

Coding Guidelines

Percutaneous Coronary Interventions (PCI) – CV-037: Billing and Coding Instructions

Contractor’s Determination Number

CV-037

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CMS National Coverage Policy

Title XVIII of the Social Security Act section 1862 (a)(7). This section excludes routine physical examinations and services.

Title XVIII of the Social Security Act section 1862(a)(1)(E). This section prohibits Medicare payment for research conducted, that is not reasonable and necessary to determine the effectiveness of health care services and procedures.

Title XVIII of the Social Security Act section 1862(a)(1)(A). This section excludes coverage and payment for items and services that are not considered reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the function of a malformed body member.

Title XVIII of the Social Security Act section 1833(e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Coding Information

1. List the appropriate ICD-9 code that best supports the medical necessity for the procedure. ICD-9 codes must be present on all Physicians’ Service claims and must be coded to the highest degree of accuracy and digit level completeness. (See LCD CV-037 Documentation Requirements)
2. Apply only one interventional procedure code per session to each of the three major coronary arteries and their branches. Stent placement, and angioplasty and/or atherectomy may not be paid on the same vessel.
 - a. Report the appropriate “single vessel” code (92980, 92982, 92995) once per session for the most complex intervention include the appropriate coronary artery modifier (LC, LD, RC); refer to the hierarchical structure outlined above (#1, 2) or “Denial Summary” below (# 3, 4).
 - b. Report additional major vessel interventions per session using the “each additional vessel” codes (92981, 92984, 92996) include the appropriate coronary

artery modifier (LC, LD, RC); refer to the hierarchical structure outlined above (#1, 2) or “Denial Summary below (# 5”).

EXAMPLES

#1. Line 1. 92980 LC	#2. Line 1. 92980 LC	#3. Line 1. 92980 LC	#3. Line 1. 92980 LC
Line 2. 92981 LD	Line 2. 92982 LC(deny)	Line 2. 92980 LD (deny)	
Line 3. 92984 RC			

- c. If a patient must be returned to the operating room/catheterization lab on the same DOS for repeat PCI procedure report the services as described above and with the 59 modifier.
- 3. Major anatomic variants (ramus, intermediate or marginal branches, trifurcated left main, etc.) should be identified as branches of, or physiologically equivalent to, one of the defined major coronary arteries and not separately coded.
- 4. Report other procedures performed with the PCI with the appropriate procedure code that describes the procedure performed, include any appropriate modifiers.
- 5. Consult the CCI listing for services considered bundled into PCI.
- 6. Add-On Procedures:
 Percutaneous transluminal coronary thrombectomy (PTCT) (92973), intravascular ultrasound (IVUS) (92978, 92979) and transcatheter placement of radiation delivery devices (92974) are approved add-on services that may be performed with PCI.
 - a. PTCT and IVUS procedures may be reported with specified PCI procedures when clinically necessary but are not necessarily required with every PCI procedure. Excessive procedures may be reviewed for clinical appropriateness.
 - b. Payment in addition to the Medicare allowed charge for the PTCT procedure will not be made when FDA approved thrombectomy devices (e.g. Angioject) are used to perform the PTCT procedure on bypass conduits and/or native vessels.
- 7. Medicare multiple surgery standard payment adjustment rules apply to PCI.
- 8. Surgical assistant, co-surgeons, and team surgeons are not permitted with cardiac catheterizations, intracoronary thrombolysis and PCI.
- 9. Procedure 92975 is defined by CCI as inclusive when performed in the same session/location as stent placement. When other than the same session/location this procedure may be reported with a 59 modifier.
- 10. Additional bypass conduits should be coded with:
 the “additional vessel” codes for the intervention performed
 the appropriate coronary artery modifier (LC, LD, RC)
 and a 22 modifier.

The PCI operative report should document this intervention, and the operative note must be available to the carrier on request. For electronic claim submission indicate the documentation is available in the appropriate comment field.

Notes

* - An asterisk indicates a revision to that section of the policy.

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