

Surgery: Cardiovascular System

This section contains information to assist providers in billing for surgical procedures related to the cardiovascular system.

Complex Venipunctures: Age Restrictions

CPT-4 code 36410 may be used to bill non-routine venipunctures for recipients 3 years of age or older. Anesthesiology services and assistant surgeon services are not payable for this procedure.

Complex venipunctures for recipients younger than 3 years of age are reimbursable with CPT-4 codes 36400 and 36405. Code 36400 is for billing complex venipuncture using the femoral vein or jugular vein and code 36405 is for billing complex venipuncture using the scalp vein. Assistant surgeon services are not payable for this procedure.

Note: Reimbursement for routine venipuncture is included in the reimbursement for laboratory procedures and is not separately reimbursable.

Implantable Infusion Pump for Regional Chemotherapy

CPT-4 codes 36260 – 36262 are billed for inserting, revising and removing implantable infusion pumps. These codes are restricted to procedures for the placement of intra-arterial catheters for regional chemotherapy, including Infusaid for the treatment of solid unresectable hepatic malignancies. CPT-4 code 36260 (insertion of implantable intra-arterial infusion pump) is used to bill the surgical procedure to implant the pump and insert the intra-arterial catheter. Code 36260 requires a *Treatment Authorization Request* (TAR). This procedure is normally performed on an outpatient basis. A TAR is not required for the following codes:

<u>CPT-4 Code</u>	<u>Description</u>
36261	Revision of implanted intra-arterial infusion pump
36262	Removal of implanted intra-arterial infusion pump

Billing for Infusion Pump

The pump must be supplied by the hospital and is reimbursable using CPT-4 code 36260 with modifier UA or UB, depending on the type of anesthesia used. If approved for an inpatient setting, the pump must be billed under the appropriate ancillary code. A copy of the invoice showing the actual cost of the pump must be attached to the claim. The physician performing the implantation procedure will not be reimbursed for the pump.

Selective Catheter Placement When billing for CPT-4 code 36228 (selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation), reimbursement is restricted to two per side. Providers must document “different side” when billing for quantity greater than two.

Transluminal Balloon Angioplasty CPT-4 code 35458 (transluminal balloon angioplasty, open; side for brachiocephalic trunk or branches, each vessel) is not reimbursable with CPT-4 code 37217 for ipsilateral services. Providers must document when the procedure is performed on the opposite or contralateral side in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) on the claim or on an attachment.

Radiological Supervision CPT-4 code 37217 (transcatheter placement of an intravascular stent[s], intrathoracic common carotid artery or innominate artery by retrograde treatment, via open ipsilateral cervical carotid artery exposure, including angioplasty, when performed, and radiological supervision and interpretation) is not reimbursable with CPT-4 codes 35201, 35458, 36221 – 36227 and 75962 for ipsilateral services. Providers must document when the procedure is performed on the contralateral side in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) on the claim or on an attachment.

Placement of Distal Prosthesis CPT-4 code 33886 (placement of distal extension prosthesis) may be reimbursed only once per day, any provider. Reimbursement for CPT-4 code 75959 (placement of distal extension prosthesis, radiological supervision and interpretation) is limited to once per date of service, regardless of the number of modules deployed.

Repair of Pulmonary Artery CPT-4 codes 33925 and 33926 (repair of pulmonary artery) are reimbursable for a second assistant surgeon.

Septal Defect and Venous Anomalies CPT-4 codes 33675 – 33677 (closure of septal defect), 33724 and 33726 (repair of venous anomalies) are reimbursable for a second assistant surgeon.

Venous Catheter	<p>To bill for the surgical placement of intravenous devices for recipients who need repeated intravenous administration of drugs and related substances, use CPT-4 codes 36560 – 36566, 36570 and 36571 (insertion of central venous access device).</p> <p>The placement of a reservoir (for example, Porta-Cath, Infus-a-Port) is considered incidental and is not reimbursable as an additional procedure.</p>
Simple Cutdown Placement	<p>Providers billing for the simple cutdown placement of central venous catheters (for example, for central venous pressure, hyperalimentation, hemodialysis or chemotherapy) should use CPT-4 codes 36555, 36557 or 36568 for recipients under 5 years of age and codes 36556, 36558 or 36569 for recipients ages 5 years or older.</p>
Coronary Artery Bypass	<p>When a coronary bypass procedure is performed using venous grafts and arterial grafts during the same operating session, bill the procedure using <u>two</u> surgical codes:</p> <ul style="list-style-type: none">• The appropriate arterial graft code (CPT-4 codes 33533 – 33536) with modifier AG• The appropriate combined arterial-venous graft code (CPT-4 codes 33517 – 33519, 33521 – 33523) with modifier 51 <p>These codes require an approved TAR.</p>
Percutaneous Coronary Intervention Procedures	<p>Refer to the <i>Cardiology</i> section in this manual for coverage and billing information.</p>
Re-Operation: Reimbursement Restrictions	<p>A coronary artery bypass or valve re-operation (CPT-4 code 33530) is reimbursable only if the re-operation was performed more than one month after the original operation. The re-operation (code 33530) should be billed in addition to the code for the primary procedure (codes 33400 – 33478, 33510 – 33523 and 33533 – 33536) on the same claim form.</p> <p>Providers billing with code 33410 (replacement, aortic valve, with cardiopulmonary bypass; with stentless tissue valve) may be reimbursed for a second assistant surgeon.</p>

**Low-density
Lipoprotein-Apheresis**

Low-density lipoprotein (LDL)-apheresis is reimbursable when performed to remove low-density lipoprotein cholesterol (LDL-C) from the plasma of high-risk patients when diet has been ineffective and maximum drug therapy has either been ineffective or not tolerated. The following recipients may be approved for LDL-apheresis:

- Recipients with homozygous familial hypercholesterolemia (FH) with LDL-C levels greater than 500 mg/dL
- Recipients with heterozygous FH with LDL-C levels greater than 300 mg/dL
- Recipients with heterozygous FH with LDL-C levels greater than 200 mg/dL and documented coronary artery disease

Authorization

Authorization is required for LDL-apheresis. TARs must be submitted each year for LDL-apheresis and may be approved for continuous 7- to 14-day intervals. All TARs must have a treatment plan that includes frequency and duration of proposed treatments. The initial TAR must include the following medical documentation:

- Diagnosis of familial hypercholesterolemia FH must be demonstrated by clinical assessment or by special laboratory examination.
- LDL-C levels must be obtained:
 - After the recipient with homozygous FH has been on an American Heart Association Step II Diet or an equivalent diet for at least three months or the recipient with heterozygous FH has been on a diet for six months, and
 - While the recipient is on a maximum tolerated combination drug therapy from at least two separate classes of hypolipidemic agents, one of which must include a 3-Hydroxy-3-methyl-glutaryl-Coenzyme A (HMG-CoA) reductase inhibitor.
 - Two LDL-C levels must be obtained within a two to four-week period.
- Coronary artery disease must be documented by coronary angiography, history of myocardial infarction, history of Coronary Artery Bypass Graft surgery (CABG), Percutaneous Transluminal Coronary Angioplasty (PTCA) or an alternative revascularization procedure such as atherectomy or stent, or by progressive angina documented by exercise or pharmacologic stress test for patients with heterozygous FH with LDL-C levels greater than 200 mg/dL.

Reauthorization Requirements	TARs for reauthorization must include the following medical documentation: <ul style="list-style-type: none">• Pre- and post-treatment cholesterol levels for at least two consecutive months prior to the submission date of the TAR• The post-treatment cholesterol levels should, at a minimum, be at least 50 percent less than the pre-treatment level
Billing Requirements	Providers should bill for LDL-apheresis using CPT-4 code 36516 (therapeutic apheresis; with extracorporeal selective adsorption or filtration and plasma reinfusion). Reimbursement for code 36516 includes pre-and post-cholesterol levels.

**Cardiac Implantable
Devices and Stents**

Hospital outpatient departments and outpatient surgery clinic providers only may bill the following HCPCS codes for cardiac implantable devices and stents.

Providers must bill the HCPCS codes for cardiac implantable devices in conjunction with ICD-9-CM diagnosis codes 398.0 – 429.9 and submit an invoice. Failure to submit an invoice will result in denial of the claim.

HCPCS

<u>Codes</u>	<u>Description</u>
C1721	Cardioverter-defibrillator, dual chamber
C1722	Cardioverter-defibrillator, single chamber
C1777	Lead, cardioverter-defibrillator, endocardial single coil
C1785	Pacemaker, dual chamber, rate-responsive
C1786	Pacemaker, single chamber, rate-responsive
C1882	Cardioverter-defibrillator, other than single or dual chamber
C1895	Lead, cardioverter-defibrillator, endocardial dual coil
C1896	Lead, cardioverter-defibrillator, other than endocardial single or dual coil
C2619	Pacemaker, dual chamber, non rate-responsive
C2620	Pacemaker, single chamber, non rate-responsive (implantable)
C2621	Pacemaker, other than single or dual chamber

Providers must bill the following HCPCS codes for stents in conjunction with ICD-9-CM diagnosis codes 410.0 – 429.9 and submit an invoice. Failure to submit an invoice will result in denial of the claim.

HCPCS

<u>Codes</u>	<u>Description</u>
C1874	Stent, coated/covered, with delivery system
C1875	Stent, coated/covered, without delivery system

Note: For invoice requirements, refer to the “Surgical Implantable Device Reimbursement” subsection in the *Surgery* section in the appropriate Part 2 manual.

Frequency Restriction

Cardiac implantable devices and stents have a frequency restriction of once a year for the same recipient by the same provider. Medical justification documented in the *Remarks* field (Box 80) is required for any surgical implantable device claims billed more than once in a year.

Surgical Treatment of Varicose Veins

Varicose veins may be surgically treated when conservative treatment has been unsuccessful in resolving symptoms.

Definition

Symptomatic varicose veins are defined as one of more of the following:

- Documented persistent or recurrent symptoms attributable to venous insufficiency such as pruritis, burning or edema that interfere with daily activity, or pain requiring analgesics. Submitted documentation should summarize the diagnostic evaluation and describe the nature of the functional limitation. These individuals must have failed a three-month trial of conservative management, including analgesics and prescription gradient support stockings providing at least 20 mm Hg of compression at the ankle.
- Hemorrhage from venous varicosity.
- Venous stasis ulceration.

TAR Requirements

An approved *Treatment Authorization Request* (TAR) is required for all reimbursements for stab phlebectomy, ligation and division with or without vein stripping, and radiofrequency ablation (RFA) or endovenous laser ablation (EVLA) of incompetent veins.

The following data must be clearly reported and accompany all TARs for surgery:

- Duplex ultrasound demonstrating clinically significant venous reflux of the great saphenous, small saphenous or perforating veins defined as greater than or equal to 0.5 seconds retrograde flow in the vein to be treated.
- Vein diameter must be 4.5 mm or greater in diameter, not severely tortuous, and vein diameter no greater than 12 mm for RFA or 20 mm for EVLA.
- Adequate patency of the deep veins of the leg documented by ultrasound.

Limitations

Additional limitations for surgical treatment of varicose veins:

- Duplex ultrasound when performed during a procedure or to monitor postoperative progress is not separately reimbursable.
- Stab phlebectomy may only be performed concurrently or shortly after RFA or EVLA if varicosities remain following successful RFA or EVLA. Duplex ultrasound must demonstrate no residual reflux and patency of the deep veins of the leg.
- No TARs will be approved for multiple treatment sessions of the same procedure on the same extremity. Repeat procedures are only indicated if clinical and anatomic failure unresponsive to conservative treatment is demonstrated after the 90-day post-operative period.

Contraindications

Contraindications for surgical treatment of varicose veins include but are not limited to:

- Pregnancy and three months following delivery
- Acute febrile illness or infection
- Recent deep vein thrombosis
- Acute superficial thrombophlebitis
- Severe peripheral artery disease (ankle-brachial index of 0.4 or less)
- Obliteration of deep venous system

Ventricular Assist Devices

Claims for HCPCS codes Q0478 – Q0504 and Q0506 – Q0509 (ventricular assist devices and accessories) will be reimbursed at invoice cost. Code Q0506 must be billed with modifier NU.

Second Assistant Surgeon

Reimbursement for a second assistant surgeon is allowed for the following CPT-4 codes:

32852, 32854, 33031, 33120, 33251, 33259, 33261, 33305, 33315, 33321, 33322, 33332, 33335, 33400, 33403, 33405, 33406, 33410 – 33412, 33415 – 33417, 33422, 33425 – 33427, 33430, 33460, 33465, 33468, 33474, 33476, 33478, 33496, 33500, 33504, 33510 – 33514, 33516 – 33519, 33521 – 33523, 33530, 33533 – 33536, 33542, 33545, 33572, 33641, 33645, 33647, 33660, 33665, 33670, 33675 – 33677, 33681, 33684, 33688, 33692, 33694, 33702, 33710, 33720, 33724, 33726, 33730, 33736, 33774 – 33783, 33786, 33788, 33814, 33840, 33845, 33851 – 33853, 33860, 33863, 33864, 33870, 33875, 33877, 33910, 33916, 33922, 33925, 33926, 33945, 35081, 35082, 35091, 35092, 35103, 35211, 35241, 35271, 35331, 35361, 35363, 35526, 35531, 35560, 35626, 35631, 35646

Providers must document in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim that the services were rendered by more than one assistant surgeon for the same surgery on the same date

Transcatheter Therapy Infusion

CPT-4 code 37202 (transcatheter therapy, infusion other than for thrombolysis, any type [e.g., spasmolytic, vasoconstrictive]) is billed for the infusion of medication other than chemotherapy and thrombolysis through an inserted arterial catheter for the purpose of delivering specific medication to a localized vascular bed.

Transcatheter therapy must be infused under the direct supervision of a physician and is considered medically necessary when:

- The drug cannot be delivered effectively via any other route (eg, sublingual, intramuscular, subcutaneous, etc.) to achieve its intended purpose; and
- The drug is effective when infused intra-arterially

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Indications

Treatment indications for transcatheter therapy include the following:

- Cerebrovasospasm
- Bleeding involving the head or neck
- Gastrointestinal hemorrhage
- Raynaud's syndrome
- Non-occlusive mesenteric ischemia

Required Diagnosis Codes

Reimbursement of CPT-4 code 37202 will be restricted to one of the following ICD-9-CM diagnosis codes:

Diagnosis

<u>Codes</u>	<u>Descriptor</u>
430	Subarachnoid hemorrhage
431	Intracerebral hemorrhage
432.0	Nontraumatic extradural hemorrhage
432.1	Subdural hemorrhage
432.9	Unspecified intracranial hemorrhage
435.9	Unspecified transient cerebral ischemia
443.0	Raynaud's syndrome
456.0	Esophageal varices with bleeding
456.20	Esophageal varices in diseases classified elsewhere with bleeding
557.0	Acute vascular insufficiency of intestine
557.1	Chronic vascular insufficiency of intestine
557.9	Unspecified vascular insufficiency of intestine
578.0	Hematemesis
578.1	Blood in stool
578.9	Hemorrhage of gastrointestinal tract, unspecified