LCD - Cardiac Catheterization and Coronary Angiography (L33557)

Links in PDF documents are not guaranteed to work. To follow a web link, please use the MCD Website.

Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATES
National Government Services, Inc.	MAC - Part A	06101 - MAC A	J - 06	Illinois
National Government Services, Inc.	MAC - Part B	06102 - MAC B	J - 06	Illinois
National Government Services, Inc.	MAC - Part A	06201 - MAC A	J - 06	Minnesota
National Government Services, Inc.	MAC - Part B	06202 - MAC B	J - 06	Minnesota
National Government Services, Inc.	MAC - Part A	06301 - MAC A	J - 06	Wisconsin
National Government Services, Inc.	MAC - Part B	06302 - MAC B	J - 06	Wisconsin
National Government Services, Inc.	A and B and HHH MAC	13101 - MAC A	J - K	Connecticut
National Government Services, Inc.	A and B and HHH MAC	13102 - MAC B	J - K	Connecticut
National Government Services, Inc.	A and B and HHH MAC	13201 - MAC A	J - K	New York - Entire State
National Government Services, Inc.	A and B and HHH MAC	13202 - MAC B	J - K	New York - Downstate
National Government Services, Inc.	A and B and HHH MAC	13282 - MAC B	J - K	New York - Upstate
National Government Services, Inc.	A and B and HHH MAC	13292 - MAC B	J - K	New York - Queens
National Government Services, Inc.	A and B and HHH MAC	14111 - MAC A	J - K	Maine
National Government Services, Inc.	A and B and HHH MAC	14112 - MAC B	J - K	Maine
National Government Services, Inc.	A and B and HHH MAC	14211 - MAC A	J - K	Massachusetts
National Government Services, Inc.	A and B and HHH MAC	14212 - MAC B	J - K	Massachusetts

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATES
National Government Services, Inc.	A and B and HHH MAC	14311 - MAC A	J - K	New Hampshire
National Government Services, Inc.	A and B and HHH MAC	14312 - MAC B	J - K	New Hampshire
National Government Services, Inc.	A and B and HHH MAC	14411 - MAC A	J - K	Rhode Island
National Government Services, Inc.	A and B and HHH MAC	14412 - MAC B	J - K	Rhode Island
National Government Services, Inc.	A and B and HHH MAC	14511 - MAC A	J - K	Vermont
National Government Services, Inc.	A and B and HHH MAC	14512 - MAC B	J - K	Vermont

LCD Information

Document Information

LCD ID
L33557

LCD Title
Cardiac Catheterization and Coronary Angiography

Proposed LCD in Comment Period
N/A

Source Proposed LCD
N/A

Original Effective Date
For services performed on or after 10/01/2015

Revision Effective Date
For services performed on or after 10/01/2019

Revision Ending Date
N/A

Retirement Date
N/A

AMA CPT / ADA CDT / AHA NUBC Copyright Statement

CPT codes, descriptions and other data only are copyright 2022 American Medical Association. All Rights Reserved. Applicable FARS/HHSARS apply.

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

Current Dental Terminology © 2022 American Dental Association. All rights reserved.

Copyright © 2022, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the American Hospital Association (AHA) copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB□04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312□893□6816.

Making copies or utilizing the content of the UB□04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB□04 Manual and/or codes and descriptions; and/or making any commercial use of UB□04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. The American Hospital Association (the "AHA") has not reviewed, and is not responsible for, the completeness or

Notice Period Start Date
N/A

Notice Period End Date
N/A

accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.

CMS National Coverage Policy

Language quoted from Centers for Medicare and Medicaid Services (CMS), National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals is italicized throughout the policy. NCDs and coverage provisions in interpretive manuals are not subject to the Local Coverage Determination (LCD) Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See §1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, *italicized* text represents quotation from one or more of the following CMS sources:

Title XVIII of the Social Security Act (SSA):

Section 1862(a)(1)(A) excludes expenses incurred for items or services, which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Section 1833(e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Code of Federal Regulations:

42 CFR Section 410.32 indicates that diagnostic tests may only be ordered by the treating physician (or other treating practitioner acting within the scope of his or her license and Medicare requirements).

CMS Publications:

CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 12:

100.1.5 Other Complex or High Risk Procedures

National Correct Coding Initiative Policy Manual for Medicare Services, version 14.3, Chapter 11, Section I Cardiovascular Services, Bullets 12, 15-19 and 21.

Federal Register, Vol. 75, No. 228, November 29, 2010, pages 167-169, Medicare Program; Final Rule for Payment Policies Under the Physician Fee Schedule for CY 2011

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

Abstract:
Cardiac catheterization is the introduction and positioning of a catheter in the heart to assess cardiac function and structure, for diagnosis, treatment planning or to assess therapy. This assessment may include the measurement of intracardiac and intra- vascular pressures, obtaining blood samples for blood gas or other constituent analysis, determination of cardiac output, injection of contrast for angiography, and performing endomyocardial biopsy. The

conduct and evaluation of these procedures are then documented and interpreted by the physician, in a report.

Cardiac catheterization may be utilized in various clinical situations ranging from those requiring only a right heart catheterization to those requiring the performance of right and left heart catheterization with simultaneous diagnostic procedures including coronary and bypass angiography, angiography of the cardiac chambers, aortic and pulmonary angiography, endomyocardial biopsy, and extra-cardiac angiography. The guidelines in this policy outline the indications for coverage of each procedure.

Indications:

Right Heart Catheterization

This is the introduction of a catheter(s) into the right atrium, right ventricle and pulmonary artery. It generally includes hemodynamic measurements, and cardiac output determination, and may also include, when medically indicated, shunt determinations, and/or blood sampling, and/or hydrogen arrival time as part of the procedure. Placement of catheter(s), repositioning, and replacement with other catheters are included as part of the procedure. Cannulation of the coronary sinus is included in this procedure. Right heart catheterization is a formal diagnostic procedure (with report) performed in a catheterization or other procedure suite, as compared to Swan-Ganz catheterization which is generally performed for ongoing monitoring of the patient (after the initial diagnostic results are recorded), performed at the bedside, or in an operating room, emergency department or other intensive/critical care unit. The results of the Swan-Ganz catheterization may be recorded in the progress notes rather than by a formal report.

Right heart catheterization, performed along with left heart catheterization, coronary angiography, or both, is seldom medically reasonable and necessary unless one disease process appears to affect both sides of the heart, or a different disease process appears to affect each side of the heart.

Indications for Right Heart Catheterization

Right heart catheterization is indicated to evaluate:

1. Valvular heart disease;
2. Congestive heart failure;
3. Congenital heart disease;
4. Cor pulmonale;
5. Pulmonary hypertension;
6. Intracardiac shunts (including septal rupture) and extracardiac vascular shunts;
7. Suspected cardiomyopathy or myocarditis;
8. Endocarditis anticipated to require valvular surgical repair;
9. Suspected rejection of a transplanted heart;
10. Suspected pericardial tamponade or constriction.

General Limitations:

Cardiac catheterizations for which an overnight stay is anticipated, for routine recovery, should not be billed as inpatient services. Furthermore, the routine recovery period should not be billed as observation hours in addition to the catheterization unless the patient has sustained untoward complications necessitating the continued monitoring. An inpatient or observation stay following a routine outpatient cardiac catheterization would be considered not medically necessary and denied.

Limitations for Right Heart Catheterization

This procedure is performed in a cardiac catheterization laboratory or interventional radiology laboratory, and does not include "bedside placement" of a flow directed (Swan-Ganz type) catheter.

There is no reimbursement for a right heart catheterization performed in conjunction with electrophysiologic tests or interventions, HIS bundle studies, pacing studies, temporary pacemaker insertion, pulmonary angiography, endomyocardial biopsy or interventional cardiac procedures, when **routinely performed** for reasons other than a

hemodynamic evaluation. Right heart catheterization with hemodynamic measurements done at the same time as these other procedures must be medically necessary based upon the underlying cardiovascular pathophysiology. Right heart catheterization for the purpose of monitoring hemodynamic status during an electrophysiologic or other interventional cardiac procedure or angioplasty is included in that procedure and is not separately reimbursable.

There is no additional reimbursement for leaving a catheter in place for monitoring at the conclusion of a right heart catheterization or for the introduction of a Swan-Ganz type catheter at the time of a right heart catheterization, or for its subsequent removal.

Right heart catheterization **is not** indicated for:
1. Atherosclerotic heart disease without heart failure; or
2. Angioplasty, electrophysiologic studies or other interventional procedures.

Left Heart Catheterization

Indications and Limitations for Left Heart Catheterization

This is the introduction of a catheter(s) into the left ventricle (LV). The catheter may be inserted retrograde from the brachial, axillary or femoral artery; by cutdown or percutaneously; or transseptally via a patent foramen ovale or by septal puncture; or transapically. The catheterization also includes catheterization of the left atrium and aorta when performed with the LV catheterization. It includes all hemodynamic measurements (with and without maneuvers and/or infusions or medication), blood sampling and shunt determinations as part of the procedure. Placement of multiple catheters and their repositioning or replacement is included in this procedure. Injection procedures for selective opacification of cardiac chambers or structures, arteries and conduits **and the supervision and interpretation of such services are reimbursable as part of all-inclusive codes for these services (see Supplementary Instructions Article).**

There is no additional reimbursement for a left heart catheterization done for reasons other than hemodynamic evaluation or LV angiography **required for patient management** (i.e., when **routinely** performed with coronary/bypass angiography, electrophysiologic or pacing studies, or endomyocardial biopsies).

Left heart catheterization is indicated for the diagnosis of, or treatment planning in patients with myocardial abnormalities or dysfunction (including ischemic disease, myocarditis, cardiomyopathy, etc), valvular dysfunction, intracardiac shunts, congenital heart abnormalities, cardiac trauma, or pericardial tamponade.

Left Heart Catheterization by Transseptal Puncture

A catheter with an enclosed transseptal puncture needle is positioned into the right atrium, and under fluoroscopic and/or ultrasonic guidance is advanced, puncturing an intact intra-atrial septum thereby entering the left atrium. The needle is then removed, leaving the catheter through which a guide wire may be advanced to facilitate placement of appropriate catheters into the left atrium and left ventricle. This procedure should not be billed if the catheter is advanced into the left atrium through a patent foramen ovale or atrial septal defect.

The transseptal catheterization may be indicated in those cases in which access to the left ventricle is required for hemodynamic measurements or angiography, when retrograde access is not feasible or appropriate; when access to the left atrium and pulmonary veins is necessary for hemodynamic measurements and angiography; and when access to the left atrium and ventricle is necessary for the performance of diagnostic and therapeutic electrophysiological procedures.

Cardiac Angiography

Indications and Limitations for Angiography

Angiograms of the individual cardiac chambers (atria and ventricles) are indicated for the assessment of mitral or tricuspid valve function, ventricular function or morphology (including tumors and clots), suspected ventricular aneurysms, intracardiac shunts, congenital heart disease and cardiac trauma. Each procedure (atrial or ventricular angiography) may be reimbursed only once regardless of the number of injections of contrast, views or actual

pictures taken.

Aortography is reimbursable only for diagnoses of aortic root and ascending aorta disease, valvular heart disease or congenital heart disease. It is not reimbursable for atherosclerotic heart disease. Angiograms to visualize the coronary ostia are included as part of coronary angiography. A diagnosis of "rule out (valvular lesion)" is not reimbursable.

The injection procedure for supravalvular angiography for evaluation of an ascending aortic aneurysm, performed during cardiac catheterization, may be covered if it is medically necessary based on the presence of signs/symptoms related to an ascending aneurysm or other imaging tests, when providing additional diagnostic information. It is not separately payable when performed with a thoracic aortogram.

Coronary angiography is a single procedure which includes arteriograms of all coronary arteries and their branches, regardless of the number of vessels selectively catheterized or visualized, with and without the administration of diagnostic or therapeutic vasoactive medications. Replacement and repositioning of catheters are considered as part of the procedure, and are not reimbursable separately. The selective injection procedures may be performed without a formal left heart catheterization. Arterial conduit and venous bypass graft angiography are reimbursed using the same criteria as are used for the native coronary circulation (reimbursed only once regardless of the number of contrast injections, views or films, or whether medications were administered).

Coronary and bypass angiography are indicated for the diagnosis of, or treatment planning for patients with anginal syndromes, atypical chest pain syndrome suggesting ischemia, congenital heart disease, following cardiac arrest suspected to be due to ischemia or infarction, myocardial infarction, known atherosclerotic or other coronary disease, suspected graft or stent/PTCA closure, Prinzmetal's angina, coronary shunts and fistulae, cardiac trauma and for treatment planning in patients undergoing non-coronary cardiac surgical procedures (e.g., aortic or mitral valve surgery when not requiring left heart catheterization). It is also indicated for treatment planning in high-risk patients with evidence of ischemic heart disease undergoing high-risk non-cardiac surgical procedures (arterial or aortic surgery, or surgery with large fluid shifts).

Pulmonary Angiography

Indications for Pulmonary Angiography

Indications for pulmonary angiography include suspected pulmonary emboli, pulmonary hypertension, pulmonary A-V malformations or shunts, pulmonary artery stenosis, and congenital heart disease affecting the pulmonary vasculature or pulmonary vasculature or pulmonary venous return.

Intra-Coronary Ultrasound and Doppler Functional Flow Reserve Studies

Indications for Intracoronary ultrasound and Doppler functional flow reserve studies

Intracoronary ultrasound may be separately covered when needed to assess the extent of coronary stenosis if equivocal on angiography, or when needed to assess the patency and integrity of a coronary artery post-intervention. Alternatively, intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement may be performed to assess the degree of stenosis within a vessel. Only intracoronary ultrasound or functional flow reserve measurement should be performed on an individual artery, so that both services performed on the same artery will not be reimbursed.

Pharmacologic Agent Administration With Hemodynamic Assessment

The administration of pharmacologic agents to assess hemodynamic effects is covered and separately reimbursable when performed as diagnostic test or to assess the potential therapeutic interventions. All such interventions must include pre-, intra- and post-infusion measurement of ventricular function (e.g., ejection fraction or wall motion) or hemodynamics (changes in intracardiac pressures, pulmonary artery pressures, or shunts ratios). Drug administration to affect coronary angiography or to treat acute symptoms or adverse events occurring during the catheterization such as acute ischemia or coronary artery spasm, congestion (e.g., intravenous diuretics), arrhythmias (e.g., beta-blockers, calcium channel blockers, digitalis, antiarrhythmic drugs, etc) are not included in

this code.

Physiologic Exercise Study with Hemodynamic Measurement

The performance of physiologic exercise to assess hemodynamic effects is covered and separately reimbursable when performed as a diagnostic test to evaluate cardiac abnormalities such as valve dysfunction, ventricular dysfunction or shunt ratios. All such interventions must include pre-, intra- and post-exercise measurement of ventricular function (e.g., ejection fraction or wall motion) or hemodynamics.

Angioplasty/Stent Placement/Atherectomy

Indications and Limitations for Angioplasty/Stent Placement/Atherectomy

The interventional procedures - percutaneous transluminal angioplasty, coronary stent placement and atherectomy are described in a separate LCD "Percutaneous Coronary Intervention". These are separately reimbursable procedures.

Diagnostic cardiac catheterization with coronary angiography is separately reimbursable when performed prior to an interventional procedure. It may be performed on the same day or on a previous day, when used as a diagnostic tool to evaluate the need for the intervention, but only once prior to the interventional procedure. Additionally, when the diagnostic and interventional procedures are performed on the same day, multiple surgery pricing will be applied. Angiography **before,** during, **or** after an interventional procedure to evaluate results or to guide the catheter(s) is considered incidental to the procedure and not separately reimbursable.

Performance of a diagnostic cardiac catheterization and interventional procedure on the same day is increasingly the standard of practice. While there may be reasons for delaying the interventional procedure (e.g., transfer from a community hospital to a tertiary center, excessive dye load, further treatment planning or evaluation of angiography, etc.), it is recommended that both procedures be performed during the same encounter when medically appropriate. Separation of these procedures for the purpose of circumventing the multiple surgery pricing, or for the convenience of physician or hospital scheduling, could be considered an inappropriate practice and subject the services to review and denial for medical necessity. Reasons for delaying indicated intervention should be documented in the medical record.

Teaching Physician

Cardiac catheterization requires personal ("at the elbow") supervision of its performance by a physician. When performed in a teaching setting, the teaching physician must be present, in the room, with the resident, throughout the **entire** procedure. The performance of these services by the resident alone would not establish a basis for Medicare payment and will be denied as not medically necessary.

Vascular Closure Devices

Vascular closure (with or without an implantable device or other mechanical intervention) of the puncture site is an inherent part of all procedures for arterial access. It is included in the arterial access codes for all angiographic and catheterization procedures, and may not be billed separately.

Extra-Cardiac Angiography performed with Cardiac Catheterization.

Extra-cardiac angiography (e.g., injection of the abdominal aorta, carotid, ileofemoral or renal arteries) is sometimes performed during the same session with cardiac catheterization.

These procedures are generally not indicated during cardiac catheterization and will be denied unless there are specific medical conditions that would have been appropriate to require angiography *independent of* the cardiac catheterization being performed during the same encounter (i.e., these extra-cardiac angiograms would have been performed at this point in the patient's medical course even if cardiac catheterization had not been performed). The determination of medical necessity will require that there are reasonably anticipated therapeutic implications for which these angiograms will be used. Angiography to assess the site of arterial access at the completion of the procedures or to assess for vascular closure is included in the catheterization procedure and is not separately

reimbursable. Extra-cardiac angiographic services must be specifically requested (and documented in the patient's medical record) by the treating (referring) physician. Extra-cardiac angiography performed during an encounter other than with cardiac catheterization is not subject to the indications and limitations of this LCD.

Dye injection during catheterization or angiographic procedures for the purpose of guiding the catheter placement is an integral part of the procedures and is not separately reimbursable.

Other Non-covered Procedures During Catheterization

1. Assistant at surgery;
2. Right heart catheterization solely for the purpose of inserting a temporary pacemaker, performing endomyocardial biopsy or performing electrophysiologic studies;
3. Standby anesthesia or surgeon during angioplasty.

Services and Procedures Included in Cardiac Catheterization Procedures.

1. Prophylactic insertion of temporary transvenous pacemaker;
2. Repositioning and replacement of catheters;
3. Administration of medications during catheterization;
4. Insertion or use of percutaneous vascular closure devices;
5. Anesthesia.

Training Requirements

The American College of Cardiology (ACC) and the American Heart Association (AHA) have issued joint guidelines on training in cardiac catheterization and interventional cardiology. Providers who submit claims for diagnostic catheterization services must have a minimum of Level 2 training as outlined by the ACC/AHA Task Force 3. Submission of claims will be viewed as an attestation that the provider has met these requirements.

Summary of Evidence

N/A

Analysis of Evidence (Rationale for Determination)

N/A

General Information

Associated Information

N/A

Sources of Information

This bibliography presents those sources that were obtained during the development of this policy. National Government Services is not responsible for the continuing viability of Web site addresses listed below.

American College of Cardiology/American Heart Association Task Force. Guidelines for coronary angiography. *J Am Coll Cardiol.* 1987;10:935-950.

American College of Cardiology Position Statement on Right Heart Catheterization. Adopted by the American College

of Cardiology Executive Committee on March 9, 1985; re-approved in 1990.

American College of Cardiology/American Heart Association Ad Hoc Task Force on Cardiac Catheterization. ACC/AHA guidelines for cardiac catheterization and cardiac catheterization laboratories. *J Am Coll Cardiol.* 1991;18(5):1149-1182.

American College of Cardiology/American Heart Association Task Force. Guidelines for the evaluation and management of heart failure. *J Am Coll Cardiol.* 1995;26:1376-1398.

Braunwald E. Heart Disease: A Textbook of Cardiovascular Medicine. Sixth Edition. St. Louis, MO: WB Saunders Co; February 2001.

HealthGate Data Corporation. Swan-Ganz Catheterization. May 1998.

Other carrier's local medical review policy (legacy Empire Medicare Services Part B and Administar Federal Part B).

Practice Guidelines for Pulmonary Artery Catheterization: A report by the American Society of Anesthesiologists Task Force on pulmonary artery catheterization. *Anesthesiology.* 1993;78:380-394.

Bibliography

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
10/01/2019	R14	This LCD was converted to the new "no-codes" format. There has been no change in coverage with this LCD revision.	• Revisions Due To Code Removal
08/01/2019	R13	Consistent with Change Request 10901, all coding information, National coverage provisions, and Associated Information (Documentation Requirements, Utilization Guidelines) have been removed from the LCD and placed in the related Billing and Coding Article, A52850. There has been no change in coverage with this LCD revision.	• Provider Education/Guidance
10/01/2018	R12	LCD revised for annual ICD-10 updates. ICD-10 code G71.0 was deleted and replaced by G71.01, G71.02, and G71.09 for groups 1 and 2.	• Revisions Due To ICD-10-CM Code Changes

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
		ICD-10 code R93.8 was deleted and replaced by R93.89 for groups 1, 2, 3 and 4. ICD-10 codes I67.850 and I67.858 were added to group 6. *DATE 10/01/2018: At this time, the 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which require comment and notice. This revision is not a restriction to the coverage determination; and therefore, not all the fields included are applicable as noted in this policy.*	
01/01/2018	R11	LCD revised for annual CPT/HCPCS update. CPT codes 36120 and 75658 have been deleted effective 01/01/2018 and removed from the LCD. CPT code 36140 was revised. *DATE 01/01/2018: At this time, the 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which require comment and notice. This revision is not a restriction to the coverage determination; and therefore, not all the fields included are applicable as noted in this policy.*	• Revisions Due To CPT/HCPCS Code Changes
12/01/2017	R10	ICD-10 code Z48.21 was added as payable to ICD-10 code Groups 1, 3 and 5. A note was added to CPT/HCPCS Code Group 2 that code 75658 was deleted for the 2018 update but is effective through 12/31/2017. *DATE 12/01/2017: At this time, the 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which require comment and notice. This revision is not a restriction to the coverage determination; and therefore, not all the fields included are applicable as noted in this policy.*	• Request for Coverage by a Practitioner (Part B) • Revisions Due To CPT/HCPCS Code Changes
10/01/2017	R9	Correction to revision 8: ICD-10 code I27.83 was also added to Group 1 (CPT codes 93451, 93453, 93456, 93457. 93460, 93461). *DATE (10/01/2017): At this time, the 21st Century Cures Act will apply to new and revised LCDs that restrict coverage*	• Revisions Due To ICD-10-CM Code Changes

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
		which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.	
10/01/2017	R8	LCD revised for annual ICD-10 updates for 2018. • For Group 1, (CPT codes 93451, 93453, 93456, 93457, 93460, 93461) deleted code E85.8 was replaced by E85.81, E85.82, and E85.89. Deleted code I27.2 was replaced by I27.20-I27.29. ICD-10 codes I50.810-I50.814 and I50.82-I50.89 were added. • For Group 2 (CPT codes 93452, 93453, 93458, 93459, 93460, 93461) deleted code E85.8 was replaced by E85.81, E85.82, and E85.89. ICD-10 codes I21.9, I21.A1, I21.A9, I50.810-I50.814 and I50.82-I50.89 were added. • For Group 3 (CPT codes 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461), ICD-10 codes I21.9, I21.A1, and I21.A9 were added. *DATE (10/01/2017): At this time, the 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.*	• Revisions Due To ICD-10-CM Code Changes
01/01/2017	R7	CPT descriptor changes due to 2017 updates.	• Revisions Due To CPT/HCPCS Code Changes
10/01/2016	R6	LCD revised for annual ICD-10 updates for 2017 with the following changes: • For group 4 (CPT codes 93531, 93532, 93533, 93563), ICD-10 codes Q25.21 and Q25.29 replaced deleted code Q25.2. ICD-10 codes Q25.40-Q25.49 replaced deleted code Q25.4. • For group 6, (CPT Codes 75625, 75630, 75658, 75705, 75710, 75716 and 36120, 36140, 36200, 36215-36218,	• Revisions Due To ICD-10-CM Code Changes

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
		36245-36248, 36251-36254), ICD-10 codes I16.0, I16.1, I16.9, I72.5, I72.6, I77.70, and I77.75-I77.77 were added. In addition, CPT code 93530 was deleted from the ICD-10 group 4 CPT codes.	
01/01/2016	R5	Corrected cauterization to catheterization in Group 3 ICD-10 asterisk note.	• Typographical Error
01/01/2016	R4	LCD updated with revised description of HCPCS code G0269.	• Revisions Due To CPT/HCPCS Code Changes
10/01/2015	R3	This note was added to clarify the requirement for two diagnoses for some CPT codes: **(If the same diagnosis appears in both required groups, then one diagnosis is sufficient for coverage.** Example: CPT code 93458 requires a diagnosis from groups 2 and 3. If the patient's diagnosis is atherosclerotic heart disease of native coronary artery with unstable angina pectoris, ICD-10 code I25.110 is the correct diagnosis. This code appears in both groups and does not require an additional diagnosis.)	• Provider Education/Guidance
10/01/2015	R2	ICD-10 codes were revised to add the 7th digit for D=subsequent encounter and S=sequela, where the 7th digit, A=initial encounter was already included.	• Provider Education/Guidance
10/01/2015	R1	The LCD was revised to remove coding provisions for add-on CPT/HCPCS codes 92978, 92979, 93462, 93463, 93464, 93563, 93564, 93565, 93566, 93567, 93568, 93571, 93572, 36248, and G0278. A note was added to the ICD-10 section stating that while there are no ICD-10 code lists for add-on codes within this LCD, all provisions for these services, as specified in the Indications and Limitations section of the LCD, must be followed for coverage to apply. In addition, this note was added to the list of ICD-10 codes for Extra-cardiac Angiography: The ICD-10 code list below applies to these procedures only when related to provisions in this LCD. The Indications section was revised to clarify coverage for patients undergoing non-coronary cardiac surgical procedures by adding this example: (e.g., aortic or mitral valve surgery when not requiring left heart catheterization). An asterisk note was added for ICD-10 codes R93.1, R93.8,	• Public Education/Guidance

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
		and R94.39 on reporting this situation.	

Associated Documents

Attachments

N/A

Related Local Coverage Documents

Articles

A52850 - Billing and Coding: Cardiac Catheterization and Coronary Angiography

Related National Coverage Documents

N/A

Public Versions

UPDATED ON	EFFECTIVE DATES	STATUS
09/17/2019	10/01/2019 - N/A	Currently in Effect (This Version)
Some older versions have been archived. Please visit the MCD Archive Site to retrieve them.		

Keywords

- heart
- circulatory