Cardiology Coding Alert

CPT®: Don't Forget to Check the Errata List from AMA

Get ready to mark your coding manual with changes.

Although the 2020 CPT® updates just went to effect on Jan. 1, 2020, you already have some revisions to make to these codes and guidelines. The American Medical Association (AMA) recently released the CPT® 2020 Errata and Technical Corrections that it made to the 2020 CPT® manual. The effective date for these updates was Jan. 1, 2020.

Take a look to make sure you are updated on these changes.

Errata Adds Codes to Parenthetical Notes

You will see several instances for cardiology where AMA has added codes to parenthetical notes.

First, you will see changes to the first parenthetical note for code +34709 (Placement of extension prosthesis(es) distal to the common iliac artery(ies) or proximal to the renal artery(ies) for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, penetrating ulcer, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed, per vessel treated (List separately in addition to code for primary procedure)). In addition to the codes already listed in the note, you can also report +34709 in conjunction with endovascular repair codes 34845-34848.

Secondly, you will see changes to the parenthetical note for +93662 (Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)). In addition to the codes already listed, you can also report 93662 in conjunction with codes 93582 (Percutaneous transcatheter closure of patent ductus arteriosus) or 93583 (Percutaneous transcatheter septal reduction therapy (eg, alcohol septal ablation) including temporary pacemaker insertion when performed) as appropriate.

These parenthetical note revisions are really important because you must always be aware of which add-on codes you can appropriately report with which primary codes to submit clean claims.

Note Changes to the Index

AMA also corrected numerous typos in the index for cardiology. They are as follows:

Mistake 1: If you look under "Angiography," then "Carotid Artery," the correct codes should read 36221, 36222, 36223, 36224, 36225, 36226, 36227, and 36228. The original manual had a typo because it listed "37227" instead of 36227. Code 37227 (Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed) is a revascularization code, not an angiography code.

Mistake 2: Also, if you look under "Artery," then "Coronary," then "Angiography," the AMA has removed codes from that list. The errata will delete 92924-92295, 92933, and 92934, which are atherectomy codes, not angiography codes. Since "Atherectomy" comes right below "Angiography" in the index, it looks like those codes were mistakenly posted under "Angiography."

Mistake 3: Finally, if you look under "Radiology," then "Diagnostic Imaging," then "Heart," you will see an incorrect

code range. Instead of 75557-75524, the correct range should be 75557 (Cardiac magnetic resonance imaging for morphology and function without contrast material)-75574 (Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)). This merely seems like a typo.

Observe Descriptor Changes to New Codes

AMA will also make some changes to the descriptors for new codes 98970-98971.

Take a look at this example: 98970 Qualified nonphysician health care professional online digital evaluation and management service assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes. (Emphasis added).

As you can see, AMA has removed "evaluation and management service" from the code descriptor and added "assessment and management" instead.

Dial Into 99457, 99458 Guidelines Revisions

You will see some corrections to the CPT® guidelines for 99457 (Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes) and new code +99458 (… each additional 20 minutes (List separately in addition to code for primary procedure)).

Take a look at the changes. (Emphasis added.) "For the first completed 20 minutes of clinical staff/physician/other qualified health care professional time in a calendar month report 99457, and report 99458 for each additional completed 20 minutes," per the guidelines. "Do not report 99457, 99458 for services of less than 20 minutes. Report 99457 one time regardless of the number of physiologic monitoring modalities performed in a given calendar month."

Bottom line: AMA has revised the "Remote Physiologic Monitoring and Treatment Management Services" guidelines to specify that you should report 99457 for the first completed 20 minutes of clinical staff/physician/ other qualified health care professional time in a calendar month. Also, you should report +99458 for each additional completed 20 minutes, per the revisions.

Code +99458: You will also see some revisions to the parenthetical notes for new code +99458. For example, the second parenthetical note has been completely deleted. (Emphasis added): (Report only 99457 if you have not completed 20 minutes of additional treatment regardless of time spent).

AMA has also revised the third parenthetical note for +99458. Now the guidelines specify that you cannot report +99458 for "services of less than an additional increment of 20 minutes." (Emphasis added.) This revision clarifies how important it is to document the exact time when reporting 99457 and +99458.

You should report 99457 for the first 20 minutes of remote physiologic monitoring treatment management services. When reporting +99458, you must check the documentation to make sure that the provider performed an additional 20 minutes of this service. Code +99458 is an add-on code, so you must always report it in conjunction with primary code 99457, which explains how the words "an additional increment" add clarity to this reporting rule.

Add-on codes: You should never report an add-on code like +99458 as the primary code for a procedure on your claims. Add-on codes are always reported with an appropriate primary code. Add-on codes are identified with the special symbol "+."

"This is a feature of add-on codes that some people forget," says **Gregory Przybylski, MD** at the JFK Medical Center in Edison, New Jersey. "One cannot report an add-on code unless the valid primary code (to which the add-on code is associated with) is also reported. CPT® lists the specific primary codes to which add-on codes may be used if that service is performed."

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