INSIDE

2006 CPT Coding Changes................. 1
2006 Conversion Factor........................ 1
2006 ICD-9-CM Changes................. 5
NPI Update & Correction.................... 6
Split E&M, Consultation Update.... 6
Recovery Audit Contractors (RAC)... 7
Reporting Arch Grafts.........................8
Coding Workshop...............................8
STSCodingToday..............................8

2006 CPT Coding Changes & Tips

There are several coding changes for 2006. The majority of the changes affect congenital cardiac surgery and vascular surgery. The new codes and changes, as well as coding tips, are as follows:

**General Thoracic**

**Deleted Codes**

- 32520 – Resection of lung; with resection of chest wall.
- 32522 – Resection of lung; with reconstruction of chest wall, without prosthesis.
- 32525 – Resection of lung; with major reconstruction of chest wall, with prosthesis.

**Coding Tip:** To report these services, you should use the appropriate lung resection code, 32480-32500, with the appropriate chest wall resection codes 19260, 19271, 19272. If you perform chest wall resection without rib resection, use codes 21555-21557 as appropriate.

**New Codes**

- 32503 – Resection of apical lung tumor (e.g., Pancoast tumor), including chest wall resection, rib(s) resection(s), neurovascular dissection; when performed without chest wall reconstruction(s)
- 32504 – Resection of apical lung tumor (e.g., Pancoast tumor), including chest wall resection,

(Continued on Page 2)

2006 Conversion Factor Frozen at 2005 Rate

On Feb. 8, President Bush signed the Deficit Reduction Act of 2005 (DRA) into law, with some provisions retroactive to Jan. 1, 2006. The following provides a summary of what to expect from these provisions and how Medicare will retroactively implement these changes:

The DRA prevents payments for physicians’ services delivered on or after Jan. 1 from being reduced by a negative update of 4.4 percent.

Medicare claims-processing contractors are preparing to pay all 2006 claims at the higher rates within two business days following the President’s signing of the bill into law. January claims that have been paid will be reprocessed. The large volume of claims reprocessing is expected to be completed by July 1. Physicians and other practitioners paid under Medicare’s physician fee schedule should expect several aggregated (versus claim-by-claim) payments during that time. CMS held a second 45-day participation enrollment period to allow physicians to change their participation decision.
(Continued From Page 1)

rib(s) resection(s), neurovascular dissection; when performed with chest wall reconstruction(s).
(Do not report 32503, 32504 in conjunction with 19260, 19271, 19272, 32002, 32020, 32100.)

Coding Tip: These new Pancoast tumor codes include chest wall resection. If thoracic, mediastinal, or peritracheal lymph node sampling is performed in conjunction with these procedures, report code 38746 in conjunction.

Congenital

Deleted Codes
• 33918 – Repair of pulmonary atresia with ventricular septal defect, by unifocalization of pulmonary arteries; without cardiopulmonary bypass.
• 33919 – Repair of pulmonary atresia with ventricular septal defect, by unifocalization of pulmonary arteries; with cardiopulmonary bypass.

Coding Tip: These codes were deleted and replaced with new codes to better represent current practices. To report, use new codes 33925, 33926 listed below.

New Codes
• 33925 – Repair of pulmonary artery arterization anomalies by unifocalization; without cardiopulmonary bypass.
• 33926 – Repair of pulmonary artery arterization anomalies by unifocalization; with cardiopulmonary bypass.

(Do not report 33925, 33926 in conjunction with 33697.)

Coding Note: STS is working to have changed the parenthetical note (and bundling edits) that do not allow the Tetralogy of Fallot (33697) to be reported in conjunction with the new unifocalization codes. We anticipate that this change will be published in Oct. 2006, and will go into effect Jan. 2007. STS will keep you updated on changes and will provide new coding instructions when they become available.
• 33507 – Repair of anomalous (e.g., intramural) aortic origin of coronary artery by unroofing or translocation.
• +33768 – Anastomosis, cavopulmonary, second superior vena cava (List separately in addition to primary procedure.)
(Use 33768 in conjunction with 33478, 33617, 33767.)
(Do not report 33768 in conjunction with 32020, 33210, 33211.)

Coding Tip: Code 33768 should be used to report a bilateral, bidirectional Glenn procedure.

Descriptor Changes
As a result of the development for the new coronary artery unroofing code, the descriptors for the existing family of anomalous coronary artery codes were changed to clarify that the anomalous coronary artery arises from the pulmonary artery origin. The descriptor change reads as follows:
• 33502 – Repair of anomalous coronary artery from pulmonary artery origin; by ligation.
• 33503 – by graft, without cardiopulmonary bypass.
• 33504 – by graft, with cardiopulmonary bypass.
• 33505 – with construction of intrapulmonary artery tunnel (Takeuchi procedure).
• 33506 – by translocation from pulmonary artery to aorta.

Adult Cardiac

New Code
• 33548 – Surgical Ventricular restoration procedure, includes prosthetic patch, when performed (e.g., ventricular remodeling, SVR, SAVER, DOR procedures).
(Do not report 33548 in conjunction with 32020, 33210, 33211, 33310, 33315.)
(For Batista procedure or pachopexy, use 33999.)

Coding Tip: These procedures were formerly reported using code 33542-22. The new code covers a variety of methods to accomplish ventricular remodeling. Ensure that the payer doesn’t confuse it with the Batista procedure which is considered non-covered under Medicare policy. If you have questions about coverage, contact the STS Coding Hotline at (303) 209-7358.

Vascular

New Codes: Surgical
Descending thoracic aorta repair using endovascular techniques is a new service that is being performed by a number (Continued on Page 3)
of cardiothoracic surgeons around the country. STS has offered courses on these new techniques and is offering more in July. See www.sts.org/sections/education/thoracicendografting/ for more information.

In 2006, these codes moved from Category III CPT tracking codes to covered Category I CPT codes. Several procedural codes were developed, as well as some radiologic supervision and interpretation counterparts in the 70000 series of codes. The -26 modifier should be appended to all radiological S&I codes.

- **33880** – Endovascular repair of descending thoracic aorta (e.g., aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); **involving** coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin. (For radiological supervision and interpretation, use 75957 in conjunction with 33881.)

**Coding Tip:** Codes 33880 and 33881 include the insertion of all distal extensions placed. There are times when the size of the defect requires more than one graft for coverage. The grafts are generally placed proximal to distal along the defect. Do not report the proximal extension codes if the grafts planned to cover the defect are placed distal to proximal 33880. Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (e.g., aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); initial extension. (For radiological supervision and interpretation, use 75958 in conjunction with 33883.) (Do not report 33881, 33883 when extension placement converts repair to cover left subclavian origin. Use only 33880.)

- **33884** – Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (e.g., aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); each additional proximal extension (List separately in addition to code for primary procedure.) (Use 33884 in conjunction with 33883.) (For radiological supervision and interpretation, use 75958 in conjunction with 33884.)

**Coding Tip:** Codes 33883 and 33884 are generally used for covering a type I endoleak.

- **33886** – Placement of distal extension prosthesis(es) delayed after endovascular repair of descending thoracic aorta. (Do not report 33886 in conjunction with 33880, 33881.) (Report 33886 once, regardless of number of modules deployed.) (For radiological supervision and interpretation, use 75959 in conjunction with 33886.)

- **33889** – Open subclavian to carotid artery transposition performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision, unilateral. (Do not report 33889 in conjunction with 35694.)

**Coding Tip:** Code 33889 was designed for use when the physician anticipates that the repair will require coverage of the subclavian artery origin. This procedure represents ligation of the subclavian artery with anastomosis to the carotid in order to preserve blood flow to the arms.

- **33891** – Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by
(Continued From Page 3) neck incision. (Do not report 33891 in conjunction with 35509, 35601.)

Coding Tip: Code 33891 was designed for use when the aortic aneurysm is proximal to the origin of the left common carotid and coverage of the carotid origin is required. This procedure represents a cross-neck carotid-carotid bypass performed using synthetic material.

Coding Tip: Codes 33889 and 33891 may be reported as bilateral procedures by appending the -50 modifier, if appropriate.

Coding Tips: Some general coding principles that should be applied to the descending thoracic aortic endografting procedures (33880-33891) include the following:

• Do not report the following in conjunction with the thoracic endografting codes:
  – Device introduction, manipulation, positioning, and deployment;
  – Balloon angioplasty and/or stent deployment in target treatment zone.

• If provided, the services listed below may be reported in addition to the thoracic endografting procedures:
  – Open arterial exposure and associated closure of the arteriotomy sites (e.g., 34812, 34820, 34883, 34834).
  – Introduction of guidewires and catheters (e.g., 36140, 36200-36218).
  – Extensive repair or replacement of an artery (e.g., 35226, 35286).
  – Transposition of subclavian to carotid and carotid-carotid bypass (e.g., 33889, 33891).

New Codes: Radiological Supervision & Interpretation

• 75956 – Endovascular repair of descending thoracic aorta (e.g., aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation. (For implantation of endovascular graft, use 33880.)

• 75957 – Endovascular repair of descending thoracic aorta (e.g., aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation. (For implantation of endovascular graft, use 33880.)

• 75958 – Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (e.g., aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption), radiological, and interpretation. (Report 75958 for each proximal extension.) (For implantation of proximal endovascular extension, see 33883, 33884.)

• 75959 – Placement of distal extension prosthesis(s) (delayed) after endovascular repair of descending thoracic aorta, as needed, to level of celiac origin, radiological supervision and interpretation. (Do not report 75959 in conjunction with 75956, 75957.) (Report 75959 once regardless of number of modules deployed.) (For implantation of distal endovascular extension, use 33886.)

Coding Tips: Some general coding principles that should be applied to the descending thoracic aortic endografting procedures with radiological supervision and interpretation procedures (75956-75959) include the following:

• Do not report the following in conjunction with the thoracic endografting codes:
  – Device introduction, manipulation, positioning, and deployment;
  – Balloon angioplasty and/or stent deployment in target treatment zone;
  – Angiography of the thoracic aorta and its branches for diagnostic

(Continued on Page 5)
imaging prior to deployment of device:
- Fluoroscopic guidance for component delivery.
- Intraprocedural arterial angiography to:
  • Confirm position;
  • Detect endoleak;
  • Evaluate runoff.
• If provided, the services listed below may be reported in addition to the thoracic endografting procedures:
  - Open arterial exposure and associated closure of the arteriotomy sites (e.g., 34812, 34820, 34883, 34834).
  - Introduction of guidewires and catheters (e.g., 36140, 36200-36218).
  - Extensive repair or replacement of an artery (e.g., 35226, 35286).
  - Transposition of subclavian to carotid and carotid-carotid bypass (e.g., 33889, 33891).
  - Other interventional procedures in addition to thoracic endografting procedure:
    • Examples
      - Innominate;
      - Carotid;
      - Subclavian;
      - Visceral;
      - Iliac artery; transluminal angioplasty or stenting;
      - Arterial embolization;
      - Intravascular ultrasound.

2006 ICD-9-CM Coding Changes

The renal disease diagnosis codes were changed in 2006. The new coding structure will affect the way that cardiothoracic surgeons calculate severity measures for patients. The old ICD-9-cm code 585 – Chronic kidney disease (CKD) has been changed to require a fourth digit indicating the stage (I-V) of the disease. The new ICD-9 codes include the following:

585 – Chronic kidney disease (CKD) (requires a fourth digit)
585.1 – Chronic kidney disease, Stage I
585.2 – Chronic kidney disease, Stage II (mild)
585.3 – Chronic kidney disease, Stage III (moderate)
585.4 – Chronic kidney disease, Stage IV (severe)
585.5 – Chronic kidney disease, Stage V
585.6 – End stage renal disease
585.9 – Chronic kidney disease, unspecified.

Other codes affected by the renal disease diagnosis code changes include changes to codes 403 and 404. Diagnosis code 403 – Hypertensive kidney disease was changed to include a note that additional codes from 585.1-585.6 should be used in addition to 403 to identify the stage of chronic kidney disease, if known. In addition, the fourth and fifth digit descriptors were revised, they now read as follows:

0 – Without heart failure or chronic kidney disease
1 – With heart failure
2 – With chronic kidney disease
3 – With heart failure and chronic kidney disease.

Other 2006 ICD-9-CM coding changes that pertain to cardiothoracic surgery include the following: The phrase “ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction” was added to the “includes” of the text under the descriptors for diagnosis codes 410-410.9 dealing with myocardial infarctions.

A new code was added to the 426 series of codes: Other specified conduction disorders code 426.82 – Long QT syndrome.

New body mass index codes for defining obesity were also added:
V85 – Body Mass Index
V85.0 – Body Mass Index less than 19, adult
V85.1 – Body Mass Index between 19-24, adult
V85.2 – Body Mass Index between 25-29, adult
V85.21 – Body Mass Index 25.0-25.9, adult
V85.22 – Body Mass Index 26.0-26.9, adult
V85.23 – Body Mass Index 27.0-27.9, adult

(Continued on Page 6)
V85.24 – Body Mass Index 28.0-28.9, adult
V85.25 – Body Mass Index 29.0-29.9, adult
V85.3 – Body Mass Index between 30-39, adult
V85.30 – Body Mass Index 30.0-30.9, adult
V85.31 – Body Mass Index 31.0-31.9, adult
V85.32 – Body Mass Index 32.0-32.9, adult
V85.33 – Body Mass Index 33.0-33.9, adult
V85.34 – Body Mass Index 34.0-34.9, adult
V85.35 – Body Mass Index 35.0-35.9, adult
V85.36 – Body Mass Index 36.0-36.9, adult
V85.37 – Body Mass Index 37.0-37.9, adult
V85.38 – Body Mass Index 38.0-38.9, adult
V85.39 – Body Mass Index 39.0-39.9, adult
V85.4 – Body Mass Index 40 and over, adult.

NATIONAL PROVIDER IDENTIFIER (NPI) AND CORRECTION

An article on the NPI was included in the Vol. 14 No. 2 & 3, Summer/Fall 2005 issue of the STS/AATS Coding Newsletter. In that article, readers were informed that as a result of The Health Insurance Portability and Accountability Act of 1996 (HIPAA) it was mandated that a standard unique health identifier for health care providers be adopted by all health plans (Medicare, Medicaid, and private health plans) by May 23, 2007. The National Provider Identifier (NPI) was adopted as this standard, and after May 23, 2007, it will be the only identifier that health care providers will use to identify themselves in standard electronic transactions, where the NPI is required. The NPI will replace current health care provider identifiers used for standard transactions. All health care providers who transmit health information electronically in connection with any of the HIPAA standard transactions are required to obtain an NPI. You will need to apply for and acquire only one NPI to be used for all Medicare and non-Medicare standard transactions. The NPI does not replace any enrollment or credentialing process with any health plans. There are three methods available to apply for your NPI.

1. Apply online at https://nppes.cms.hhs.gov
2. Call (800) 465-3203 to receive a paper application. (The wrong phone number was given in the previous article, so please be sure to use the one noted here.)
3. Given your permission, an organization may submit your application in an electronic file. (i.e., a professional association or a health care provider who is your employer).

SPLIT E&M SERVICES AND CONSULTATION UPDATE

Since the publication of the article on Reporting Shared or Split E&M Services included in Vol. 14, No. 2 & 3, Summer/Fall 2005 STS/AATS Coding Newsletter, CMS has published an update on reporting consultations. One issue that is clearly spelled out in the CMS update is that while consultations may be performed and reported by qualified non-physician practitioners, consultations do not qualify for a shared or split E&M service. This provision differs from what was published in the previous STS/AATS Coding Newsletter article. STS is planning to work with other societies to try and get this policy changed. The consultation update results in the development of slightly more precise rules for reporting consultations without resulting in any significant changes. Some of the main issues touched upon in the update include the following:

1. Clarification of documentation of the request for consultation. It is clarified that both the requesting physician and the consulting physician must document the request for a consultation in their respective patient records. The revised regulations imply the need to, but stop short of requiring, verification of documentation in the requesting physician’s record on the part of the consulting physician. It will be important that cardiothoracic surgeons clearly document in patients’ medical records any requests to other physicians or qualified non-physician practitioners (NPP) for a consultation, as well as the request.
from another physician or qualified NPP (the request can be office to office, it does not need to be practitioner to practitioner). It is our understanding that additional regulations will be released from CMS further clarifying this issue.

2. The CMS update also addressed the issue of transfer of care. The regulations still result in grey areas in determining transfer of care, however. The basic concept is that if a referring physician requests specific treatment for a diagnosed problem from a second physician and the referring physician is not going to be involved during the course of the treatment, it is considered a transfer of care. However, if the referring physician will still be involved in the patient’s care at some level, it is not considered a transfer of care. The majority of requests for cardiothoracic surgeons qualify as consultations rather than a transfer of care.

3. In the 2006 CPT book, the follow-up consultation services (99261-99263) were deleted. CMS regulations clarify that with the deletion of these codes, the appropriate method of reporting services previously reported by these codes would be to use either the appropriate initial consultation codes 99241-99245 for outpatient or 99251-99255 for inpatient if the visit qualifies as a consultation. If the visit does not qualify as a consultation, then the subsequent hospital care codes (99231-99233) should be reported for inpatients and the established patient codes (99211-99214) should be reported for office or other outpatient settings.

4. The 2006 CPT book also deletes the confirmatory consultation codes (99271-99275). For this service, CMS clarifies that second opinions requested by the patient and/or family or mandated by a third party do not qualify as consults because they do not come from a physician or qualified NPP. Therefore, the request for a second opinion from these sources should be reported as subsequent hospital care codes (99231-99233) and in the office or other outpatient setting the new patient codes (99201-99205) or the established patient codes (99211-99215) as appropriate. Medicare does not recognize modifier -32 (mandated services) and second opinions to satisfy requirements for third party payers are also noncovered.

RECOVERY AUDIT CONTRACTORS (RACs)

As part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), the Department of Health and Human Services (HHS) was directed to use RACs under the Medicare Integrity Program to help identify underpayments and overpayments in the Medicare program recouping overpayments. CMS began the process of identifying RACs in Jan. 2005 with contracts awarded to five RACs in March 2005. Three of the five RACs are now performing post-payment medical reviews in California, Florida, and New York. The contractors for these states are Connolly Consulting in New York; PRG Schultz and its subcontractor, Concentra Preferred Systems in California; and HealthData Insights in Florida.

The review process is three tiered, with the first level review targeted to Part A DRGs. The second level is for overpayments that do not meet Medicare policy requirements for Part A or Part B. The third level involves the actual request of medical records for Part B Services. Cardiothoracic surgeons in California, Florida, and New York should be aware of this initiative. STS has already received notice from some practices in these states that they have been contacted by the RACs with overpayment notices. It has come to our attention that in at least two states (Florida and New York) the RACs have incorrectly interpreted the application of the -78 modifier for a return to surgery on the same day as the original procedure. The RACs are trying to apply the multiple procedure reduction (50 (Continued on Page 8)
percent) for the return to surgery the same day. This would be considered an incorrect interpretation according to CMS regulations in the Medicare Claims Processing Manual 100-4, Chapter 12, Section 40.4(C). STS will send out a more detailed letter regarding the RACs to STS members in these states.

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REPORTING ARCH GRAFTS

The Coding Hotline has received several questions about when it is appropriate to report code 33870 – Transverse arch graft, with cardiopulmonary bypass in conjunction with other procedures. STS suggests that code 33870 should only be reported if a direct anastomosis of graft to the descending aorta with a side of graft to end of head vessel island (includes the grafting or reimplantation of the brachiocephalic, left common carotid, and left subclavian arteries) anastomosis is performed. It would not be appropriate to report this code when only the lesser curve of the arch is done as part of a beveled ascending aortic graft (hemiarch).

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SAVE THE DATE!

The next STS Coding Workshop will be held October 20-21, at the Anaheim Marriott Hotel in Anaheim, CA. Registration, hotel information, and program information can be found on www.sts.org, under Education.

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STS CODING TODAY

STS Coding Today is a web-based coding resource available to STS members and their staff. The member price is $249 for the first user, and $99 for each additional user. STS Coding Today offers cardiothoracic surgery offices a fast, easy way to look up coding and billing related information and regulations. STS Coding Today combines data from more than five databases and is updated quarterly or as changes occur. Each CPT code contains the following information: CPT code; full descriptor; global fee period; Medicare status; modifier usage for modifiers: modifier -50 (bilateral procedures), modifier -51 (multiple procedures), modifier -80, -81, and -82 (assistant surgeons), modifier -62 (co-surgeons), and modifier -66 (team surgeons); state and national fee data; National Correct Coding Initiative (NCCI) bundling edits; national regulations; links to Local Coverage Decisions (LCDs) for each state; and coding tips for the code developed by the STS Nomenclature and Coding Workforce. In addition, the user also has access to all ICD-9 codes which can be searched by descriptor or code directing users to the highest specificity for reporting; a complete listing of modifiers with tips and examples for how they should be used; a bundling matrix which allows a quick view of bundled codes ranked from highest to lowest relative value; and a cardiothoracic notes section to address broader cardiothoracic coding issues. To order or sign up for a 30-day free trial, go to www.stscodingtoday.com or call PRS at (800) 972-9298 for more information.

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The material presented herein is, to the best of our knowledge, accurate and factual to date. The information and suggestions are provided as guidelines for coding and reimbursement and should not be construed as organizational policy. The STS/AATS disclaim any responsibility for the consequences of actions taken, based on the information presented in this newsletter.

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CODING HOTLINE ASSISTANCE AVAILABLE FOR STS & AATS MEMBERS

The STS Coding Hotline is available to assist STS/AATS members and their staff with coding questions. Questions may be submitted by calling (303) 209-7358, faxing (303) 209-7359, by postal mail, or by e-mailing jpainter@physiciancoding.com. Please limit operative notes to one per month, per physician. All requests must include the physician’s name, STS or AATS membership number, and a phone number. All answers will be provided via a return phone call.

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STS/AATS Coding Newsletter

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