



Cardiology Coding Alert

Your practical adviser for ethically optimizing coding, reimbursement, and efficiency in cardiology practices

December 2011, Vol. 14, No. 12 (Pages 81-88)

In this issue

Crosswalk

33206 and 71090 No Longer Pair Up for Pacemaker Implant — Here's Why **p83**
▶ See at a glance how 2011 and 2012 coding compare.

Vascular Update

36251-36254 Make Old Renal Codes Obsolete **p84**
▶ Ring in the New Year with updates for IVC filters, too.

You Be the Coder

37221 and 37226 Join Forces? **p84**

E/M Update

99218-99220 Add Typical Times for 2012 **p85**
▶ Rumor has it the revisions could add options for reporting these observation codes.

ICD-10-CM

404.0x Differs From I13.- in Use of Malignant and Benign **p86**
▶ ICD-10-CM narrows your code options from 12 to 4 for hypertensive heart and CKD.

Reader Questions

93454's Global Period Affects Discharge **p85**

G0389 Counterpart Depends on Documentation **p87**

92975 Is Included in 92980 **p87**

CPT® 2012

33227-33229 Revolutionize Pacemaker Battery Change Coding

Celebrate a simpler way to report single electrode repair in a dual-chamber system.

Each CPT® update seems to bring a massive overhaul of a different cardiology coding area, and 2012 will be no exception. Starting January 1, you'll report pacemaker and pacing cardioverter-defibrillator surgical services in an all new way.

To help ease the task of mastering these changes, *Cardiology Coding Alert* will begin with the big picture view of the new codes in this issue, and then will dig even deeper into practical applications of the updated codes over the coming months.

Complete System: 33206-33208 and 33249 Get a Facelift

Pacemaker and pacing cardioverter-defibrillator codes are in the spotlight in 2012, and the updates begin with codes for complete systems.

CPT® will add the following bold, italicized text to the definitions of 33206-33208: "Insertion ***of new*** or replacement of permanent pacemaker with transvenous electrode(s) ..."

For a pacing cardioverter-defibrillator, 33249 changes as follows:

- » **2011:** *Insertion or repositioning of electrode lead(s) for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator*
- » **2012:** *Insertion or replacement of permanent pacing cardioverter-defibrillator system with transvenous lead(s), single or dual chamber.*

Electrode Repair Receives a Needed Update

When you need to code electrode repair, you'll choose between these revised codes:

- » 33218, *Repair of single transvenous electrode, permanent pacemaker or pacing cardioverter-defibrillator*
- » 33220, *Repair of 2 transvenous electrodes for permanent pacemaker or pacing cardioverter-defibrillator.*

Helpful: The change solves confusion over how to code repair of a single electrode in a dual-chamber system. In 2011, the code definitions offer no obvious solution because 33218 refers to repair of one electrode in a single-chamber system and 33220 references repair of two electrodes in a dual-chamber system.

EDITORIAL ADVISORY BOARD

- **Catherine A. Brink, CMM, CPC**
President, Healthcare Resource Management Inc., N.J.
- **Jim Collins, CCC, CPC, CHCC**
President, CardiologyCoder.Com
- **Mary I. Falbo, MBA, CPC**
President, Millennium Healthcare Consulting Inc.
- **Marti J. Geron, CPC, CMA, CM**
Coding and Reimbursement Manager, The University of Texas Southwestern Medical Center at Dallas, Pediatric Department
Past Member, AAPC National Advisory Board Instructor/Educator at University of Texas at Arlington
- **Victoria S. Jackson**
Practice Management Consultant, JCM Inc.
Former Administrator/CEO, Southern Orange County Pediatric Associates Inc., Calif.
Member, Medical Group Management Association Primary Care Assembly
- **Sheldrian Leflore, CPC**
Revenue Management Educator The Coding Group
- **Janet McDiarmid, CMM, CPC, MPC**
CEO, McDiarmid Consultants LLC
Past President
American Academy of Professional Coders National Advisory Board
- **Rebecca Sanzone, CPC**
Coding Consultant American College of Cardiology
- **Laura Siniscalchi, RHIA, CCS, CCS-P, CPC**
Manager, Deloitte & Touche
- **Cynthia A. Swanson, RN, CPC, CEMC, CHC**
Senior Manager, Healthcare Consulting
Seim Johnson, Neb.
- **Denise White, CPC**
Associate Consultant
Acevedo Consulting Inc., Fla.

2 Codes No Longer Needed for Battery Change

Coding for removing and replacing a pulse generator at a single session will look very different in 2012. This service is often called a battery change. In 2011, you report one code for the removal and a second code for inserting the new pulse generator. In 2012, you'll report a single code that captures both the removal and the insertion.

The following new codes will describe pacemaker pulse generator removal with replacement:

- » 33227, *Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system*
- » 33228, ... *dual lead system*
- » 33229, ... *multiple lead system.*

CPT® similarly adds codes to describe replacing a pacing cardioverter-defibrillator pulse generator:

- » 33262, *Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator; single lead system*
- » 33263, ... *dual lead system*
- » 33264, ... *multiple lead system.*

Battery removal only: In line with these changes, CPT® revises battery removal codes to indicate they are for removal *only*:

- » 33233, *Removal of permanent pacemaker pulse generator only* (don't use with 33227-33229)
- » 33241, *Removal of pacing cardioverter-defibrillator pulse generator only* (don't use with 33262-33264).

Battery insertion: Codes 33212-33213 have revised descriptors for 2012 and are joined by new code 33221:

- » 33212, *Insertion of pacemaker pulse generator only; with existing single lead*
- » 33213, ... *with existing dual leads*
- » 33221, ... *with existing multiple leads.*

Likewise, the pacing cardioverter-defibrillator insertion category has changed to indicate the number of leads, with 33240 now describing "Insertion of pacing cardioverter-defibrillator pulse generator only; with existing single lead." And you'll find the following two new codes to expand that section:

- » 33230, ... *with existing dual leads*
- » 33231, ... *with existing multiple leads.*

Get a Taste of Code Change Consequences

In 2012, you're likely to find that you rarely report the generator insertion codes because they'll apply only "when a new generator is inserted by itself

Cardiology Coding Alert (USPS #019-177) (ISSN 1522-7472 for print; ISSN 1947-6892 for online) is published monthly 12 times per year by The Coding Institute LLC, 2222 Sedwick Drive, Durham, NC 27713. ©2011 The Coding Institute. All rights reserved. Subscription price is \$249. Periodicals postage is paid at Durham, NC 27705 and additional entry offices.

POSTMASTER: Send address changes to *Cardiology Coding Alert*, 2222 Sedwick Drive, Durham, NC 27713

without removal of an existing generator,” explains **Christina Neighbors, MA, CPC, CCC, ACS-CA**, charge capture reconciliation specialist and coder at St. Joseph Heart & Vascular Center in Tacoma, Wash.

You’ll be more likely to use the new generator change out codes (33227-33229 and 33262-33264), Neighbors says.

Fee fall out: Unfortunately, the American College of Cardiology (ACC) calculates the change to a single code for the combined removal and replacement of the pulse generator will result in roughly a 29 percent decrease from 2011 payment rates under Medicare.

This drop is large compared to the expected overall impact for cardiologists of negative 2 percent under Medicare’s 2012 Physician Fee Schedule, noted by

ACC CEO **Jack Lewin, MD**, in his Nov. 1, 2011, blog post (<http://blog.cardiosource.org/post/No-Rest-for-the-Politically-Weary.aspx>).

And keep in mind that the 2 percent cut is distinct from the possible 27.4 percent cut to overall Medicare payments due to the Sustainable Growth Rate (SGR). Even CMS officials agree that the 27.4 percent cut would be devastating: “This payment rate cut would have dire consequences that should not be allowed to happen,” said CMS administrator **Donald Berwick, MD**, in a Nov. 1 statement. “We need a permanent SGR fix to solve this problem once and for all.” Experts remain hopeful that the government will offer at least a temporary fix before the pay cuts kick in (as the government has done almost every year in the last decade). □

Crosswalk

33206 and 71090 No Longer Pair Up for Pacemaker Implant — Here’s Why

See at a glance how 2011 and 2012 coding compare.

Coding changes for pacemakers and implantable cardioverter-defibrillators are sure to be the talk of the cardiology water cooler for a long while.

“33227-33229 Revolutionize Pacemaker Battery Change Coding” on page 81 offers an overview of the changes, but there’s plenty more to learn. For example, CPT® 2012 includes radiological supervision and interpretation in 33206-33249 and deletes 71090 (*Insertion pacemaker, fluoroscopy and radiography, radiological supervision and interpretation*).

Simplify the transition with this table, based on information provided by **Christina Neighbors, MA, CPC, CCC, ACS-CA**, charge capture reconciliation specialist and coder at St. Joseph Heart & Vascular Center in Tacoma, Wash.

Remember: Your final code choice should be based on the documentation for the particular case you’re coding. □

Pacemaker/Defibrillator 2011 to 2012 Crosswalk

Procedure Description	2011 Codes	2012 Codes
Atrial Single PM Implant	33206, 71090	33206
Ventricular Single PM Implant	33207, 71090	33207
CRT-P Dual Implant	33208, 33225, 71090	33208, 33225
CRT-P Atrial PM Implant	33206, 33225, 71090	33206, 33225
Single Chamber PM Generator Change	33233, 33212	33227
Dual Chamber PM Generator Change	33233, 33213	33228
CRT-P Generator Change	33233, 33213	33229
Dual PM Generator Change, Cap RA, New RA Lead Placement	33233, 33206, 71090	33233, 33206
Dual PM Generator Change, Lead Removal, New RV Lead Placement	33233, 33235, 33207, 71090	33233, 33235, 33207
Upgrade PM to CRT-D, Pocket Revision, DFT Testing	33233, 33249, 33225, 33223, 71090	33233, 33249, 33225, 93641
Single or Dual Defibrillator Implant, DFT Testing	33249, 93641, 71090	33249, 93641
Single Chamber Defibrillator Generator Change, DFT Testing	33240, 33241, 93641	33262, 93641
Dual Chamber Defibrillator Generator Change, DFT Testing	33240, 33241, 93641	33263, 93641
CRT-D Generator Change, DFT Testing	33240, 33241, 93641	33264, 93641
Single, Dual or CRT-D Change, Cap Lead(s), New Lead, DFT Testing	33241, 33244, 33249, 93641, 71090	33241, 33244, 33249, 93641

Vascular Update

36251-36254 Make Old Renal Codes Obsolete

Ring in the New Year with updates for IVC filters, too.

The trend toward more all-in-one codes isn't slowing under CPT® 2012. Renal angiography and IVC filter procedures will see new codes that combine surgical and imaging services into one neat package.

Replace Your Old Renal Angiography Codes

Renal angiography sports four new codes effective Jan. 1, 2012. Key elements distinguishing the codes include whether the service is first order or higher and whether the service is unilateral or bilateral:

- » 36251, *Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral*
- » 36252, ... *bilateral*
- » 36253, *Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral*
- » 36254, ... *bilateral*.

Tip: When reporting the new renal codes, do not report 36254 in conjunction with 36252, says **Christina Neighbors, MA, CPC, CCC, ACS-CA**, charge capture reconciliation specialist and coder at St. Joseph Heart & Vascular Center in Tacoma, Wash., citing CPT® guidelines.

You Be the Coder

37221 and 37226 Join Forces?

Question:

How should I code external iliac and common femoral angioplasty stent procedures? Would it be only 37221? Or may I also code 37226?

SuperCoder.com Member

Answer: See page 87. □

You also should not report 36253 in conjunction with 36251 “when performed on the same renal/kidney. The accessory renal arteries only influence coding if the catheter placement is in a second or higher order position,” Neighbors says.

Don't miss: The addition of these codes means you'll no longer use a code from 36245+36248 (*Selective catheter placement, arterial system...*) to report the catheterization. And because imaging services are included in the new codes, CPT® deletes 75722-75724 (*Angiography, renal ...*).

37191-37193 Change Your IVC Filter Options

Prepare for an all new way to report inferior vena cava (IVC) filter services, too:

- » 37191, *Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed*
- » 37192, *Repositioning of intravascular vena cava filter ...*



Give Your Cardiology Coding a Lift

Turn to **2012 SuperCoder Illustrated for Cardiology** to raise your coding accuracy & efficiency.

Print lovers will rejoice at mini digests of top-used cardiology CPT®. Get the code's official descriptor, Medicare details, & more. **Code Better** with illustrations & coding tips from The Coding Institute editors.

Inside this handy book:

- ◆ RVUs
- ◆ CCI Edits
- ◆ ICD-9 & ICD-10 Cross-References
- ◆ Concise Code Explanations
- ◆ Practical Coding Tips
- ◆ Anatomical Illustrations

Pre-order your **SuperCoder Illustrated specialty book** Today!

Call **1-877-912-1691** and mention code ABKCC101

 **SuperCoder.com**
Inspired by Coders. Powered by Coding Experts.

» 37193, *Retrieval (removal) of intravascular vena cava filter ...*

In 2011, you report IVC filter placement with 36010 (*Introduction of catheter, superior or inferior vena cava for catheterization*), 37620 (*Interruption, partial or complete, of inferior vena cava by suture, ligation, plication, clip, extravascular, intravascular [umbrella device]*), and 75940 (*Percutaneous placement of IVC filter, radiological supervision and interpretation*). Because 37191 includes all of these elements, CPT® 2012 deletes the IVC-specific codes 37620 and 75940.

Coding removal wasn't as clear cut in 2011. Before creation of 37193, payers may have requested unlisted procedure codes or transcatheter retrieval codes 75961 (*Transcatheter retrieval, percutaneous, of intravascular foreign body [e.g., fractured venous or arterial catheter], radiological supervision and interpretation*) and 37203 (*Transcatheter retrieval, percutaneous, of intravascular foreign body [e.g., fractured venous or arterial catheter]*) to describe the service. Guidelines for 2012 make it clear that you should not report 37193 alongside 75961 and 37203. □

E/M Update

99218-99220 Add Typical Times for 2012

Rumor has it the revisions could add options for reporting these observation codes.

Have you ever wished that CPT® would put a time guide on its observation codes? Then you'll be in luck as of Jan. 1, 2012, when the new manual will offer specific typical times that relate to each of the initial observation care codes.

Observation Time Guidelines Could Open Doors

When CPT® 2011 debuted 99224-99226 (*Subsequent observation care, per day, for the evaluation and management of a patient ...*), many coders were left scratching their heads at the fact that those new codes featured typical times associated with them, even though initial observation care codes 99218-99220 don't have typical times. CPT® 2012 will remedy that problem with the addition of the following typical time guidelines:

- » 99218, ... *Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit*
- » 99219, ... *Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit*
- » 99220, ... *Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.*

Although the specific reasons for the CPT® committee's inclusion of these codes won't be crystal clear until the AMA's November Symposium, it looks like the addition of typical times could open the door for coding based on time.

"There are only two ways that you can use time as a basis for selecting an E/M code," says **Barbara J. Cobuzzi, MBA, CPC, CENTC, CPC-H, CPC-P, CPC-I, CHCC**, president of CRN Healthcare Solutions, a consulting firm in Tinton Falls, N.J. "If counseling/coordination of care takes up 50 percent or more of the visit, and if the code has a typical time associated with it. So by these codes now having a time reference, it sounds like we may have a way to reference time used if counseling or coordination of care takes up at least 50 percent of a visit. In addition, this could open the door to collecting for prolonged service times if the time the doctor spends exceeds 30 minutes more than the allotted time, and the visit notes are documented as such," Cobuzzi adds.

We'll keep you posted in future issues with news straight from the AMA Symposium. □

Reader Questions

93454's Global Period Affects Discharge

Question:

May I report 99238, discharge from hospital, on the same date as coronary angiogram? Medicare says discharge is covered in the surgery's global days, but coronary angiography has 0 global days.

SuperCoder.com Member

Answer:

A 0-day global period means that Medicare will bundle all E/M services on the surgery date into the surgical code.

As a result 99238 (*Hospital discharge day management; 30 minutes or less*) is bundled into 93454 (*Catheter placement in coronary artery[s] for coronary angiography, including intraprocedural injection[s] for coronary angiography, imaging supervision and interpretation*).

The classification XXX (*Global surgical rules do not apply*) means that the service is truly free of global surgical bundling issues, and you can separately report services performed on the same date as the surgical procedure (such as E/M services). □

(Reader Questions continued on page 87)

ICD-10-CM

404.0x Differs From I13.- in Use of Malignant and Benign

ICD-10-CM narrows your code options from 12 to 4 for hypertensive heart and CKD.

You can expect ICD-10-CM to provide you with combination codes for certain chronic conditions just as ICD-9-CM does, but that doesn't mean the code definitions will be precisely the same.

To see a practical example, review the codes below, which you assign when a patient has both hypertensive heart disease (documentation indicates hypertension causes heart disease) and hypertensive chronic kidney disease (hypertension with chronic kidney disease [CKD] even if no relationship is indicated in the documentation).

ICD-9 coding rules: The terms “benign” and “malignant” feature in the ICD-9 hypertensive heart disease codes. When the physician doesn't document benign or malignant, you must choose an “unspecified” code.

Additionally, you should report the heart failure type (428.x), if known, and the CKD stage (585.x) as secondary codes.

The ICD-9 codes include:

- » 404.0x, *Hypertensive heart and chronic kidney disease; malignant*
- » 404.1x, ... *benign*
- » 404.9x, ... *unspecified*.

ICD-9 fifth digit options are:

- » 0, *without heart failure and with chronic kidney disease stage I through stage IV, or unspecified*
- » 1, *with heart failure and with chronic kidney disease stage I through stage IV, or unspecified*
- » 2, *without heart failure and with chronic kidney disease stage v or end stage renal disease*
- » 3, *with heart failure and with chronic kidney disease stage v or end stage renal disease*.

ICD-10 changes: You'll see a switch from 12 ICD-9 options to four ICD-10 options. This is because

under ICD-10 you won't have to distinguish between “benign” and “malignant.”

ICD-10 2011 codes include:

- » I13.0, *Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease*
- » I13.10, *Hypertensive heart and chronic kidney disease without heart failure, with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease*
- » I13.11, *Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease, or end stage renal disease*
- » I13.2, *Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease*.

Documentation: Although you won't have to scour the documentation for “benign” or “malignant” to choose an ICD-10 code, you still will need to use an additional code to identify heart failure type (I50.-) and CKD stage (N18.1-N18.4, N18.9).

Coder tips: If you've discovered a method of reminding the team to code heart failure and CKD types in addition to 404.xx codes, stick with it and apply it to I13.- when ICD-10 goes into effect. Also, let the coding team know that if the documentation doesn't mention heart failure and doesn't mention the stage of CKD, the appropriate code will be I13.10, which has this note: “Hypertensive heart disease and hypertensive chronic kidney disease NOS.”

Remember: When ICD-10-CM goes into effect on Oct. 1, 2013, you should apply the code set and official guidelines in effect for the date of service reported. Learn more at www.cms.gov/ICD10/ and www.cdc.gov/nchs/icd/icd10cm.htm#10update. □

2012 Coding Updates Sign Up Today

Get the 2012 codes you need to keep on rolling

www.audioeducator.com

ae audioeducator
KNOWLEDGE FOR HEALTHCARE

(866)-458-2965

customerservice@audioeducator.com

G0389 Counterpart Depends on Documentation

Question:

We use G0389 for AAA screening of Medicare patients. What is the corresponding CPT® code for commercial payers?

SuperCoder.com Member

Answer:

CPT® doesn't provide a precise match for G0389 (*Ultrasound B-scan and/or real time with image documentation; for abdominal aortic aneurysm [AAA] screening*), but your most likely options are 76700-

76705 (*Ultrasound, abdominal, real time with image documentation ...*) and 76770-76775 (*Ultrasound, retroperitoneal [e.g., renal, aorta, nodes], real time with image documentation ...*).

CPT® guidelines state that retroperitoneal ultrasound includes examination of the abdominal aorta, and experts indicate physicians are most likely to perform a limited retroperitoneal ultrasound (76775, ... *limited*) to screen for AAA.

Caution: Coverage for screening will depend on the particular payer's policy. Be sure to choose the appropriate diagnosis code. If no AAA is found, consider using V81.2 (*Special screening for cardiovascular, respiratory, and genitourinary diseases; other and unspecified cardiovascular conditions*). □

You Be the Coder

37221 and 37226 Join Forces?

(Question on page 84)

Answer:

If the physician performed separate therapies for the iliac and femoral arteries, you should report both 37221 (*Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement[s], includes angioplasty within the same vessel, when performed*) and 37226 (*Revascularization, endovascular, open or percutaneous, femoral, popliteal artery[s], unilateral; with transluminal stent placement[s], includes angioplasty within the same vessel, when performed*).

Support: The iliac and femoral arteries are considered to be separate territories for these codes. Coding guidelines state, "When multiple vessels in multiple territories in a single leg are treated at the same setting, the primary code for the treatment in the initial vessel in each vascular territory is reported."

Caution: In some cases, a lesion may cross from one territory to another but the physician will be able to treat the lesion with a single therapy. In that case, "this intervention should be reported with a single code despite treating more than one vessel and/or vascular territory." When choosing your code, keep in mind that the relative value units (RVUs) for 37226 are higher than those for 37221. When there is a break in stenosis and multiple stents are deployed then you may (dependent on the documentation) be able to code two territory procedural codes. □

92975 Is Included in 92980

Question:

May I report 92975 for TPA with stent code 92980, or is the TPA included? I see that a modifier is allowed, but under what circumstance would this be correct coding?

SuperCoder.com Member

Answer:

The Correct Coding Initiative (CCI) edit that bundles 92975 (*Thrombolysis, coronary; by intracoronary infusion, including selective coronary angiography*) into 92980 (*Transcatheter placement of an intracoronary stent[s], percutaneous, with or without other therapeutic intervention, any method; single vessel*) tells you not to code the two together unless they are distinct procedures.

In other words: You may consider reporting both codes for the same date when the physician performs them at different encounters or anatomic sites. To override the edit, you should append modifier 59 (*Distinct procedural service*) to 92975.

To learn more about proper modifier 59 use, check out CMS's Modifier 59 Article at www.cms.gov/NationalCorrectCodInitEd/Downloads/modifier59.pdf. □

— Coding expertise for this issue provided by **Christina Neighbors, MA, CPC, CCC, ACS-CA**, charge capture reconciliation specialist and coder at St. Joseph Heart & Vascular Center in Tacoma, Wash., and member of AAPC's Certified Cardiology Coder steering committee.

Cardiology

CODING ALERT

Mary Compton, PhD, CPC

maryc@codinginstitute.com
Editorial Director and Publisher

We would love to hear from you. Please send your comments, questions, tips, cases, and suggestions for articles related to *Cardiology coding and reimbursement* to the Editor indicated below.

Deborah Dorton, JD, MA, CPC, CHONC

deborahd@codinginstitute.com
Editor

Christina Neighbors, MA, CPC, CCC, ACS-CA

Consulting Editor

Jennifer Godreau, CPC, CPMA, CPEDC

jenniferg@codinginstitute.com
Content Director

The Coding Institute - 2222 Sedwick Drive, Durham, NC 27713 Tel: 1-877-912-1691 Fax: (800) 508-2592 service@codinginstitute.com

Cardiology Coding Alert is designed to provide accurate and authoritative information in regard to the subject matter covered. It is sold with the understanding that the publisher is not engaged in rendering legal, accounting, or other professional services. If legal advice or other expert assistance is required, the services of a competent professional should be sought.

CPT® codes, descriptions, and material only are copyright 2011 American Medical Association. All rights reserved. No fee schedules, basic units, relative value units, or related listings are included in CPT®. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

Rates: USA: 1 yr. \$249. Bulk pricing available upon request. Contact Medallion Specialist Team at medallion@codinginstitute.com. Credit Cards Accepted: Visa, MasterCard, American Express, Discover

This publication has the prior approval of the American Academy of Professional Coders for 0.5 Continuing Education Units. Granting of this approval in no way constitutes endorsement by the Academy of the content. Log onto SuperCoder.com/membersarea to access CEU quiz. To request log in information, e-mail service@codinginstitute.com



The Coding Institute also publishes the following specialty content both online and in print. Call 1-877-912-1691 for a free sample of any or all of the specialties below:

- | | | | | |
|---------------------------|---------------------------------|-------------------------|--------------------------------------|----------------|
| ■ Part B (Multispecialty) | ■ Gastroenterology | ■ Neurosurgery | ■ Otolaryngology | ■ Pulmonology |
| ■ Anesthesia | ■ General Surgery | ■ Ob-Gyn | ■ Pathology/Lab | ■ Radiology |
| ■ Billing & Collections | ■ Health Information Compliance | ■ Oncology & Hematology | ■ Pediatrics | ■ Rehab Report |
| ■ Dermatology | ■ Internal Medicine | ■ Ophthalmology | ■ Physical Medicine & Rehabilitation | ■ Urology |
| ■ Emergency Medicine | ■ Neurology & Pain Management | ■ Optometry | ■ Podiatry | |
| ■ Family Medicine | | ■ Orthopedics | | |

Announcing SuperCoder, the online coding wiz. Call us (800-508-2582) with your customer number for a special price, free trial, or just to find out more.

Order or Renew Your Subscription!

Yes! Enter my: one-year subscription (12 issues) to Cardiology Coding Alert for just \$249.

Extend! I already subscribe. Extend my subscription for one year for just \$249.

Subscription Version Options: (check one) Print Online* Both*(Add online to print subscription FREE) E-mail _____

* Must provide e-mail address if you choose "online" or "both" option to receive issue notifications

Name _____

Title _____

Company _____

Address _____

City, State, ZIP _____

Phone _____

Fax _____

E-mail _____

To help us serve you better, please provide all requested information

PAYMENT OPTIONS

Charge my: MasterCard VISA
 AMEX Discover

Card # _____

Exp. Date: ____/____/____

Signature: _____

Check enclosed
(Make payable to *The Coding Institute*)

Bill me (please add \$15 processing fee for all billed orders)

Cardiology Coding Alert

The Coding Institute
PO Box 933729
Atlanta, GA 31193-3792
Call 1-877-912-1691
Fax (801) 705-3942

E-mail: service@codinginstitute.com



SuperCoder is a property of CodingInstitute.com