33233, 33234, 33235, 33240, 33249, 33263, 33264)
(Use 33225 in conjunction with 33222 only with pacemaker pulse generator pocket relocation and with 33233 only with pacing cardioverter-defibrillator [ICD] pocket relocation)

New Codes:

33361 – Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach
33362 – open femoral artery approach
33363 – open axillary artery approach
33364 – open iliac artery approach
33365 – transaortic approach (eg, median sternotomy, mediastinotomy)
+33367 – cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels) (List separately in addition to code for primary procedure)
+33368 – cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels) (List separately in addition to code for primary procedure)
+33369 – cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery) (List separately in addition to code for primary procedure)
0318T – Implantation of catheter-delivered prosthetic aortic heart valve, open thoracic approach, (eg, transapical, other than transaortic)
33990 – Insertion of ventricular assist device, percutaneous including radiological supervision and interpretation; arterial access only
33991 – both arterial and venous access, with transseptal puncture
33992 – Removal of percutaneous ventricular assist device at separate and distinct session from insertion
33933 – Repositioning of percutaneous ventricular assist device with imaging guidance at separate and distinct session from insertion
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**Pacemaker Coding Revision**

The parenthetical note within code +33225 was changed to provide an example of the code use rather than a specific situation. The changes to the code are identified with the new language underlined and deleted language crossed out.

+33225 – Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator (including eg, for upgrade to dual chamber system and pocket revision) (List separately in addition to code for primary procedure)

New parenthetical notes were also added following the code to clarify what procedures the code can be reported with as primary procedures and further clarifying when it can be reported with codes 33222 and 33223.

**Transcatheter Aortic Valve Replacement (TAVR) Codes**

There are nine new codes describing the replacement of the aortic valve using a transcatheter technique. The codes and values are provided in the table above. Please see the separate handout titled *Reporting TAVR in 2013* for detailed information on how to report these services.

**Percutaneous Ventricular Assist Device (VAD) Procedures**

There are four new codes for reporting procedures associated with percutaneous VADs. These include two codes for insertion, one code for removal, and one code for repositioning a device.

The insertion codes are distinguished by one requiring only arterial access for insertion (33990) and the other requiring both arterial and venous access with transeptal puncture for the insertion (33991).
Additional codes that may be reported with the percutaneous VAD insertions include:

- Open femoral arterial exposure (34812) should be separately reported when performed.
- Extensive repair or replacement of an artery may be reported using an appropriate code (e.g., 35226, 35286).
- Other surgical procedures that are not directly related to the insertion.
- Other interventional procedures that are not directly related to the insertion.

The percutaneous VAD removal code (33992) should not be reported if performed during the same session as the insertion—only the insertion code should be reported. If the percutaneous VAD is removed during a separate and distinct session from the insertion later the same day, the removal code may be reported and the -59 modifier appended to the removal code to indicate that this was done in a separate session on the same day. If the removal is performed on a different day than the insertion, then no modifier is required unless you are in the global period of another procedure, in which case an appropriate modifier should be reported as applicable for the situation.

Repositioning of the percutaneous VAD (33993) when performed in the same session as the insertion is not separately reportable. Percutaneous VAD repositioning that does not require or utilize imaging guidance is not a reportable service. If the percutaneous VAD is repositioned using imaging guidance during a separate and distinct session from the insertion later the same day, the repositioning code may be reported and the -59 modifier appended to the repositioning code to indicate that this was done in a separate session on the same day. If the repositioning is performed on a different day than the insertion, then no modifier is required unless you are in the global period of another procedure, in which case an appropriate modifier should be reported as applicable for the situation.

If the percutaneous VAD is replaced by removing the entire device and inserting a new device in the same session, only the appropriate insertion code (33990 or 33991) should be reported. Do not also report the removal code (33992).

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