Documentation Dissection

Procedure Type:

Diagnostic Procedure: Left Heart Catheterization, Coronary Angiography [1].

Peripheral Catheterization Diagnostic Procedure: Femoral Angiography [1].

Miscellaneous: Angio*Seal [2].

Procedure:

Indications: Chest pain and congestive heart failure [3].

------- PROCEDURE DATA -------

Procedure Start Time: 01/08/2010 07:29 PM.

The procedure was explained in detail to the patient. Risks, complications and alternative treatments were reviewed. Written consent was obtained. The attending physician was present and scrubbed for the entire procedure, providing direct supervision.

Diagnostic Cath Status: Emergency

------- ENTRY LOCATIONS -------

* Retrograde Percutaneous access was performed through the Right Femoral artery [4]. A 6 Fr sheath was inserted. The puncture point was successfully closed. Hemostasis achieved with AngioSeal VIP 6 Fr (St. Jude).

Procedure Medications [5]:

* Fentanyl I.V. bolus 25 mcg [5].

* Versed I.V. bolus 1 mg [5].

* Lidocaine 1% S.Q. 10 ml [5].

* Oxygen NC 2 L [5].

Diagnostic Catheters:

* 6 FrSiteSeer JR4 6FR 100CM was used for Right coronary angiography [6].

* 6 FrSiteSeer Van Tassel 145-deg Angled Pigtail 6 (xT) was used For Left ventriculography [6].

Complications: No Complications.

Contrast Material: * Isovue60 ml.

Fluoroscopy Time: Total: 1:26 minutes.

IABP: No IABP.

Hemodynamics
Condition: Baseline.

O_2 Consumption: Estimated: 295.06 Heart Rate: 123 bpm.

Pressure

Site	Pressure
FA	111/80 (91)
AO	221/147 (276)
AO	97/78 (85)
LV	107/10 ,22
LV	105/8 ,21
LV	106/8 ,20
AO	107/24 (60)

Hemodynamic Comments

------- ANGIOGRAPHIC FINDINGS -------

Cardiac Arteries and Lesion Findings

LMCA: Normal.

LAD: Diffuse irregularity.

LCx: Normal.

RCA: Diffuse irregularity.

------- PROCEDURE SUMMARY -------

Final diagnoses.

1. Non obstructive coronary artery disease with angina.

2. LV filling pressures elevated.

---

[1] Procedure performed.

[2] Angio*Seal vascular closure device was used.

[3] The indications for the procedure are chest pain and congestive heart failure.

[4] Retrograde percutaneous access was performed through the Right Femoral artery.

[5] Moderate sedation.

[6] Diagnostic catheters were used for both RCA and Left ventriculography.

What CPT® and ICD-10-CM codes are reported?

CPT® Code: 93458-26

ICD-10-CM Codes: I25.119, I50.9

Rationales:

CPT®: The note documents diagnostic procedures of a left heart catheterization with coronary angiography and peripheral catheterization femoral angiography. The catheter entry site was documented as retrograde percutaneous access via the right femoral artery. The Vascular Procedures tabular guidelines in the Aorta and Arteries category indicate that catheterization codes are not additionally reported for diagnostic lower extremity angiography when performed through the same access site as the therapy performed in the same session. Catheterization for the diagnostic lower extremity angiogram may be reported separately if a different arterial puncture site is necessary. In this instance, the same access site was used for both procedures in the same session; therefore, a separate code to report the femoral angiography is not necessary. The Cardiac Catheterization tabular guidelines advice that the left heart catheterization involves catheter placement in a left-sided (systemic), cardiac chamber(s) (left ventricle or left atrium) and includes left ventricular injection(s) when performed. Codes for left heart catheterization, other than those for congenital heart disease, include intraprocedural injection(s) for left ventricular/left atrial angiography, imaging supervision, and interpretation.

In the Alphabetic Index look up Cardiac Catheterization/for Angiography/Coronary which directs you to code range 93454–93461, 93563, and 93571. In reviewing the code descriptions, CPT 93458 *Catheter placement in the coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography; imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography* when performed is the appropriate code assignment. CPT code 93458 does not include moderate sedation. Verify selection in the numeric section. Moderate Sedation was used during the procedure; however, it is not reported because there is no information about the time and who administered the sedation. Only the drugs are listed.

In this case, the provider performed a procedure that contained both a professional and technical component. Per Appendix A in the CPT book, when the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number. The facility will bill for the technical component as they incur the expense for the equipment. Additional examples of modifier 26 can be found in the Introduction section of the CPT book.

ICD-10-CM: The final diagnoses are documented as non-obstructive coronary artery disease with angina and congestive heart failure. In the ICD-10-CM Alphabetic Index look for Disease/coronary (artery) see Disease/heart/ischemic/atherosclerotic (of)/ with angina pectoris and you are directed to see Arteriosclerosis, coronary (artery). Look for Arteriosclerosis/coronary (artery)/ native vessel/with/angina pectoris and you are directed to I25.119. An inclusion term under I25.119 reads atherosclerotic heart disease with angina NOS. I25.119 is correct. The indications for the procedure show chest pain and congestive heart failure. The chest pain is reported as the angina. Look in the ICD-10-CM Alphabetic Index look up Failure/heart/congestive which directs you to code I50.9. Documentation does not state the type of heart failure for this patient.