# CARDIOLOGY TOOL BOX

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The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) is published by the United States Government. A CD-ROM, which may be purchased through the Government Printing Office, is the only official Federal government version of the ICD-9-CM. ICD-9-CM is an official Health Insurance Portability and Accountability Act standard.

## CPT DISCLAIMER AMERICAN MEDICAL ASSOCIATION (AMA) NOTICE AND DISCLAIMER



This guide is offered as a reference tool and does not replace content found in the *1995 Documentation Guidelines for Evaluation and Management Services* and the *1997 Documentation Guidelines for Evaluation and Management Services*. It is recommended that health care providers refer to the *1995* ***Documentation Guidelines for Evaluation and Management Services*** **in order to identify differences between the two sets of guidelines.**

It is recommended that providers refer to the following publications, which were used to prepare this guide:

- *1995 Documentation Guidelines for Evaluation and Management Services*, available at *www.cms.hhs.gov/MLNProducts/Downloads/1995dg.pdf* on the Centers for Medicare & Medicaid Services (CMS) website;
- *1997 Documentation Guidelines for Evaluation and Management Services*, available at *www.cms.hhs.gov/MLNProducts/Downloads/MASTER1.pdf* on the CMS website;
- Medicare Claims Processing Manual (Pub. 100-4), available at *www.cms.hhs.gov/Manuals/* on the CMS website; and
- *Current Procedural Terminology* book, available from the American Medical Association (800-621-8335 or *www.amapress.org* on the Web).

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## MEDICAL RECORD DOCUMENTATION

“If it isn’t documented, it hasn’t been done” is a saying that is frequently heard in the health care field.

**Background**

Succinct medical record documentation is critical to receiving accurate and timely reimbursement as well as providing patients with quality care. Documentation should be chronological and document the care of the patient. It is required to record the facts, findings, and observations about the patient’s health history including past and present illnesses, examinations, tests, treatments, and outcomes. Medical record documentation also assists physicians and other health care professionals in evaluating and planning the patient’s treatment and monitoring his or her health care over time.

Payers may require documentation for services that are consistent with the codes being billed in order to validate:

- The site of service;
- The medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or
- That services furnished have been accurately reported.

To ensure that medical record documentation is accurate, the following principles should be followed:

- The medical record should be complete and legible.
- The documentation of each patient encounter should include:
  - Reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results.
  - Assessment, clinical impression, or diagnosis.
  - Medical plan of care.
  - Date and legible identity of the observer.

- If there is no documentation the rationale for ordering diagnostic and other ancillary services should be easily inferred.
- Past and present diagnoses should be accessible to the treating and/or consulting physician.
- Any health risk factors should be identified and noted.
- The patient's changes, response to and progress in treatment, and any revision of diagnosis should be documented.
- The Current Procedural Terminology (CPT) and International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

When billing for a patient’s visit, codes are selected that best represent the services furnished during the visit. The two common sets of codes used are:

- Diagnostic or International Classification of Diseases, 9th Revision, Clinical Modification codes; and
- Procedural or American Medical Association Current Procedural Terminology (CPT) codes.

These codes are organized into various categories and levels. It is the physician’s responsibility to ensure that documentation reflects the services furnished and that the codes selected reflect those services. The more work performed by the physician, the higher the level of code he or she may bill within the appropriate category. The billing specialist or alternate source reviews the physician’s documentation of services and assists with selecting codes that best reflect the extent of the physician’s personal work necessary to furnish the services.

Evaluation and management (E/M) services are visits and consultations by physicians. Billing Medicare for a patient visit requires the selection of a CPT code that best represents the level of E/M service performed. For example, there are five CPT codes that may be selected to bill for office or other outpatient visits for a new patient:

## KEY ELEMENTS OF SERVICE

To determine the appropriate level of service for a patient’s visit, it is necessary to first determine whether the patient is new or already established. The physician then uses the presenting illness as a guiding factor and his or her clinical judgment about the patient’s condition to determine the extent of key elements of service to be performed. The key elements of service are:

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- History;
- Examination; and
- Medical decision making.

The key elements of service and documentation of an encounter dominated by counseling and/or coordination of care are discussed below.

**I. History**

The elements required for each type of history are represented in the table below. Note that each history type requires more information as you read down the left hand column. For example, a problem focused history requires the documentation of the chief complaint (CC) and a brief history of present illness (HPI) and a detailed history requires the documentation of a CC, extended HPI, extended review of systems (ROS), and pertinent past, family and/or social history (PFSH), judgment and the nature of the presenting problem.

Documentation of patient history includes some or all of the following elements:

**Elements Required for Each Type of History**

| TYPE OF HISTORY | CHIEF COMPLAINT | HISTORY OF PRESENT ILLNESS | REVIEW OF SYSTEMS | PAST, FAMILY, AND/OR SOCIAL HISTORY |
|---|---|---|---|---|
| **Problem Focused** | Required | Brief | N/A | N/A |
| **Expanded Problem Focused** | Required | Brief | Problem Pertinent | N/A |
| **Detailed** | Required | Extended | Extended | Pertinent |
| **Comprehensive** | Required | Extended | Complete | Complete |

*A. **Chief Complaint***

A CC is a concise statement that describes the symptom, problem, condition, diagnosis, or reason for the patient encounter. The CC is usually stated in the patient's own words. For example, patient complains of upset stomach, aching joints, and fatigue.

***B. History of Present Illness***

HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. HPI elements are:

- Location. I.e.: pain in left leg;
- Quality. I.e.: aching, burning, radiating;
- Severity. I.e.: 10 on a scale of 1 to 10;
- Duration. I.e.: it started three days ago;
- Timing. I.e.: it is constant or it comes and goes;
- Context. I.e.: lifted large object at work;
- Modifying factors. I.e.: it is better when heat is applied; and
- Associated signs and symptoms. I.e.: numbness.

There are two types of HPIs:

1) *Brief*, which includes documentation of one to three HPI elements. In the following example, three HPI elements – location, severity, and duration – are documented:

- CC: A patient seen in the office complains of left ear pain.
- Brief HPI: Patient complains of dull ache in left ear over the past 24 hours.

2) *Extended*; includes documentation of at least four HPI elements or the status of at least three chronic or inactive conditions. In the following example, five HPI elements – location, severity, duration, context, and modifying factors – are documented:

- Extended HPI: Patient complains of dull ache in left ear over the past 24 hours. Patient states he went swimming two days ago. Symptoms somewhat relieved by warm compress and ibuprofen.

***Review of Systems (ROS)***

ROS is an inventory of body systems obtained by asking a series of questions in order to identify signs and/or symptoms that the patient may be experiencing or has experienced. The following systems are recognized:

- Constitutional Symptoms (e.g., fever, weight loss);
- Eyes;
- Ears, Nose, Mouth, Throat;
- Cardiovascular;
- Respiratory;
- Gastrointestinal;
- Genitourinary;
- Musculoskeletal;
- Integumentary (skin and/or breast);
- Neurological;
- Psychiatric;
- Endocrine;
- Hematologic/Lymphatic; and
- Allergic/Immunologic.

**There are three types of ROS:**

1. *Problem pertinent*; inquires about the system directly related to the problem identified in the HPI. In the following example, one system – the ear – is reviewed:
   - CC: Earache.
   - ROS: Positive for left ear pain. Denies dizziness, tinnitus, fullness, or headache.

2. *Extended*; inquires about the system directly related to the problem(s) identified in the HPI and a limited number (two to nine) of additional systems? In the following example, two systems – cardiovascular and respiratory – are reviewed:
   - CC: Follow up visit in office after cardiac catheterization. Patient states “I feel great.”
   - ROS: Patient states he feels great and denies chest pain, syncope, palpitations, and shortness of breath. Relates occasional unilateral, asymptomatic edema of left leg.

3. *Complete*; inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional (minimum of 10) body systems. In the following example, 10 signs and symptoms are reviewed:
   - CC: Patient complains of “fainting spell.”
   - ROS:
     - Constitutional: weight stable, + fatigue.
     - Eyes: + loss of peripheral vision.
     - Ear, Nose, Mouth, Throat: no complaints.
     - Cardiovascular: + palpitations; denies chest pain; denies calf pain, pressure, or edema.
     - Respiratory: + shortness of breath on exertion.

- Gastrointestinal: appetite good, denies heartburn and indigestion. episodes of nausea. Bowel movement daily; denies constipation or loose stools.
- Urinary: denies incontinence, frequency, urgency, nocturia, pain, or discomfort.
- Skin: + clammy, moist skin.
- Neurological: + fainting; denies numbness, tingling, and tremors.
- Psychiatric: denies memory loss or depression. Mood pleasant.

**Past, Family, and/or Social History**

PFSH consists of a review of the patient's:

- Past personal history including experiences with illnesses, operations, injuries, and treatments;
- Family history including a review of medical events, diseases, and hereditary conditions that may place him or her at risk; and
- Social history including an age appropriate review of past and current activities.

The two types of PFSH are:

1. *Pertinent*; is a review of the history areas directly related to the problem(s) identified in the HPI. The pertinent PFSH must document one item from any of the three history areas. In the following example, the patient's past surgical history is reviewed as it relates to the current HPI:

   *Patient returns to office for follow up of coronary artery bypass graft in 1992. Recent cardiac catheterization demonstrates 50 percent occlusion of vein graft to obtuse marginal artery.*

2. *Complete*; is a review of two or all three of the areas, depending on the category of E/M service. A complete PFSH requires a review of all three history areas for services that, by their nature, include a comprehensive assessment or reassessment of the patient. A review of two history areas is sufficient for other services. At least one specific item from two of the three history areas must be documented for a complete PFSH for the following categories of E/M services:
   - Office or other outpatient services, established patient;
   - Emergency department;
   - Domiciliary care, established patient; and
   - Home care, established patient.

At least one specific item from each of the history areas must be documented for the following categories of E/M services:

- Office or other outpatient services, new patient;
- Hospital observation services;
- Hospital inpatient services, initial care;
- Consultations;
- Comprehensive Nursing Facility assessments;
- Domiciliary care, new patient; and
- Home care, new patient.

In the following example, the patient's genetic history is reviewed as it relates to the current HPI:

• Family history reveals the following:

- Maternal grandparents: grandmother - + diabetes, hypertension; grandfather - + heart attack at age 55.
- Paternal grandparents: both + for coronary artery disease; grandfather deceased at age 69; grandmother still living.
- Parents: mother - + obesity, diabetes; father - + heart attack age 51, deceased age 57 of heart attack.
- Siblings: sister - + diabetes, obesity, hypertension, age 39; brother - + heart attack at age 45, living.

**II. Examination**

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An examination may involve several organ systems or a single organ system. The extent of the examination performed is based upon clinical judgment, the patient's history, and nature of the presenting problem.

**THE CHART BELOW REPRESENTS THE BODY AREAS AND ORGAN SYSTEMS THAT ARE RECOGNIZED ACCORDING TO THE CURRENT PROCEDURAL TERMINOLOGY (CPT) BOOK:**

| BODY AREAS | ORGAN SYSTEMS |
|---|---|
| Head, including face Neck Chest, including breasts and axilla Abdomen Genitalia, groin, buttocks Back Each extremity | Eyes Ears, Nose, Mouth, and Throat Cardiovascular Respiratory Gastrointestinal Genitourinary Musculoskeletal Skin Neurologic Hematologic/Lymphatic/Immunologic Psychiatric |

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There are two types of examinations that can be performed during a patient's visit:

1) *General multi-system examination*, which involves the examination of one or more organ systems or body areas. According to the *1997 Documentation Guidelines for Evaluation and Management Services* each body area or organ system contains two or more of the following examination elements:

- Constitutional Symptoms (e.g., fever, weight loss);
- Eyes;
- Ears, Nose, Mouth, Throat;
- Neck;
- Respiratory;
- Cardiovascular;
- Chest (breasts);
- Gastrointestinal;
- Genitourinary;
- Lymphatic;
- Musculoskeletal;
- Integumentary;
- Neurological; and
- Psychiatric.

*Single organ system examination*, which involves a more extensive examination of a specific organ system.

Both types of examinations may be performed by any physician, regardless of specialty. The chart below compares the elements of the **cardiovascular system/body area** for both a general multi-system and single organ system examination.

| SYSTEM/ BODY AREA | GENERAL MULTI-SYSTEM EXAMINATION | SINGLE ORGAN SYSTEM EXAMINATION |
|---|---|---|
| Cardiovascular | Palpation of heart (e.g., location, size, thrills). Auscultation of heart with notation of abnormal sounds and murmurs. Examination of: • Carotid arteries (e.g., pulse amplitude, bruits) • Abdominal aorta (e.g., size, bruits); • Femoral arteries (e.g., pulse amplitude, bruits); • Pedal pulses (e.g., pulse amplitude); and • Extremities for edema and/or varicosities. | Palpation of heart (e.g., location, size, and forcefulness of the point of maximal impact; thrills; lifts; palpable S3 or S4). Auscultation of heart including sounds, abnormal sounds, and murmurs. Measurement of blood pressure in two or more extremities when indicated (e.g., aortic dissection, coarctation). Examination of: • Carotid arteries (e.g., waveform, pulse amplitude, bruits, apical-carotid delay); • Abdominal aorta (e.g., size, bruits); • Femoral arteries (e.g., pulse amplitude, bruits); • Pedal pulses (e.g., pulse amplitude); and • Extremities for peripheral edema and/or varicosities. |

**THE ELEMENTS REQUIRED FOR EACH TYPE OF EXAMINATION ARE REPRESENTED IN THE TABLE BELOW.**

| | |
|---|---|
| **Problem Focused** | A limited examination of the affected body area or organ system. |
| **Expanded Problem Focused** | A limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s). |
| **Detailed** | An extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body areas(s) or organ system(s). |
| **Comprehensive** | A general multi-system examination OR complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s). |

**The elements required for general multi-system examinations are represented in the following chart.**

**General Multi-System Examinations**

| TYPE OF EXAMINATION | DESCRIPTION |
|---|---|

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| | |
|---|---|
| **Problem Focused** | Include performance and documentation of 1 - 5 elements identified by a bullet in 1 or more organ system(s) or body area(s). |
| **Expanded Problem Focused** | Include performance and documentation of at least 6 elements identified by a bullet in 1 or more organ system(s) or body area(s). |
| **Detailed** | Include at least 6 organ systems or body areas. For each system/area selected, performance and documentation of at least 2 elements identified by a bullet is expected. Alternatively, may include performance and documentation of at least 12 elements identified by a bullet in 2 or more organ systems or body areas. |
| **Comprehensive** | *1997 Documentation Guidelines for Evaluation and Management Services*: Include at least 9 organ systems or body areas. For each system/area selected, all elements of the examination identified by a bullet should be performed, unless specific directions limit the content of the examination. For each area/system, documentation of at least 2 elements identified by bullet is expected. *1995 Documentation Guidelines for Evaluation and Management Services*: Eight organ systems ***must*** be examined. If body areas are examined and counted, they must be over and above the 8 organ systems. |

According to the *1997 Documentation Guidelines for Evaluation and Management Services*, the 10 single organ system examinations are:

- Cardiovascular;
- Ear, Nose, and Throat;
- Eye;
- Genitourinary;
- Hematologic/Lymphatic/Immunologic;
- Musculoskeletal;
- Neurological;
- Psychiatric;
- Respiratory; and
- Skin.

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**The elements required for single organ system examinations are depicted in the following chart.**

**Single Organ System Examinations**

| TYPE OF EXAMINATION | DESCRIPTION |
|---|---|
| **Problem Focused** | Include performance and documentation of 1 - 5 elements identified by a bullet, whether in a box with a shaded or unshaded border. |
| **Expanded Problem Focused** | Include performance and documentation of at least 6 elements identified by a bullet, whether in a box with a shaded or unshaded border. |
| **Detailed** | Examinations other than the eye and psychiatric examinations should include performance and documentation of at least 12 elements identified by a bullet, whether in a box with a shaded or unshaded border. Eye and psychiatric examinations include the performance and documentation of at least 9 elements identified by a bullet, whether in a box with a shaded or unshaded border. |
| **Comprehensive** | Include performance of all elements identified by a bullet, whether in a shaded or unshaded box. Documentation of every element in each box with a shaded border and at least 1 element in a box with an unshaded border is expected. |

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**The chart below compares the elements that are required for both general multisystem and single organ system examinations.**

**Multi-System and Single Organ Examinations**

| TYPE OF EXAMINATION | MULTI-SYSTEM EXAMINATIONS | SINGLE ORGAN SYSTEM EXAMINATIONS |
|---|---|---|
| **Problem Focused** | 1 - 5 elements identified by a bullet in 1 or more organ system(s) or body area(s). | 1 - 5 elements identified by a bullet, whether in a box with a shaded or unshaded border. |
| **Expanded Problem Focused** | At least 6 elements identified by a bullet in one or more organ system(s) or body area(s). | At least 6 elements identified by a bullet, whether in a box with a shaded or unshaded border. |
| **Detailed** | At least 6 organ systems or body areas. For each system/area selected, performance and documentation of at least 2 elements identified by a bullet is expected. **OR** At least 12 elements identified by a bullet in 2 or more organ systems or body areas. | At least 12 elements identified by a bullet, whether in a box with a shaded or unshaded border. Eye and psychiatric: At least 9 elements identified by a bullet, whether in a box with a shaded or unshaded border. |
| **Comprehensive** | Include at least 9 organ systems or body areas. For each system/area selected, all elements of the examination identified by a bullet should be performed, unless specific directions limit the content of the examination. For each area/system, documentation of at least 2 elements identified by bullet is expected. | Perform all elements identified by a bullet, whether in a shaded or unshaded box. Document every element in each box with a shaded border and at least 1 element in a box with an unshaded border. |

Some important points that should be kept in mind when documenting general multi-system and single organ system examinations are:

- Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of “abnormal” without elaboration is not sufficient;
- Abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ system(s) should be described; and
- A brief statement or notation indicating “negative” or “normal” is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s). (However, an entire organ system should not be documented with a statement such as “negative.”)

**III. Medical Decision Making**

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option, which is determined by considering the following factors:

- The number of possible diagnoses and/or the number of management options that must be considered;
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
- The risk of significant complications, morbidity, and/or mortality as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options.

The chart below depicts the elements for each level of medical decision making. Note that to qualify for a given type of medical decision making**,** two of the three elements must either be met or exceeded.

**Elements of Medical Decision Making**

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| TYPE OF DECISION MAKING | NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS | AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED | RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY, AND/OR MORTALITY |
|---|---|---|---|
| **Straightforward** | Minimal | Minimal or None | Minimal |
| **Low Complexity** | Limited | Limited | Low |
| **Moderate Complexity** | Multiple | Moderate | Moderate |
| **High Complexity** | Extensive | Extensive | High |

*Number of Diagnoses or Management Options*

The number of possible diagnoses and/or the number of management options that must be considered is based on:

- The number and types of problems addressed during the encounter;
- The complexity of establishing a diagnosis; and
- The management decisions that are made by the physician.

In general, decision making with respect to a diagnosed problem is easier than that for an identified but undiagnosed problem. The number and type of diagnosed tests performed may be an indicator of the number of possible diagnoses. Problems that are improving or resolving are less complex than those problems that are worsening or failing to change as expected. Another indicator of the complexity of diagnostic or management problems is the need to seek advice from other health care professionals.

Some important points that should be kept in mind when documenting the number of diagnoses or management options are:

- For each encounter, an assessment, clinical impression, or diagnosis should be documented which may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.

- For a presenting problem with an established diagnosis, the record should reflect whether the problem is:

- *Improved, well controlled, resolving, or resolved.*
- *Inadequately controlled, worsening, or failing to change as expected*.

- For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of differential diagnoses or as a “possible,” “probable,” or “rule out” diagnosis.
    - The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies, and medications.
    - If referrals are made, consultations requested, or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom advice is requested.

***Amount and/or Complexity of Data to be reviewed***

The amount and/or complexity of data to be reviewed are based on the types of diagnostic testing ordered or reviewed. Indications of the amount and/or complexity of data being reviewed include:

- A decision to obtain and review old medical records and/or obtain history from sources other than the patient (increases the amount and complexity of data to be reviewed);

- Discussion of contradictory or unexpected test results with the physician who performed or interpreted the test (indicates the complexity of data to be reviewed); and
- The physician who ordered a test personally reviews the image, tracing, or specimen to supplement information from the physician who prepared the test report or interpretation (indicates the complexity of data to be reviewed).

Some important points that should be kept in mind when documenting amount and/or complexity of data to be reviewed include:

- If a diagnostic service is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service should be documented.

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- The review of laboratory, radiology, and/or other diagnostic tests should be documented. A simple notation such as "White blood count elevated" or "Chest x-ray unremarkable" is acceptable. Alternatively, the review may be documented by initialing and dating the report that contains the test results.
- A decision to obtain old records or obtain additional history from the family, caretaker, or other source to supplement information obtained from the patient should be documented.
- Relevant findings from the review of old records and/or the receipt of additional history from the family, caretaker, or other source to supplement information obtained from the patient should be documented. If there is no relevant information beyond that already obtained, this fact should be documented. A notation of “Old records reviewed” or “Additional history obtained from family” without elaboration is not sufficient.
- Discussion about results of laboratory, radiology, or other diagnostic tests with the physician who performed or interpreted the study should be documented.
- The direct visualization and independent interpretation of an image, tracing, or specimen previously or subsequently interpreted by another physician should be documented.

*Risk of Significant Complications, Morbidity, and/or Mortality*

The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the following categories:

- Presenting problem(s);
- Diagnostic procedure(s); and
- Possible management options.

The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next encounter. The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment. The highest level of risk in any one category determines the overall risk.

The level of risk of significant complications, morbidity, and/or mortality can be:

- Minimal;
- Low;
- Moderate; or
- High.

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Some important points that should be kept in mind when documenting level of risk are:

- Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented;
- If a surgical or invasive diagnostic procedure is ordered, planned, or scheduled at the time of the E/M encounter, the type of procedure should be documented;
- If a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter, the specific procedure should be documented; and
- The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.

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The table on the following page may be used to assist in determining whether the level of risk of significant complications, morbidity, and/or mortality is minimal, low, moderate, or high. Because determination of risk is complex and not readily quantifiable, the table includes common clinical examples rather than absolute measures of risk.

| *Level of Risk* | Presenting Problem(s) | Diagnostic Procedure(s) Ordered | Management Options Selected |
|---|---|---|---|
| ***Minimal*** | One self-limited or minor problem, eg, cold, insect bite, tinea corporis | Laboratory tests requiring venipuncture Chest x-rays EKG/EEG Urinalysis Ultrasound, eg, echocardiography KOH prep | Rest, Gargles, Elastic bandages, Superficial dressings |
| ***Low*** | Two or more self-limited or minor problems One stable chronic illness, eg, well controlled hypertension, non-insulin dependent diabetes, cataract, BPH Acute uncomplicated illness or injury, eg, cystitis, allergic rhinitis, simple sprain | Physiologic tests not under stress, eg, pulmonary function tests Non-cardiovascular imaging studies with contrast, eg, barium enema Superficial needle biopsies Clinical laboratory tests requiring arterial puncture Skin biopsies | Over-the-counter drugs, Minor surgery with no identified risk factors, Physical therapy Occupational therapy IV fluids without additives |
| ***Moderate*** | One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis, eg, lump in breast Acute illness with systemic symptoms, eg, pyelonephritis, pneumonitis, colitis Acute complicated injury, eg, head injury with brief loss of consciousness | Physiologic tests under stress, eg, cardiac stress test, fetal contraction stress test Diagnostic endoscopies with no identified risk factors Deep needle or incisional biopsy Cardiovascular imaging studies with contrast and no identified risk factors, eg, arteriogram, cardiac catheterization Obtain fluid from body cavity, eg lumbar puncture, thoracentesis, culdocentesis | Minor surgery with identified risk factors, Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors, Prescription drug management ,Therapeutic nuclear medicine, IV fluids with additives ,Closed treatment of fracture or dislocation without manipulation |
| ***High*** | One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment Acute or chronic illnesses or injuries that pose a threat to life or bodily function, eg, multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure An abrupt change in neurologic status, eg, seizure, TIA, weakness, sensory loss | Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests Diagnostic Endoscopies with identified risk factors Discography | Elective major surgery (open, percutaneous or endoscopic) with identified risk factors, Emergency major surgery (open, percutaneous or endoscopic), Parenteral controlled substances, Drug therapy requiring intensive monitoring for toxicity, Decision not to resuscitate or to de-escalate care because of poor prognosis |

**IV. Documentation of an Encounter Dominated by Counseling and/or Coordination of Care**

When counseling and/or coordination of care dominates (more than 50 percent of) the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting, floor/unit time in the hospital, or Nursing Facility), time is considered the key or controlling factor to qualify for a particular level of E/M services. If the level of service is reported based on counseling and/or coordination of care, the total length of time of the encounter should be documented and the record should describe the counseling and/or activities to coordinate care. For example, if 25 minutes was spent face-to-face with an established patient in the office and more than half of that time was spent counseling the patient or coordinating his or her care, CPT code 99214® should be selected.

The Level I and Level II CPT books available from the American Medical Association list average time guidelines for a variety of E/M services. These times include work done before, during, and after the encounter. The specific times expressed in the code descriptors are averages and, therefore, represent a range of times that may be higher or lower depending on actual clinical circumstances.

# CARDIOLOGY TOOL BOX

Place of Service Codes for Professional Claims

***From CMS Database (last updated September 10, 2007)***

**LISTED BELOW ARE PLACE OF SERVICE CODES AND DESCRIPTIONS. THESE CODES SHOULD BE USED ON PROFESSIONAL CLAIMS TO SPECIFY THE ENTITY WHERE SERVICE(S) WERE RENDERED. CHECK WITH INDIVIDUAL PAYERS (E.G., MEDICARE, MEDICAID, OTHER PRIVATE INSURANCE) FOR REIMBURSEMENT POLICIES REGARDING THESE CODES. IF YOU WOULD LIKE TO COMMENT ON A CODE(S) OR DESCRIPTION(S), PLEASE SEND YOUR REQUEST TO THE ADDRESS GIVEN BELOW.**

| PLACE OF SERVICE CODE(S) | Place of Service Name | Place of Service Description |
|---|---|---|
| 01 | Pharmacy** | A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients. (effective 10/1/05) |
| 02 | Unassigned | N/A |
| 03 | School | A facility whose primary purpose is education. |
| 04 | Homeless Shelter | A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters). |
| 05 | Indian Health Service Free-standing Facility | A FACILITY OR LOCATION, OWNED AND OPERATED BY THE INDIAN HEALTH SERVICE, WHICH PROVIDES DIAGNOSTIC, THERAPEUTIC (SURGICAL AND NON-SURGICAL), AND REHABILITATION SERVICES TO AMERICAN INDIANS AND ALASKA NATIVES WHO DO NOT REQUIRE HOSPITALIZATION. |
| 06 | Indian Health Service Provider-based Facility | A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients. |
| 07 | Tribal 638 Free-standing Facility | A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization. |
| 08 | Tribal 638 Provider-based Facility | A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members |

# CARDIOLOGY TOOL BOX

| PLACE OF SERVICE CODE(S) | Place of Service Name | Place of Service Description |
|---|---|---|
| 09-10 | Unassigned | N/A |
| 11 | Office | Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis. |
| 12 | Home | Location, other than a hospital or other facility, where the patient receives care in a private residence. |
| 13 | Assisted Living Facility | Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services. (effective 10/1/03) |
| 14 | Group Home * | A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration). |
| 15 | Mobile Unit | A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services. |
| 16 | Temporary Lodging | A short term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code. (effective 4/1/08) |
| 17-19 | Unassigned | N/A |
| 20 | Urgent Care Facility | Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention. |
| 21 | Inpatient Hospital | A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions. |
| 22 | Outpatient Hospital | A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. |
| 23 | Emergency | A portion of a hospital where emergency |

# CARDIOLOGY TOOL BOX

| PLACE OF SERVICE CODE(S) | Place of Service Name | Place of Service Description |
|---|---|---|
| 24 | Ambulatory Surgical Center | A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis. |
| 25 | Birthing Center | A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of new born infants. |
| 26 | Military Treatment Facility | A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF). |
| 27-30 | Unassigned | N/A |
| 31 | Skilled Nursing Facility | A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital. |
| 32 | Nursing Facility | A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals. |
| 33 | Custodial Care Facility | A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component. |
| 34 | Hospice | A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided. |
| 35-40 | Unassigned | N/A |
| 41 | Ambulance - Land | A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured. |
| 42 | Ambulance – Air or Water | An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured. |
| 43-48 | Unassigned | N/A |
| 49 | Independent Clinic | A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only. (effective 10/1/03) |
| 50 | Federally Qualified Health | A facility located in a medically underserved area that |

# CARDIOLOGY TOOL BOX

| PLACE OF SERVICE CODE(S) | Place of Service Name | Place of Service Description |
|---|---|---|
| 51 | Inpatient Psychiatric Facility | A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician. |
| 52 | Psychiatric Facility-Partial Hospitalization | A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility. |
| 53 | Community Mental Health Center | A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services. |
| 54 | Intermediate Care Facility/Mentally Retarded | A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF. |
| 55 | Residential Substance Abuse Treatment Facility | A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board. |
| 56 | Psychiatric Residential Treatment Center | A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment. |
| 57 | Non-residential Substance Abuse Treatment Facility | A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing. (effective 10/1/03) |
| 58-59 | Unassigned | N/A |
| 60 | Mass | A location where providers administer |

# CARDIOLOGY TOOL BOX

**MODIFIERS**

Here is a partial list of Modifiers normally used in the physician office setting.

22 **Increased Procedural Services:** When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work. (i.e.: increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required).

24 **Unrelated Evaluation and Management Service by the Same physician During a Postoperative Period:** They physician may need to indicate that an E/M service service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.

25 **Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service**: It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant separately identifiable E/M Service above and beyond the other service provided or beyond the usual preoperative and postoperative case associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported. The E/M service may be prompted by the symptom of condition of which the procedure and/or service was provided. As such, different diagnosis is not required for reporting of the E/M services on the same date. This circumstance may be reported adding the modifier 25 to the appropriate level of E/M service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery.

26 **Professional Component:** Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

32 **Mandated Services**: Service related to mandated consultation and/or related service (eg, third-party payer, governmental, legislative or regulatory requirement) may be identified by adding to modifier 32 to the basic procedure.

50 **Bilateral Procedure:** Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding modifier 50 to the appropriate five digit code.

51 **Multiple Procedures**: When multiple procedures, other than Evaluation and Management Service, are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service may be identified by appending modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated add-on code.

52 **Reduced Services**: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52 signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note; for hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74.

**53** **Discontinued Procedure:** Under certain circumstances, the physician may elect to terminate the surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient’s anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances of those that threaten the well being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74.

# CARDIOLOGY TOOL BOX

**54** **Surgical Care Only**: when one physician performs a surgical procedure and another provide preoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.

**55** **Postoperative Management Only:** when on physician performs the postoperative management and another physician has performed the surgical procedure, the postoperative component may be identified by adding the modifier 55 to the usual procedure number.

**56** **Preoperative Management Only:** When one physician performs the preoperative care and evaluation and another physician performs the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.

**57** **Decision for surgery:** An evaluation and management service that resulted in the initial decision to perform the surgery maybe identified by adding modifier 57 to the appropriate level of E/M service.

**58** **Staged or Related Procedure or Service by the Same Physician during the Postoperative Period;** It may be necessary to indicate that the performance of a procedure or service during the postoperative period was (a) planned or anticipated (staged) (b) more extensive than the original procedure;; or (c) for therapy following a surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. Note; for treatment of a problem that requires a return to the operative or procedure room (eg, unanticipated clinical condition).

**59** **Distinct Procedural Service:** under certain circumstances, it may by necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same or independent from other non E/M services performed on the same day. Modifier 59 is used to identify procedures or services other than E/M services that are not normally reported together but are appropriate under the circumstances. Documentation must support a different session. Different procedure or surgery, different site or organ system, separate incision or excision separate lesion or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available and the use of modifier 59 best explains the circumstances should modifier 59 be used.

Modifier 59 should be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25

**76** **Repeat Procedure or service by Same Physician:** it may be necessary to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. The circumstance may be reported by adding modifier 76 to the repeated procedure or service.

**77** **Repeat Procedure by another Physician**: The physician may be to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier 77 to the repeated procedure/service.

**78** **Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a related procedure during the post Operative Period**: It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first and requires the use of an operating or procedure room it may be reported by adding modifier 78 to the related procedure.

**79** **Unrelated Procedure or service by the same Physician during the Postoperative Period**: The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79.

**80** **Assistant Surgeon**: Surgical assistant service may be identified by adding modifier 80 to the usual procedure number(s)

**81** **Minimum Assistant Surgeon:** Minimum surgical assistant service is identified by adding modifier 81 to the usual procedure number.

**90** **Reference (outside) Laboratory:** When Laboratory Procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding modifier 90 to the usual procedure number.

# CARDIOLOGY TOOL BOX

**Here is the official summary of the Healthcare Information, Portability and Accountability Act. (HIPAA). If you are interested in the full version here is a link to the CMS website where it is published.** http://www.cms.hhs.gov/HIPAAGenInfo/Downloads/HIPAALaw.pdf
HTTP://WWW.HHS.GOV/OCR/PRIVACY/HIPAA/UNDERSTANDING/SUMMARY/INDEX.HTML

## Health Insurance Portability and Accountability Act of 1996
## Summary of Administrative Simplification Provisions

**Standards for electronic health information transactions.** Within 18 months of Enactment, the Secretary of HHS is required to adopt standards from among those already approved by private standards developing organizations for certain electronic health transactions, including claims, enrollment, eligibility, payment, and coordination of benefits. These standards also must address the security of electronic health information systems.

**Mandate on providers and health plans, and timetable.** Providers and health plans are required to use the standards for the specified electronic transactions 24 months after they are adopted. Plans and providers may comply directly, or may use a health care clearinghouse. Certain health plans, in particular workers compensation, are not covered.

**Privacy.** The Secretary is required to recommend privacy standards for health information to Congress 12 months after enactment. If Congress does not enact privacy legislation within 3 years of enactment, the Secretary shall promulgate privacy regulations for individually identifiable electronic health information.

**Pre-emption of State Law.** The bill supersedes state laws, except where the Secretary determines that the State law is necessary to prevent fraud and abuse, to ensure appropriate state regulation of insurance or health plans, addresses controlled substances, or for other purposes. If the Secretary promulgates privacy regulations, those regulations do not pre-empt state laws that impose more stringent requirements. These provisions do not limit a State's ability to require health plan reporting or audits.

**PENALTIES.** The bill imposes civil money penalties and prison for certain violations.

# CARDIOLOGY TOOL BOX

**BELOW ARE CPT CODES THAT ARE TYPICALLY USED IN FAMILY PRACTICE. KEEP IN MIND THAT EVERY PRACTICE IS DIFFERENT AND SOME PHYSICIAN'S WILL USE OTHER SPECIFIED CODES BASED ON THEIR PRACTICES DEMOGRAPHIC.**

## CARDIOLOGY

| ICD9 CODE 1 | ICD9 CODE 2 | ICD9 CODE 3 | ICD9 CODE 4 | INJURY DATE |
|---|---|---|---|---|
| | | | | |

| CODE | MOD | DESCRIPTION | | CODE | MOD | DESCRIPTION | | CODE | MOD | DESCRIPTION | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **OFFICE VISIT - NEW PATIENTS** | | | | **TREADMILL / THALIUM STRESS TESTS** | | | | 94760 | | OXIMETRY; SGL DETERMINATION | |
| 99201 | | LEVEL 1, BRIEF; 10 min | | 93015 | | STRESS TEST / TREADMILL | | 94761 | | OXIMETRY; MULT. DETERMIN. | |
| 99202 | | LEVEL 2, LIMITED: 20 min | | 78465 | | SPECT | | 94762 | | BY CONT. OVERNIGHT MONITOR. | |
| 99203 | | LEVEL 3, EXPANDED; 30 min | | 36410 | | VENIPUNCTURE REQ MD SKILL | | 99195 | | PHLEBOTOMY | |
| 99204 | | LEVEL 4, COMPREHENSIVE; 45 min | | 02594 | | THALLIUM | | 36415* | | VENIPUNCTURE | |
| 99205 | | LEVEL 5, COMPREHENSIVE; 60 min | | 02593 | | CARDIOLYTE / MYLOVIEW | | **ADMINISTRATION/INJECTIONS/SOLUTIONS** | | | |
| 99025 | | **NEW PT. INITIAL VISIT W/*PROC.** | | J1245 | | DIPYRIDAMOLE per 10mg | | 90780 | | IV INFUSION THERAPY; UP TO 1HR | |
| **OFFICE VISITS - EST. PATIENTS** | | | | J0280 | | AMINOPHYLLINE per 250 mg | | 90781 | | EA. ADD'L HR UP TO 8: _____ hrs | |
| 99211 | | LEVEL 1, BRIEF: 5 min | | J0150 | | ADENOSINE per 6mg DOSE VIAL | | 90782 | | SUB Q OR IM INJECTION | |
| 99212 | | LEVEL 2, LIMITED: 10 min | | **ECHOCARDIOGRAPHY** | | | | 90788 | | IM INJECTION OF ANTIBIOTIC | |
| 99213 | | LEVEL 3, EXPANDED: 15 min | | 93307 | | ECHOCARDIOGRAPHY; COMPLETE | | J0570 | | BICILLIN LA 1.2 M.U. | |
| 99214 | | LEVEL 4, COMPREHENSIVE: 25 min | | 93308 | | ECHO; F/U OR LIMITED | | 03338 | | BREVITAL UP TO 500mg | |
| 99215 | | LEVEL 5, COMPREHENSIVE: 40min | | 93312 | | TRANSESOPHAGEAL/PROBE/IMAGE | | J7060 | | DEXTROSE & WATER (500ml) | |
| 99024 | | POST OP FU @ N/C | N/C | 93313 | | PLACE TRANSESOPH.PROBE | | J3010 | | FENTANYL UP TO 2ML | |
| **OFFICE OR OUTPATIENT CONSULTATIONS** | | | | 93314 | | IMAGE AQUISITION, INT & REPT | | J1940 | | FUROSEMIDE (LASIX) 20mg | |
| 99241 | | LEVEL 1: 15 min | | 93320 | | DOPPLER ECHO | | J7120 | | LACTATED RINGERS (500cc) | |
| 99242 | | LEVEL 2: 30 min | | 93321 | | DOPPLER; F/U OR LTD STUDY | | J1160 | | LANOXIN (DIGOXIN) .5 mg | |
| 99243 | | LEVEL 3: 40 min | | 93325 | | DOPPLER COLOR FLOW MAP. | | J7040 | | NORMAL SALINE (500cc) | |
| 99244 | | LEVEL 4: 60 min | | 93350 | | STRESS ECHO W/TREADMILL | | 03339 | | VERAPAMIL HCL 5MG/2ML AMP | |
| 99245 | | LEVEL 5: 80 min | | **PACEMAKER CHECKS** | | | | J2250 | | VERSED(MIDOLOZAN) 1mg | |
| **CARDIOVASCULAR PROCEDURES** | | | | 93731 | | DUAL CHAMBER W/O REPROGRAM. | | **TRAYS (ADD TO SURGICAL PROCEDURE)** | | | |
| 92950 | | CPR | | 93732 | | DUAL CHAMBER W/ REPROGRAM | | 02645 | | IV TRAY | |
| 92960 | | CARDIOVERSION | | 93733 | | DUAL CHAMBER TELEPH. ANALYS. | | 02097 | | SUTURE TRAY W/ANESTHESIA | |
| 93000 | | EKG W/INTERP. & REPORT | | 93734 | | SINGLE CHAMBER W/O REPROGRAM | | 02098 | | TRAY, MED. W/SPEC. ROOM | |
| 93005 | | EKG, TRACING ONLY | | 93735 | | SINGLE CHAMBER W/REPROGRAM | | 02095 | | TRAY/RM/SPEC EQUIP | |
| 93010 | | EKG; INTERPRETATION & REPORT | | 93736 | | SGL CHAMBER TELEPH. ANALYS. | | 02094 | | TRAY, SMALL W/ANESTHESIA | |
| 93012 | | POST SYMPTOM RHYTHM STRIP | | 93737 | | CARDIOVERTER/DEFIB;W/O REPROG | | **MATERIALS AND SUPPLIES** | | | |
| | | TRACING ONLY | | 93738 | | CARDIOVERTER/DEFIB/W/REPROG. | | 02030 | | BUTTERFLIES | |
| 93014 | | POST SYMPTOM RHYTHM STRIP | | 93797 | | CARDIAC REHAB SESSIONS_____ | | 02029 | | CATHLON | |
| | | PHYS. REV. W/INTERP & REPORT | | **MISCELLANEOUS TEST/PROCEDURES** | | | | 02027 | | IV TUBING | |
| 93040 | | RHYTHM STRIP W/INT & REPORT | | 90471 | | IMMUNIZATION ADMIN. 1 SHOT | | 02026 | | OXYGEN SUPPLIES | |
| 93224 | | HOLTER MONITOR; COMPLETE | | 90472 | | IMMUNIZATION ADMIN. EA ADD'L | | 02034 | | PHLEBOTOMY BOTTLE | |
| 93268 | | EVENT MONITOR W/MEMORY LOOP | | 90658 | | FLU SHOT; SPLIT VIRUS (V04.8) | | 02092 | | PHLEBOTOMY TUBING | |
| 93278 | | SIGNAL AVG.ECG W/WO ECG | | 90659 | | FLU SHOT; WHOLE VIRUS (V04.8) | | | | | |
| 93784 | | AMB BP MONITOR/ 24 HRS | | 90732 | | PNEUMOCOCCAL VACCINE (V03.82) | | | | | |
| 93790 | | AMB BP MONITOR-REV/INTERP | | 82270 | | OCCULT BLOOD | | | | | |
| *****AMB BP MONITOR NON-COVERED BY MEDICARE***** | | | | 82948 | | GLUCOSE FINGER STICK | | | | | |

| **OTHER SURGERY / PROCEDURES** CPT CODE/MODIFIERS* | **FEE** |
|---|---|
| 1ST | $ |
| 2ND | $ |
| 3RD | $ |
| 4TH | $ |
| 5TH | $ |
| 6TH | $ |

**SPECIAL INSTRUCTIONS:**

- ☐ ACCIDENT
- ☐ COORD. OF BENEFITS
- ☐ NON COVERED SERVICE
- ☐ THIRD PARTY LIEN
- ☐ WORKERS COMP
- ☐ OTHER; SPECIFY

# CARDIOLOGY TOOL BOX

# CARDIOLOGY TOOL BOX

**Date of Service:** _____

PATIENT: _____ PATIENT ID: _____ REFERRING PHYSICIAN: _____

_____

## *NUCLEAR CARDIOLOGY*

| TREADMILL – CARDIOLITE | X | CPT | FEE |
|---|---|---|---|
| MYOCARDIAL SPECT, REST/STRESS | | 78465 | |
| WALL MOTION, STRESS | | 78478 | |
| EJECTION FRACTION, STRESS | | 78480 | |
| DIAGNOSTIC INJECTION, REST | | 90784 | |
| DIAGNOSTIC INJECTION, STRESS | | 90784 | |
| CARDIOLITE, REST | | A9500 | |
| CARDIOLITE, STRESS | | A9500 | |
| STRESS TEST-SUPV.INTERP.& REPORT | | 93015N | |
| MYOCARDIAL SPECT, SINGLE STUDY | | 464 | |
| SALINE INFUSION | | J7050 | |
| COMPUTER ANALYSIS | | 78890 | |

| Dobutamine - Cardiolite | X | CPT | FEE |
|---|---|---|---|
| MYOCARDIAL SPECT, REST/STRESS | | 78465 | |
| WALL MOTION, STRESS | | 78478 | |
| EJECTION FRACTION, STRESS | | 78480 | |
| DIAGNOSTIC INJECTION, REST | | 90784 | |
| DIAGNOSTIC INJECTION, STRESS | | 90784 | |
| CARDIOLITE, REST | | A9500 | |
| CARDIOLITE, STRESS | | A9500 | |
| DOBUTAMINE INFUSION | | J1250 | |
| STRESS TEST-SUPV.,INTERP. & REPORT | | 93015N | |
| MYOCARDIAL SPECT, SINGLE STUDY | | 464 | |
| SALINE INFUSION | | J7050 | |
| COMPUTER ANALYSIS | | 78890 | |

| DIAGNOSIS | X | ICD9 | |
|---|---|---|---|
| ABNORMAL EKG | | 794.31 | |
| ANGINA PECTORIS | | 413.9 | |
| ANGINA, VARIANT – PRINZMETAL ANGINA | | 413.1 | |
| AORTIC INSUFFICIENCY/STENOSIS | | 424.1 | |
| ASHD | | 414.01 | |
| ATRIAL FIBRILLATION | | 427.31 | |
| ATRIAL FLUTTER | | 427.32 | |
| AV BLOCK, 1ST DEGREE | | 426.11 | |
| BRADYCARDIA | | 427.89 | |
| CAD OF THE NATIVE CORONARY ARTERY | | 414.01 | |
| CAD UNSPECIFIED TYPE OF VESSEL, GRAFT | | 414.00 | |
| CAD AUTOLOGOUS BYPASS GRAFT | | 414.02 | |
| CAD NONAUTOLOGOUS BYPASS GRAFT | | 414.03 | |
| CAD OF ARTERY BYPASS GRAFT | | 414.04 | |
| CAD BYPASS GRAFT (NOS) | | 414.05 | |
| CARDIOVASCULAR DISEASE, UNSPECIFIED | | 429.2 | |
| CARDIOMEGALY | | 429.3 | |
| CARDIOMYOPATHY, CONGESTIVE | | 425.4 | |
| CARDIOMYOPATHY, HOCM | | 425.1 | |
| CARDIOMYOPATHY, ISCHEMIC, OTHER | | 414.8 | |
| CARDIOMYOPATHY, SECONDARY, UNSPECS. | | 425.9 | |
| CHEST PAIN (NOT ANGINAL) | | 786.50 | |
| CHEST PAIN, PRECORDIAL | | 786.51 | |
| CORONARY OCCLUSION WITHOUT MI | | 411.81 | |
| CORONARY INSUFFICIENCY | | 411.89 | |
| | | | |
| | | | |
| | | | |

| ADENOSINE - CARDIOLITE | X | CPT | FEE |
|---|---|---|---|
| MYOCARDIAL SPECT, REST/STRESS | | 78465 | |
| WALL MOTION, STRESS | | 78478 | |
| EJECTION FRACTION, STRESS | | 78480 | |
| DIAGNOSTIC INJECTION, REST | | 90784 | |
| DIAGNOSTIC INJECTION, STRESS | | 90784 | |
| CARDIOLITE, REST | | A9500 | |
| CARDIOLITE,STRESS | | A9500 | |
| ADENOSINE 90MG X ____VIALS | | J0151 | |
| STRESS TEST-SUPV.,INTERP.& REPORT | | 93015N | |
| MYOCARDIAL SPECT, SINGLE STUDY | | 464 | |
| SALINE INFUSION | | J7050 | |
| PERSANTINE STRESS 10 MG. | | J1245 | |
| COMPUTER ANALYSIS | | 78890 | |

| RADIONUCLIDE MUGA | X | CPT | FEE |
|---|---|---|---|
| MUGA LVEF WALL MOTION | | 472 | |
| ULTRA TAG KIT + TECHNETIUM | | A4641 | |
| INJECTION | | 90784 | |

| THALLIUM | X | CPT | FEE |
|---|---|---|---|
| THALLIUM X _____MCI | | A9505 | |
| THALLIUM X _____MCI | | A9505 | |

| MISCELLANEOUS | X | CPT | FEE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

| DIAGNOSIS | X | ICD9 | |
|---|---|---|---|
| DYSPNEA (RESP. DISTRESS) | | 786.09 | |
| DYSPNEA (SHORTNESS OF BREATH) | | 786.05 | |
| ENDOCARDITIS, VALVE & CAUSE UNSPECIFIED | | 424.90 | |
| ENDOCARDITIS IN DISEASES CLASS ELSEWHERE | | 424.91 | |
| ENDOCARDITIS, OTHER | | 424.99 | |
| ENDOMYOCARDIAL FIBROSIS | | 425.0 | |
| ENDOCARDIAL FIBROELASTOSIS | | 425.3 | |
| MITRAL REGURGITATION | | 424.0 | |
| MYOCARDITIS, UNSPECIFIED | | 429.0 | |
| MYOCARDIAL DEGENERATION | | 429.1 | |
| MYOCARDIAL INFARCTION, OLD | | 412 | |
| ORTHOPNEA | | 786.02 | |
| PAROXYSMAL SUPRAVENTRICULAR TACHYCARDIA | | 427.0 | |
| PERIPHERAL VASCULAR DISEASE | | 443.9 | |
| POSTMYOCARDIAL INFARCTION SYNDROME | | 411.0 | |
| PREMATURE ATRIAL CONTRACTION | | 427.61 | |
| PREMATURE ATRIAL UNSPECIFIED | | 427.60 | |
| PREMATURE VENTRICULAR CONTRACTION | | 427.69 | |
| PULMONARY VALVE DISORDERS | | 424.3 | |
| RBBB | | 426.4 | |
| LBBB, OTHER | | 426.3 | |
| SICK SINUS SYNDROME | | 427.81 | |
| SYNCOPE AND COLLAPSE | | 780.2 | |
| CARDIAC RISK FACTORS | | V71.7 | |
| FOLOW-UP EXAM FOLLOWING SURGERY | | V67.0 | |
| | | | |
| | | | |
| | | | |

# CARDIOLOGY TOOL BOX

**Commonly used Icd-9-cm codes for cardiology, these codes are not inclusive of the codes normally used for the specialty, but this will get you started on knowing the codes that you need to code cardiology**

| | |
|---|---|
| **401.9** | **UNSPECIFIED ESSENTIAL HYPERTENSION** |
| **402 -402.9** | **HYPERTENSIVE HEART DISEASE** |
| **410.02-410.82** | **MYOCARDIAL INFARCTION** |
| **411** | **POSTMYOCARDIAL INFARCTION SYNDROME** |
| **411.1** | **INTERMEDIATE CORONARY SYNDROME** |
| **411.81** | **CORONARY OCCLUSION WITHOUT MI** |
| **411.89** | **CORONARY INSUFFICIENCY** |
| **413.0-413.9** | **ANGINA** |
| **414.00-414.05** | **ATHEROSCLEROSIS** |
| **414.06-414-07** | **ATHEROSCLEROSIS TRANSPLANTED HEART AND OF BYPASS GRAFT OF TRANSPLANTED HEART** |
| **414.8** | **SPECIFIED CHRONIC ISCHEMIC DISEASE** |
| **414.9** | **CHRONIC ISCHEMIC HEART DISEASE, UNSPECIFIED** |
| **416** | **PULMONARY HYPERTENSION** |
| **424.0-424.3** | **VALVE DISORDERS** |
| **425.0-425.9** | **CARDIOMYOPATHY** |
| **426.10-426.9** | **CONDUCTION DISORDERS** |
| **427.0-427.89** | **CARDIAC DYSRHYTHMIAS** |
| **428.0-428.9** | **HEART FAILURE** |
| **429** | **MYOCARDITIS, UNSPECIFIED** |
| **433.1** | **OCCLUSION/STENOSIS CAROTID ARTERY** |
| **433.11** | **OCCLUSION/STENOSIS CAROTID ARTERY** |
| **440.20-440.9** | **ATHEROSCLEROSIS OF EXTREMITIES** |
| **441.00-441.9** | **AORTIC ANEURYSM** |
| **745.2-745.5** | **TETRALOGY OF FALLOT, COMMON VENTRICLE, VENTRICULAR SEPTAL DEFECT ASD** |
| **746.00-746.7** | **CONGENITAL ANOMALIES OF HEART** |
| **746.81** | **SUBAORTIC STENOSIS** |
| **746.85** | **CORONARY ARTERY ANOMALY** |
| ***780.2** | **SYNCOPE** |
| ***785.1** | |
| **786.02** | **ORTHOPNEA** |
| **786.05** | **SHORTNESS OF BREATH** |
| **786.09** | **DYSPNEA** |
| **786.5** | **CHEST PAIN, UNSPECIFIED** |
| **786.51** | **PRECORDIAL PAIN** |
| **786.59** | **OTHER CHEST PAIN** |
| **794.3** | **ABNORMAL CARDIOVASCULAR FUNCTION STUDY** |
| **794.31** | **ABNORMAL EKG** |
| **V72.81** | **PREOPERATIVE CARDIOVASCULAR EXAM** |

# CARDIOLOGY TOOL BOX
## CLAIM CORRECTION FORM

**Submitted to:**

Plan/Payer name: _____ Date submitted: _____/_____/_____

Plan/Payer address: _____
STREET SUITE CITY STATE ZIP

Telephone: (____)_____ Fax: (____)_____ E-mail: _____

Patient name: _____ Birth date: _____/_____/_____
FIRST M.I. LAST

Subscriber name: _____ Date of service: _____/_____/_____

Policy #: _____ Group #: _____ Original claim #: _____

**Submitted by:**

Provider: _____ Contact: _____ Telephone: (___)_____ Ext: ___ Fax: (___)_____

E-mail: _____

**The following corrections were made on this claim:**

❍ Patient's policy number/group number was incorrect. The correct number(s) are shown above.
❍ Date of service was incorrect. Correct date is: _____/_____/_____.
❍ CPT code was incorrect. Correct CPT code is _____ instead of _____.
❍ Diagnosis code was incorrect. Correct diagnosis code is _____ instead of _____.
❍ Visit was denied as over carrier's utilization limits. Please see attached letter to justify extensions of these limits.
❍ Procedure was denied as over carrier's utilization limits. Please see attached letter to justify extensions of these limits.
❍ Carrier indicated that the patient is covered by another plan that is primary. Patient indicates you are primary.
❍ Secondary carrier is _____. ❍ There is no secondary carrier.
❍ Procedure was denied as not medically necessary. Supporting documentation is attached.
❍ Carrier's clerk failed to enter correct number of times (units) procedure was performed. Correct units are as follows:
DOS: _____/_____/_____ Code: _____ Units: _____ Charge total: $ _____

❍ We failed to enter correct number of times (units) procedure was performed. Correct units are as follows:
DOS: _____/_____/_____ Code: _____ Units: _____ Charge total: $ _____

Multiple surgical procedures: ❍ Carrier failed to approve any procedure at 100%.
❍ Carrier approved incorrect procedure at 100%.
Carrier should have approved code _____@ 100%/50% (circle one).
Carrier should have approved code _____@ 100%/50% (circle one).
Carrier should have approved code _____@ 100%/50% (circle one).

❍ Modifiers were omitted. Please reconsider as follows:

| Code | Code | Code | Code |
|---|---|---|---|
| -50 _____ | _____ | -51 _____ | _____ |
| -58 _____ | _____ | -59 _____ | _____ |
| -79_____ | _____ | GA_____ | _____ |

❍ E/M service was denied as included in the global surgical fee. Please reconsider with attached supporting documentation:

Code: _____ Modifier(s): ❍ -24 ❍ -25 Charge: $ _____

❍ UPIN information was omitted.
Code: _____ Physician name: _____ UPIN: _____

❍ Plan-specific provider ID#: _____.
❍ CLIA number: _____.
❍ Place of service: _____.
❍ Service was rendered at the physician's physical location listed in Box 32 of the original claim form.
❍ EOB from primary carrier is attached.
❍ Incorrect information was entered on claim form. Line #: ___ Correct information: _____
❍ Other reason for correction: _____
❍ Comment: _____

_____

# CARDIOLOGY TOOL BOX

☐ **Established Patient – General Multisystem Exam**
**Requirements must be met in 2 of 3 areas: (1) Hx (2) PE (3) Decisions**

**History**

3 OF 3 REQUIRED

99213/LEVEL III – EXP PROBLEM FOCUSED
99214/LEVEL IV -- DETAILED

| | | |
|---|---|---|
| | 99213 **>=** 1<br>99214 **>=4:**<br>☐ **LOCATION**<br>☐ **QUALITY**<br>☐ **DURATION**<br>☐ **TIMING**<br>☐ **CONTEXT**<br>☐ **MODIFYING FACTORS**<br>☐ **ASSOCIATED S/S** | **OR 99214 >=3**<br><br>☐ **CHR DZ**<br><br>☐ **CHR DZ**<br><br>☐ **CHR DZ** |
| ROS | 99213 **>=** 1<br>99214 >=2<br>**(PERTINENT SYSTEM)** | |
| | **CONSTITUTIONAL** ☐<br>**EYES** ☐<br>**ENT/MOUTH** ☐<br>**CV** ☐<br>**RESP** ☐<br>**GI** ☐<br>**GU** ☐<br>**MUSC** ☐<br>**SKIN/BREASTS** ☐<br>**NEURO** ☐<br>**PSYCH** ☐<br>**ENDO** ☐<br>**HEME/LYMPH** ☐<br>**ALLERGY/IMMUN** ☐ | |
| PFSH | 99213: **NO PFSH**<br>99214 >=1:<br>**PMH** ☐<br>**FHX** ☐<br>**SHX** ☐ | |

CC/HPI:

**Pain: _____ out of 10**

TOBACCO:

LAST TD: _____

ALLERGIES:

MEDS:

LMP:

BIRTH CONTROL:

**VISION SCREEN:**
**OD 20/**
**OS 20/**
**OU 20/**

**EXAM**

**99213/LEVEL III:** >= 6 **FROM ANY SYSTEMS/AREAS**
**99214/LEVEL IV:** >=12 **FROM** >=2 **SYSTEMS/AREAS**

**CONSTITUTIONAL**

**EYES**

**ENT**

**NECK**

**RESP**

**CV**

**CHEST (BREASTS)**

**GI (ABD)**

**GU**

**LYMPH**

**MUSC**

**SKIN**

**NEURO**

**PSYCH**

**HT:** **WT:** **T:** **P:** **BP:** / **R:** **$O_2$ SAT :**

**NURSE INITIALS**

**PATIENT EDUCATION GIVEN:** ☐ **VERBAL** ☐ **WRITTEN**

**TOPIC:** ☐ **MEDS** ☐ **DISEASE** ☐ **OTHER**

☐ **UNDERSTANDS** ☐ **NEEDS REPEAT TEACHING**

**CHECK IN TIME:**
**APPT TIME:**
**EXAM ROOM:**
Dr. Time:
**COUNSELING TIME:**

**DICTACTED**

# CARDIOLOGY TOOL BOX

ESTABLISHED PATIENT – MULTISYSTEM EXAM

DECISION MAKING

⇑ 2 OF 3 REQUIRED ⇓

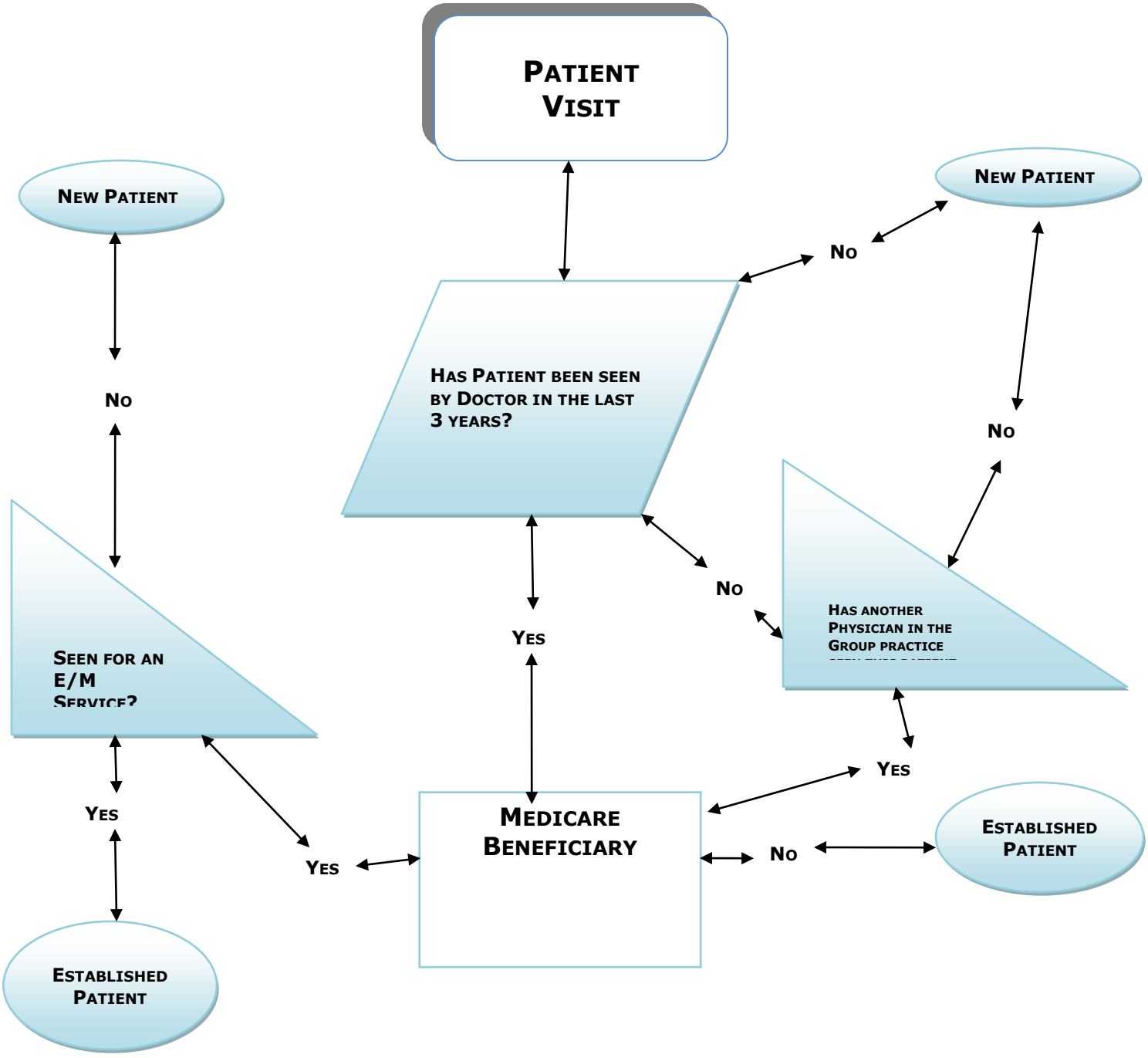
| | 99211/I | 99212/II | 99213/III | 99214/IV | 99215/V |
|---|---|---|---|---|---|
| | | **STRAIGHTFORWARD** | **LOW COMPLEXITY** | **MODERATE COMPLEXITY** | **HIGH COMPLEXITY** |
| DIAGNOSIS | | >=1 POINT<br>**(MAX 2 PTS MINOR PROBS)** | >=2 POINTS<br>**(MAX 2 PTS MINOR PROBS)** | >=3 POINTS<br>**(MAX 2 PTS MINOR PROBS)** | >=4 POINTS<br>**(MAX 2 PTS MINOR PROBS)** |
| | | ☐ **MINOR PROB** 1<br>☐ **MINOR PROB** 1 | ☐ **MINOR PROB** 1<br>☐ **MINOR PROB** 1 | ☐ **MINOR PROB** 1<br>☐ **MINOR PROB** 1 | ☐ **MINOR PROB** 1<br>☐ **MINOR PROB** 1 |
| | | ☐ **ESTAB PROB-STABLE** 1<br>☐ **ESTAB PROB-STABLE** 1 | ☐ **ESTAB PROB-STABLE** 1<br>☐ **ESTAB PROB-STABLE** 1 | ☐ **ESTAB PROB-STABLE** 1<br>☐ **ESTAB PROB-STABLE** 1 | ☐ **ESTAB PROB-STABLE** 1<br>☐ **ESTAB PROB-STABLE** 1 |
| | | ☐ **ESTAB PROB-WORSE** 2<br>☐ **ESTAB PROB-WORSE** 2 | ☐ **ESTAB PROB-WORSE** 2<br>☐ **ESTAB PROB-WORSE** 2 | ☐ **ESTAB PROB-WORSE** 2<br>☐ **ESTAB PROB-WORSE** 2 | ☐ **ESTAB PROB-WORSE** 2<br>☐ **ESTAB PROB-WORSE** 2 |
| | | MAX 3 PTS FOR NEW PROBS-STABLE | MAX 3 PTS FOR NEW PROBS-STABLE | MAX 3 PTS FOR NEW PROBS-STABLE | MAX 3 PTS FOR NEW PROBS-STABLE |
| | | ☐ **NEW PROB-STABLE** 3<br>☐ **NEW PROB-NEED W/U** 4 | ☐ **NEW PROB-STABLE** 3<br>☐ **NEW PROB-NEED W/U** 4 | ☐ **NEW PROB-STABLE** 3<br>☐ **NEW PROB-NEED W/U** 4 | ☐ **NEW PROB-STABLE** 3<br>☐ **NEW PROB-NEED W/U** 4 |
| | | TOTAL | TOTAL | TOTAL | TOTAL |
| DATA | | >=1 POINT | >=2 POINTS | >=3 POINTS | >=4 POINTS |
| | | ☐ **ORDER/STUDY LABS** 1 | ☐ **ORDER/STUDY LABS** 1 | ☐ **ORDER/STUDY LABS** 1 | ☐ **ORDER/STUDY LABS** 1 |
| | | ☐ **ORDER/STUDY X-RAYS** 1 | ☐ **ORDER/STUDY X-RAYS** 1 | ☐ **ORDER/STUDY X-RAYS** 1 | ☐ **ORDER/STUDY X-RAYS** 1 |
| | | ☐ **ORDER/STUDY MED TESTS** 1 | ☐ **ORDER/STUDY MED TESTS** 1 | ☐ **ORDER/STUDY MED TESTS** 1 | ☐ **ORDER/STUDY MED TESTS** 1 |
| | | ☐ **DISCUSSED RESULTS W/ TESTING DR.** 1 | ☐ **DISCUSSED RESULTS W/ TESTING DR.** 1 | ☐ **DISCUSSED RESULTS W/ TESTING DR.** 1 | ☐ **DISCUSSED RESULTS W/ TESTING DR.** 1 |
| | | ☐ **ORDER OLD RECS/ADD HX** 1 | ☐ **ORDER OLD RECS/ADD HX** 1 | ☐ **ORDER OLD RECS/ADD HX** 1 | ☐ **ORDER OLD RECS/ADD HX** 1 |
| | | ☐ **SUMMARY OF REVIEW OF OLD RECS/ADD HX** 2 | ☐ **SUMMARY OF REVIEW OF OLD RECS/ADD HX** 2 | ☐ **SUMMARY OF REVIEW OF OLD RECS/ADD HX** 2 | ☐ **SUMMARY OF REVIEW OF OLD RECS/ADD HX** 2 |
| | | ☐ **VIEW X-RAY, TRACING OR SLIDE PREV INTERP BY OTHER DR.** 2 | ☐ **VIEW X-RAY, TRACING OR SLIDE PREV INTERP BY OTHER DR.** 2 | ☐ **VIEW X-RAY, TRACING OR SLIDE PREV INTERP BY OTHER DR.** 2 | ☐ **VIEW X-RAY, TRACING OR SLIDE PREV INTERP BY OTHER DR.** 2 |
| | | TOTAL | TOTAL | TOTAL | TOTAL |
| RISK | | >=1 POINT | >=1 POINT | >=1 POINT | >=1 POINT |
| PROBLEMS | | ☐ **1 MINOR PROB (COLD, BUG BITE)** | ☐ **2+ MINOR PROBS** | ☐ **1+ CHRONIC PROB-MILD INCR** | ☐ **1+ CHRONIC PROB-SEV INCR** |
| | | | ☐ **1 CHRONIC PROB-STABLE** | ☐ **2+ CHRONIC PROBS-STABLE** | ☐ **CHRONIC PROB-LIFE THREAT** |
| | | | ☐ **ACUTE PROB-UNCOMPLICATED (ALLERGY, UTI, SPRAIN)** | ☐ **ACUTE PROB-SYSTEMIC (PYELO, PNEUMO)** | ☐ **ACUTE PROB-LIFE THREAT** |
| | | | | ☐ **ACUTE INJURY-COMPLICATED (HEAD INJURY W/ BRIEF LOC)** | ☐ **ACUTE MENTAL STATUS CHANGE (TIA, SEIZURE, WEAKNESS)** |
| | | | | ☐ **NEW PROB-UNCERT PX (BREAST LUMP)** | |
| PROCEDURES | | ☐ **X-RAY** | ☐ **NON-CV CONTRAST STUDIES** | ☐ **CV CONTRAST STUDIES (NO RISK FACTORS)** | ☐ **CV CONTRAST STUDIES (WITH RISK FACTORS)** |
| | | ☐ **LABS** | ☐ **PFT** | ☐ **ENDOSCOPY (NO RISK FACTORS)** | ☐ **ENDOSCOPY (WITH RISK FACTORS)** |
| | | ☐ **EKG** | ☐ **SKIN BX** | ☐ **DEEP NEEDLE BX** | |
| | | ☐ **UA** | ☐ **NEEDLE BX – SUPERFICIAL** | ☐ **INCISION BX** | |
| | | ☐ **KOH** | ☐ **PUNCTURE-ARTERIAL** | ☐ **EST** | |
| | | | | ☐ **FST** | |
| | | | | ☐ **BODY CAVITY FLUIDS** | |
| MANAGEMENT | | ☐ **REST** | ☐ **OTC DRUGS (LIST OTC MEDS)** | ☐ **RX DRUGS (LIST MEDS)** | ☐ **DRUGS-INTENSIVE MONITOR** |
| | | ☐ **GARGLE** | ☐ **PT** | | ☐ **PARENTAL TX** |
| | | | | ☐ **FRACTURE TX-CLOSED (NO MANIP)** | ☐ **FRACTURE TX-CLOSED (W/ MANIP)** |
| | | ☐ **BANDAGES-ELASTIC** | ☐ **OT** | | ☐ **DNR DECISION OR DEESCALATE CARE DUE TO POOR PX** |
| | | ☐ **SUPERFICIAL DRESSINGS** | ☐ **IVF (NO ADDITIVES)** | ☐ **IVF (W./ ADDITIVES)** | |
| | | | ☐ **MINOR SURG (NO RISK FACTORS)** | ☐ **MINOR SURG (W/ RISK FACTORS)** | |
| | | | | ☐ **MAJOR SURG-ELECTIVE (INCL ENDOSC; NO RISK FACTORS)** | ☐ **MAJOR SURG-ELECTIVE (INCL ENDOSC; WITH RISK FACTORS)** |
| | | | | | ☐ **MAJOR SURG-EMERGENT (INCL ENDOSC)** |

TIME

| | 5-MIN | 10-MIN | 15-MIN | 25-MIN | 40-MIN |
|---|---|---|---|---|---|
| **DOCUMENTATION MUST INCLUDE:** DX, DESCRIPTION OF COUNSELING/COORDINATION, TOTAL TIME, WHO WAS PRESENT.<br>⇒ **WHEN MORE THAN 50% OF THE FACE-TO-FACE TIME WITH THE PATIENT WAS SPENT IN ADDRESSING COUNSELING COMPONENTS, THE VISIT MAY BE CODED BASED ON TIME IF THE CHART DOCUMENTATION SUPPORTS THE TIME. THE DOCUMENTATION MUST LIST THE TOTAL TIME OF THE ENCOUNTER AND THAT CODING WAS BASED ON COUNSELING REGARDING...** | | | | | |
| ☐ **INSTRUCTIONS FOR MANAGEMENT**<br>☐ **RISK FACTOR REDUCTION**<br>☐ **IMPORTANCE OF COMPLIANCE W/ CHOSEN TX OPTIONS** | | ☐ **DIAGNOSTIC RESULTS**<br>☐ **PROGNOSIS** | ☐ **RISKS AND BENEFIT OF TX OPTION**<br>☐ **PATIENT & FAMILY EDUCATION** | ☐ **IMPRESSIONS** | |

# CARDIOLOGY TOOL BOX

## NEW vs. ESTABLISHED PATIENT



# CARDIOLOGY TOOL BOX

Below is the legend for the payment indicator box on the next page. To use this grid locate your code and follow the grid across to find out whether a modifier for reimbursement.

To look up a code that is not listed go to this URL:
http://www.cms.hhs.gov/pfslookup/02_PFSsearch.asp?agree=yes&next=Accept

0=Payment restriction applies to this procedure unless supporting documentation is submitted to establish medical necessity.
1=Statutory payment restriction for assistants at surgery applies to this code
2=Payment restrictions for assistants at surgery does not apply to this procedure. Assistant surgery may be paid

Modifier: 0=not allowed: 1=allowed: 9=not applicable

The ZZZ global surgery indicator: Allows payment only when the code is billed in conjunction with another base service. Alternatively, a ZZZ global period service may never be billed alone

# CARDIOLOGY TOOL BOX

| HCPC | Modifier | Short Description | Proc Stat | PCTC | Global | Asst Surg | Bilt Surg | Mult Surg | Co Surg | Team Surg | Phys Supv | Diag Imaging Family Ind |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 36410 | | NON-ROUTINE BL DRAW > 3 YRS | A | 0 | XXX | 1 | 0 | 2 | 0 | 0 | 9 | 99 |
| 78465 | | HEART IMAGE (3D), MULTIPLE | A | 1 | XXX | 0 | 0 | 0 | 0 | 0 | 9 | 99 |
| 78465 | TC | HEART IMAGE (3D), MULTIPLE | A | 1 | XXX | 0 | 0 | 0 | 0 | 0 | 1 | 99 |
| 78465 | 26 | HEART IMAGE (3D), MULTIPLE | A | 1 | XXX | 0 | 0 | 0 | 0 | 0 | 9 | 99 |
| 92950 | | HEART/LUNG RESUSCITATION CPR | A | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 9 | 99 |
| 92960 | | CARDIOVERSION ELECTRIC, EXT | A | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 9 | 99 |
| 93000 | | ELECTROCARDIOGRAM, COMPLETE | A | 4 | XXX | 0 | 0 | 0 | 0 | 0 | 1 | 99 |
| 93005 | | ELECTROCARDIOGRAM, TRACING | A | 3 | XXX | 0 | 0 | 0 | 0 | 0 | 1 | 99 |
| 93010 | | ELECTROCARDIOGRAM REPORT | A | 2 | XXX | 0 | 0 | 0 | 0 | 0 | 9 | 99 |
| 93012 | | TRANSMISSION OF ECG | A | 3 | XXX | 0 | 0 | 0 | 0 | 0 | 1 | 99 |
| 93014 | | REPORT ON TRANSMITTED ECG | A | 2 | XXX | 0 | 0 | 0 | 0 | 0 | 9 | 99 |
| 93015 | | CARDIOVASCULAR STRESS TEST | A | 4 | XXX | 0 | 0 | 0 | 0 | 0 | 2 | 99 |
| 93040 | | RHYTHM ECG WITH REPORT | A | 4 | XXX | 0 | 0 | 0 | 0 | 0 | 1 | 99 |
| 93224 | | ECG MONITOR/REPORT, 24 HRS | A | 4 | XXX | 0 | 0 | 0 | 0 | 0 | 1 | 99 |
| 93268 | | ECG RECORD/REVIEW | A | 4 | XXX | 0 | 0 | 0 | 0 | 0 | 1 | 99 |
| 93278 | | ECG/SIGNAL-AVERAGED | A | 1 | XXX | 0 | 0 | 0 | 0 | 0 | 9 | 99 |
| 93278 | TC | ECG/SIGNAL-AVERAGED | A | 1 | XXX | 0 | 0 | 0 | 0 | 0 | 1 | 99 |
| 93278 | 26 | ECG/SIGNAL-AVERAGED | A | 1 | XXX | 0 | 0 | 0 | 0 | 0 | 9 | 99 |
| 93307 | | TTE W/O DOPPLER, COMPLETE | A | 1 | XXX | 0 | 0 | 0 | 0 | 0 | 9 | 99 |
| 93307 | TC | TTE W/O DOPPLER, COMPLETE | A | 1 | XXX | 0 | 0 | 0 | 0 | 0 | 1 | 99 |
| 93307 | 26 | TTE W/O DOPPLER, COMPLETE | A | 1 | XXX | 0 | 0 | 0 | 0 | 0 | 9 | 99 |
| 93308 | | TTE, F-UP OR LMTD | A | 1 | XXX | 0 | 0 | 0 | 0 | 0 | 9 | 99 |
| 93308 | TC | TTE, F-UP OR LMTD | A | 1 | XXX | 0 | 0 | 0 | 0 | 0 | 1 | 99 |
| 93308 | 26 | TTE, F-UP OR LMTD | A | 1 | XXX | 0 | 0 | 0 | 0 | 0 | 9 | 99 |
| 93312 | | ECHO TRANSESOPHAGEAL | A | 1 | XXX | 0 | 0 | 0 | 0 | 0 | 9 | 99 |
| 93312 | TC | ECHO TRANSESOPHAGEAL | A | 1 | XXX | 0 | 0 | 0 | 0 | 0 | 3 | 99 |
| 93312 | 26 | ECHO TRANSESOPHAGEAL | A | 1 | XXX | 0 | 0 | 0 | 0 | 0 | 9 | 99 |
| 93313 | | ECHO TRANSESOPHAGEAL | A | 0 | XXX | 0 | 0 | 0 | 0 | 0 | 3 | 99 |
| 93314 | | ECHO TRANSESOPHAGEAL | A | 1 | XXX | 0 | 0 | 0 | 0 | 0 | 9 | 99 |
| 93314 | TC | ECHO TRANSESOPHAGEAL | A | 1 | XXX | 0 | 0 | 0 | 0 | 0 | 3 | 99 |
| 93314 | 26 | ECHO TRANSESOPHAGEAL | A | 1 | XXX | 0 | 0 | 0 | 0 | 0 | 9 | 99 |
| 93320 | | DOPPLER ECHO EXAM, HEART | A | 1 | ZZZ | 0 | 0 | 0 | 0 | 0 | 9 | 99 |
| 93320 | TC | DOPPLER ECHO EXAM, HEART | A | 1 | ZZZ | 0 | 0 | 0 | 0 | 0 | 1 | 99 |

# CARDIOLOGY TOOL BOX

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 93320 | 26 | DOPPLER ECHO EXAM, HEART | A | 1 | ZZZ | 0 | 0 | 0 | 0 | 0 | 9 | 99 |
| 93321 | | DOPPLER ECHO EXAM, HEART | A | 1 | ZZZ | 0 | 0 | 0 | 0 | 0 | 9 | 99 |
| 93321 | TC | DOPPLER ECHO EXAM, HEART | A | 1 | ZZZ | 0 | 0 | 0 | 0 | 0 | 1 | 99 |
| 93321 | 26 | DOPPLER ECHO EXAM, HEART | A | 1 | ZZZ | 0 | 0 | 0 | 0 | 0 | 9 | 99 |
| 93325 | | DOPPLER COLOR FLOW ADD-ON | A | 1 | ZZZ | 0 | 0 | 0 | 0 | 0 | 9 | 99 |
| 93325 | TC | DOPPLER COLOR FLOW ADD-ON | A | 1 | ZZZ | 0 | 0 | 0 | 0 | 0 | 1 | 99 |
| 93325 | 26 | DOPPLER COLOR FLOW ADD-ON | A | 1 | ZZZ | 0 | 0 | 0 | 0 | 0 | 9 | 99 |
| 93350 | | STRESS TTE ONLY | A | 1 | XXX | 0 | 0 | 0 | 0 | 0 | 9 | 99 |
| 93350 | TC | STRESS TTE ONLY | A | 1 | XXX | 0 | 0 | 0 | 0 | 0 | 2 | 99 |

# CARDIOLOGY TOOL BOX

## ACRONYMS

**AMA** American Medical Association Chief Complaint

**CC** Chief Complaint

**CMS** Centers for Medicare & Medicaid Services

**CPT** Current Procedural Terminology

**E/M** Evaluation and Management

**HPI** History of Present Illness

**ICD-9-CM** International Classification of Diseases, 9th Revision, Clinical Modification

**PFSH** Past, Family, and/or Social History

**ROS** Review of Systems

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## Status Update on CPT II Coding Issue for the 2009 PQRI and Options for Eligible Professionals (EPs)

1. CMS has identified a technical problem affecting twenty quality-data codes (QDCs) used for reporting thirteen quality measures through the claims-based method for the 2009 Physician Quality Reporting Initiative (PQRI). These twenty QDCs are new codes for the 2009 PQRI. The CPT II codes and the 2009 PQRI measures affected are listed below.

1. In most instances, the technical problem has caused line items containing any of the QDCs listed below to reject/return as unprocessable. In those circumstances the eligible professional (EP) received a message other than N365 indicating that the procedure code not accepted for reporting proposes. Since this is an issue that affects claims-based PQRI reporting only, the reporting of quality measures through registries is not affected.

1. CMS is actively working with the carriers/AB MACs to address this issue. All carriers/AB MACs will be able to accept the affected codes within the next three weeks. Once this has been accomplished, submission of the affected CPT II codes will result in the normal N365 message on the remittance advice indicating that the code has been accepted for reporting purposes.

1. In order to minimize any adverse impact on EPs for determination of satisfactory reporting for affected measures, CMS will exclude from the reporting denominator all cases for dates before which the carriers/AB MACs could accept the affected CPT II codes, unless inclusion of cases for such dates is more favorable to the EP. In view of this, EPs have the option to seek correction of first quarter QDC submissions which were returned as unprocessed if desired, but EPs would not be required to seek correction for the affected codes. The two basic options for EPs are:

A. Do not seek correction of the submitted codes which were returned unprocessed.

As indicated above, CMS will exclude from the determination of satisfactory reporting cases for dates prior to the date the carriers/AB MACs can process the relevant codes. Thus, EPs are not required to seek correction of claims. On the other hand, EPs who have begun to submit codes for the affected measures should continue to submit such codes. The beginning of acceptance of the codes will be apparent when the N365 message is noted on the remittance advice. The 2009 reporting period will not be changed and the EP who qualifies for the incentive based on the listed or affected measures will receive the 2% incentive payment with respect to the entire reporting period.

B. Seek correction of the submitted codes that were returned unprocessed.

In certain circumstances, EPs may desire to seek correction of the unprocessed claims. To accomplish this, EPs who have already billed and included any of the listed QDCs for dates of service January 1, 2009 and after and received a message other than N365 on their remittance advice, can call their Carrier/AB MAC contractor and request a correction beginning 4/1/09. In this case the EP should be prepared to give specific claim information to the carrier/AB MAC contractor, such as, the internal control number (ICN), the beneficiary's health insurance claim number (HIC), dates of service and the QDCs. EPs who began reporting the affected

measures using the Measures Group Consecutive Method during the first three months of 2009 may find that it is worthwhile to pursue correction.

## Status Update on CPT II Coding Issue for the 2009 PQRI and Options for Eligible Professionals (EPs) 2 of 2 2/18/09

Note: PQRI reporting and performance rate analysis for ONLY the affected measures will initially be performed after excluding cases for the first three months of 2009. If an EP does not qualify based on this calculation, then the EP's claims without excluding claims for the first three months of 2009 will be evaluated. Thus, the determination of satisfactory reporting will be evaluated both ways for all EPs who report on the relevant measures.

| **Heart Failure - ACE or ARB therapy measure - aged ≥ 18 - report with 99201-99205, 99212-99215, 99238, 99239, 99241-99245, 99304-99310, 99324-99328, 99334-99337, 99341-99345, 99347-99350 - report at least once in period** | |
|---|---|
| ACE inhibitor or ARB therapy prescribed in patient with heart failure & LVSD (LVEF <40 or moderately or severely depressed function, report also code 3021F) | 4009F |
| Left ventricular ejection fraction (LVEF) <40% or documentation of moderately or severely depressed left ventricular systolic function | 3021F |
| Left ventricular ejection fraction (LVEF) was not performed or documented, reason not otherwise specified | 3021F-8P |
| Left ventricular ejection fraction (LVEF) ≥40% or documentation as normal or mildly depressed left ventricular systolic function | 3022F |
| Documentation of medical reason(s) for not prescribing ACE inhibitor or ARB therapy (LVEF <40 or moderately or severely depressed function, **report also code 3021F**) | 4009F-1P |
| Documentation of patient reason(s) for not prescribing ACE inhibitor or ARB therapy (LVEF <40 or moderately or severely depressed function, **report also code 3021F**) | 4009F-2P |
| Documentation of system reason(s) for not prescribing ACE inhibitor or ARB therapy (LVEF <40 or moderately or severely depressed function, **report also code 3021F**) | 4009F-3P |
| ACE inhibitor or ARB therapy not prescribed, reason not otherwise specified (Report also code 3021F) | 4009F-8P |
| **Heart Failure - Beta-blocker therapy - aged ≥ 18, report with 99201-99205, 99212-99215, 99241-99245, 99341-99345, 99347-99350, 99304-99310, 99324-99328, 99334-99337 - report at least once in period** | |
| Beta-blocker therapy in patient with heart failure & LVSD (LVEF <40 or moderately or severely depressed function, **report also code 3021F**) | 4006F |
| Left ventricular ejection fraction (LVEF) <40% or documentation of moderately or severely depressed left ventricular systolic function | 3021F |
| Left ventricular ejection fraction (LVEF) was not performed or documented, reason not otherwise specified | 3021F-8P |
| Left ventricular ejection fraction (LVEF) ≥40% or documentation as normal or mildly depressed left ventricular systolic function | 3022F |
| Documentation of medical reason(s) for not prescribing beta-blocker therapy (**Report also code 3021F**) | 4006F-1P |
| Documentation of patient reason(s) for not prescribing beta-blocker therapy (**Report also code 3021F**) | 4006F-2P |
| Documentation of system reason(s) for not prescribing beta-blocker therapy (**Report also code 3021F**) | 4006F-3P |

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| | |
|---|---|
| Beta-blocker therapy was not prescribed, reason not otherwise specified (**Report also code 3021F**) | 4006F-8P |

| **Coronary Artery Disease - Beta-blocker therapy measure - aged ≥ 18 <u>with past MI</u>, 99201-99205, 99212-99215, 99238, 99239, 99241-99245, 99304-99310, 99324-99328, 99334-99337, 99341-99345, 99347-99350 - report at least once in period** | |
|---|---|
| Beta-blocker therapy for patient with CAD & prior myocardial infarction | 4006F |
| Documentation of medical reason(s) for not prescribing beta-blocker therapy | 4006F-1P |
| Documentation of patient reason(s) for not prescribing beta-blocker therapy | 4006F-2P |
| Documentation of system reason(s) for not prescribing beta-blocker therapy | 4006F-3P |
| Beta-blocker therapy was not prescribed, reason not otherwise specified | 4006F-8P |

| **Coronary Artery Disease - Anti-platelet therapy measure - aged ≥ 18 - report with 99201-99205, 99212-99215, 99238, 99239, 99241-99245, 99304-99310, 99324-99328, 99334-99337, 99341-99345, 99347-99350 - Report at least once in period** | |
|---|---|
| Oral antiplatelet therapy prescribed (e.g., aspirin, clopidogrel/Plavix, or combination of aspirin and dipyridamole/Aggrenox) | 4011F |
| Documentation of medical reason(s) for not prescribing oral antiplatelet therapy | 4011F-1P |
| Documentation of patient reason(s) for not prescribing oral antiplatelet therapy | 4011F-2P |
| Documentation of system reason(s) for not prescribing oral antiplatelet therapy | 4011F-3P |
| Oral antiplatelet therapy (e.g., aspirin, clopidogrel/Plavix, or combination of aspirin and dipyridamole/Aggrenox) not prescribed, reason not otherwise specified | 4011F-8P |