Chapter Seven

SURGERY PROCEDURES

Surgery is defined as the art, practice, or work of treating diseases, injuries, or deformities by manual or operative procedures. Procedures may be invasive or non-invasive (i.e. closed fracture care) and may include instrumental applications to treat such cases. Surgeries are further classified as **minor** or **major** procedures. Minor procedure examples include ear wax removal, diagnostic scope or joint injection. Major procedure examples include knee replacement or spinal fusion.

General Surgery Guidelines

Surgery codes are found in the series 10021-69979. Each section is split into chapters that are defined by the system operated on and categorized by how the procedure is being performed (i.e.: excision, incision, repairs). The systems represented are as follows:

Integumentary System: 10021-19499

Musculoskeletal System: 20005-29999

Respiratory System: 30000-32999

Cardiovascular System: 33010-39599

Digestive System: 40490-49999

Urinary System: 50010-53899

Male Genital System: 54000-55899

Reproductive System Procedures: 55920

Intersex Surgery: 55970-55980

Female Genital System: 56405-58999

Maternity Care and Delivery: 59000-59899

Endocrine System: 60000-60699

Nervous System: 61000-64999

Eye and Ocular Adnexa: 65091-68899

Auditory System: 69000-69979

Code 69990 is used to report an operating microscope and may be reported independent of the surgical procedure when the microscope is used during surgery.

Regardless of the specialty for which you are coding, there are general guidelines that must be followed. CPT provides special guidance on appropriate coding for add-on codes, separate procedures and surgical packages.

Add-on codes are procedures carried out in addition to the primary procedure performed. The add-on code cannot be billed independently. Add-on codes are also exempt from the multiple procedure rule and therefore cannot be billed utilizing the –51 modifier (multiple procedure). Since the add-on procedure is billable in addition to the primary procedure and considered separate, the reduction in reimbursement given to multiple procedure services is not applicable.

Add-on codes can be easily identified with descriptions, which include phrases such as "each additional" or where the procedure directs the coder to list the procedure separately in addition to the primary procedure.

Example: 17000 Destruction of lesion any method……first lesion (primary code)
***+** 17003 Destruction of lesion any method…….2-14 lesion (add-on code)*

The code symbol for add-on codes is a **+** in front of the numeric CPT procedure code. Add-on codes should never be coded independent of the primary code or as a stand-alone code.

Separate procedure codes are listed as such in parentheses after the numeric procedure code. There are two instances where separate procedures are utilized. The following guidelines should be followed when billing for procedures that are listed as **separate procedures**.

Some procedures listed in CPT are carried out as an *integral part* of another procedure or service and as such are designated as **"separate procedures"**. In these cases, the separate procedure should not be reported in addition to the service of which it is considered an integral part. An example of this would be surgical services listed as diagnostic surgery. All diagnostic surgeries listed as primary component codes are listed as separate procedures and therefore may be billed only if they are the ONLY service that is performed in that series of codes. If the diagnostic service is performed and there is no other surgical procedure performed (i.e.: repair) due to the fact that no confirmation on a diagnosis is developed, then the diagnostic service is billed as it is the only service performed.

If a **diagnostic procedure** is performed and during the course of the procedure a diagnosis is confirmed and then a procedure is performed (ie: repair), then the diagnostic portion is an integral part of the primary procedure performed and therefore only the procedure performed should be coded.

Example 1*: Dr Smith schedules Ethel for a diagnostic knee arthroscopy as she has had knee pain for 6 months. The patient had been to physical therapy and had joint injections yet the pain had not resolved. Dr Smith performs the diagnostic knee arthroscopy and finds no abnormality of the knee except for some inflammation.*

The procedure is completed and the physician bills for the diagnostic arthroscopy as it is a stand-alone procedure and no other service was performed. The accurate code would be 29870.

Example 2*: Dr Smith performs the diagnostic knee arthroscopy and upon review of the knee finds a medial meniscal tear. He performs a medial meniscal repair.*

The diagnostic arthroscopy procedure is an integral part of the surgical procedure (the physician had to do the diagnostic portion to determine that there was indeed a tear; therefore, the diagnostic portion is "inclusive" of the actual repair and cannot be billed in addition to the procedure). This surgical procedure would be coded as 29882.

The examples above explain each scenario and how to bill for **separate procedures** where the **diagnostic surgery** is the initial procedure performed. Remember, when a diagnostic surgery is performed initially to determine if there is a problem and results show there is nothing that requires further surgery, the diagnostic service is billed as it is the only procedure performed. If the diagnostic service is performed and results show a problem, then the diagnostic service becomes an integral part of the surgical procedure performed to correct the problem and therefore the diagnostic **"separate procedure"** is not billed separately. Only the corrective surgical procedure would be billed.

Other procedure codes listed as **"separate procedures"** may be carried out at the same session as other procedures but may be considered separate and independent of the primary procedure performed and would be billed as a **separate procedure** in addition to the primary procedure. These separate procedure codes are considered unrelated to other procedures performed at the same time. The modifier –59 should be appended to the specific "separate procedure" code to show that the procedure is separate and distinct from the other procedures performed and is not considered to be a component of the other procedures performed.

A procedure may be reported separately for cases where the separate procedure was performed during a different session, a different site or organ system, different procedure or surgery, separate excision/incision, separate lesion, or separate injury or area of injury in extensive injuries. When reporting separate procedures under these circumstances, be sure to apply the appropriate modifier when necessary to ensure accurate code assignment and adherence to reimbursement guidelines related to bundling so that claims will be paid appropriately.

Example 1*: Dr. Smith is performing a cranioplasty on a patient and drills a burr hole so that he can implant a ventricular catheter. The burr hole is listed as a separate procedure as it is a significant separately identifiable procedure. The surgery would be coded as follows: 62140, 61210 (separate procedure)*

***Example 2**: Dr. Jones performs a diagnostic colonoscopy on a patient, which results in the decision to perform an **open procedure** of the abdomen. Since the diagnostic colonoscopy was performed as a separate distinct procedure from the surgical procedure performed (different locations), both the diagnostic colonoscopy (45378 separate procedure) as well as the open abdominal surgery (49020) should be coded.*

A **diagnostic procedure** is a procedure performed for the purpose of determining a diagnosis of a patient or for investigational purposes to rule out certain conditions. Diagnostic procedures are not performed to treat or cure a condition.
When follow-up care for diagnostic procedures is performed (i.e. diagnostic endoscopy, arthroscopy), all care provided after the procedure related to the performance of the procedure itself is not reported separately. Care not related to the diagnostic procedure may be reported separately.

A **therapeutic procedure** is a procedure in which the patient experiences relief from a symptom, a stop to the progression of a disease, or some other short and long-term benefit. When follow-up care is provided for therapeutic surgical procedures, the care related to the therapeutic procedure is not reported separately. Additional services provided as a result of complications of any sort are reported separate from the therapeutic surgical procedure.

When performing surgery procedures, there are some supplies and other materials that may be reported separately when they are not a part of the normal services provided for the surgery. Surgery trays and drugs utilized during surgery are just some of the services that may be reported separate from the surgery procedure.

Global Surgery Rules

Three rules apply to global surgery for minor and major procedures. These rules are defined by CMS as follows:

Zero Day Post-Operative Period (endoscopies and some minor procedures).
• No pre-operative period • No post-operative days • Visit on day of procedure is generally not payable as a separate service

10-Day Post-operative Period (other minor procedures).
• No pre-operative period • Visit on day of the procedure is generally not payable as a separate service • Total global period is eleven days to include the day of the surgery and ten days following the day of the surgery.

90-day Post-operative Period (major procedures)
• One day pre-operative included • Day of the procedure is generally not payable as a separate service • Total global period is ninety-two days, counting one day before the day of the surgery, the day of surgery, and the ninety days immediately following the day of surgery. To obtain global periods for surgery visit the CMS website at https://www.cms.gov/apps/physician-fee-schedule/overview.aspx.

2019 Global Surgery Data Collection Efforts for Evaluating Possible Elimination of the Global Surgery Rule.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) required CMS to implement a process to collect data on postoperative visits and to utilize the data collected to assess the accuracy of reporting global surgical codes. Beginning July 1, 2017, CMS

required groups with 10 or more practitioners use the no-pay CPT code 99024 to report postoperative visits for specified procedures. There were nine states chosen to participate including Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island. Out of all of the practitioners that met the criteria for reporting in these states, only 45% of them participated in the review and the overall number varied substantially by specialty. Among postop global period procedures that were reported with the 99024 f/u global code, only 16 percent of 10-day global services and 87 percent of 90-day global services had one or more matched visits reported.

In the 2018 proposed rule (for 2019), the agency solicited comments about increased compliance and also whether visits are typically being performed in the 10-day global period. Also, they asked for comments on whether they should mandate the use of modifiers -54 "for surgical care only" and -55 "post-operative management only," whether the transfer of care is formally documented or not. In the final rule, CMS did not make any changes to the global surgery policy and said they would consider stakeholder comments and whether to propose action at a future date. The agency did, however, agree to additional education for those providers in the nine states mandated to continued reporting of CPT code 99024.

Continue to monitor the CMS website for changes regarding the global period rule and any changes that may be implemented in the future. For those providers in the nine states mandated to track this data through MACRA who have yet to do so, it is important that this be tracking begin as soon as possible.

Surgical Modifiers

Modifiers are utilized to modify certain circumstances for services provided. CPT modifiers are two-digit numeric (CPT modifiers) or alpha-numeric and alpha-alpha codes (HCPCS) placed after the usual procedure number. The modifier modifies the procedure code on which it is attached without changing the actual description of the service that is being provided. A full list of CPT modifiers can be found in the front cover of the CPT book and HCPCS modifiers can be found in the HCPCS Level II book. The following CPT modifiers may be appended to surgical codes to modify the procedure.

-22 Increased Procedural Services: When service provided is greater than that usually required for the listed procedure.

-47 Anesthesia by Surgeon: Regional or general anesthesia provided by the surgeon is reported using modifier –47 (do not use with codes 00100-01999).

-50 Bilateral Procedure: Services provided that do not indicate bilateral procedure in the code description and are performed at the same operative session utilize the modifier –50 to indicate that the procedure was performed on both areas.

-51 Multiple Procedures: When multiple procedures (not E/M) are performed at the same session or on the same day by the same provider, the primary procedure is listed first and all subsequent procedures are reported utilizing this modifier.

-52 Reduced Services: Under certain circumstances, some procedures are partially reduced or eliminated at the physician election. The modifier –52 should be added to these services.

-53 Discontinued Procedures: The physician may elect to terminate a 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.

-54 Surgical Care Only: When a physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier –54.

-55 Postoperative Management Only: When one physician performs the postoperative management and another physician has performed the surgical procedure, the postoperative component is billed utilizing the –55 modifier.

-56 Preoperative Management Only: When one physician performs the postoperative management and another physician performs the preoperative component only, modifier –56 is used on the surgical procedure code.

-58 Staged or Related 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: planned prospectively at the time of the original procedure (staged); more extensive than the original procedure; or for therapy following a diagnostic surgical procedure.

-59 Distinct Procedural Service: The modifier –59 is used to identify that a procedure or service was distinct from another procedure or service performed on the same day. In 2015, CMS added 4 new modifiers to better describe distinct separate services. These modifiers will replace the -59 for Medicare patients only. All other payers will still recognize the -59 modifier when reporting distinct, separate procedures performed at the same session by the same provider.

In 2015, Medicare developed new HCPCS Level II modifiers to define more specifically the modifier -59 separate procedure scenarios. Do not use -59 and any of the following modifiers together on the same line item;

- XE Separate Encounter: A service that is distinct because it occurred during a separate encounter.
- XS Separate Structure: A service that is distinct because it was performed on a separate organ/structure.
- XP Separate Practitioner: A service that is distinct because it was performed by a different practitioner.
- XU Unusual Non-Overlapping Service: The use of a service that is distinct because it does not overlap usual components of the main service.

-62 Two surgeons: When the skills of two surgeons are required in the management of a specific surgical procedure, modifier –62 should be used by both physicians performing surgery. The physicians are usually of different specialties.

-66 Surgical Team: High complex procedures sometimes require the services of several physicians, often of different specialties, under the surgical team concept. Such services are identified using the –66 modifier (each physician

would utilize the modifier for services that they bill).

-76 Repeat Procedure by Same Physician: When a physician must indicate that a procedure or service was repeated subsequent to the original service, the modifier –76 should be used.

-77 Repeat Procedure by Another Physician: When a physician must indicate that a procedure or service that was performed by another physician was repeated, the procedure should be billed with modifier –77.

-78 Unplanned Return to Operating Room for Related Procedure During Postoperative Period: The physician may need to indicate that another procedure was performed during the postoperative period of the initial procedure. When the subsequent procedure is related to the initial procedure, modifier -78 would be appended to the second procedure performed.

-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. The modifier –79 would be utilized when billing the subsequent unrelated procedure or service.

-80 Assistant Surgeon: When surgeon uses an assistant surgeon use -80 modifier.

-81 Minimum Assistant Surgeon: Minimum assistant surgery services are reported using the –81 modifier.

-82 Assistant Surgeon (when qualified resident surgeon not available): When a resident surgeon is unavailable or unqualified to assist in surgery, the modifier –82 should be utilized on the services billed by the surgeons.

-99 Multiple Modifiers: Under certain circumstances more than four modifiers may be necessary to code the service completely.

The following HCPCS Level II modifiers are also used for surgery section:

-E1 Upper left, eyelid

-E2 Lower left, eyelid

-E3 Upper right, eyelid

-E4 Lower right, eyelid.

-LC Left circumflex coronary artery

-LD Left anterior descending coronary artery

-LS FDA monitored Intraocular Lens Implant

-LT Left side

-PA Surgical or other invasive procedure on wrong body part

-PB Surgical or other invasive procedure on wrong patient

-PC Wrong surgery or other invasive procedure on patient

-RC Right Coronary Artery

-RT Right side

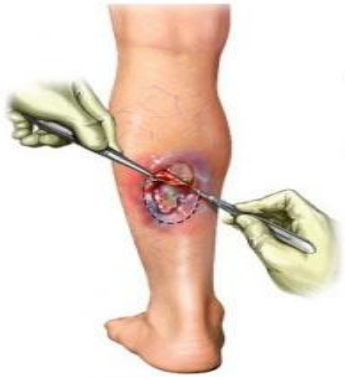
Surgery Subsection Guidelines

In addition to the surgery section guidelines that affect all surgery procedure codes, there are additional subsection guidelines that provide special guidance for specific code categories. These subsection guidelines will provide additional instructions regarding things such as what services are reported separately and what services are considered bundled into the main surgical procedure. Any surgery section that does not have subsection guidelines should be coded using the overall section guideline instructions for the surgery section as defined in the green pages before the CPT surgery code listing. The following surgery specialties have subsection guidelines.

Integumentary System Surgery Guidelines

Surgeries related to skin, glands, hair and nails are reported in the integumentary system.

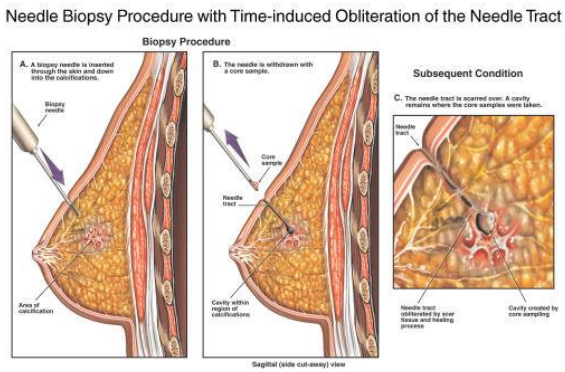
Debridement is the removal of damaged tissue or foreign body from a wound. Debridement codes 11042-11047 are reported by depth of the tissue that is removed and by the surface area of the wound. When a single wound is debrided, report the code that describes the deepest level of debridement performed. When more than one wound is being debrided, code the total sum of the surface area of wounds with same depth and report appropriately.

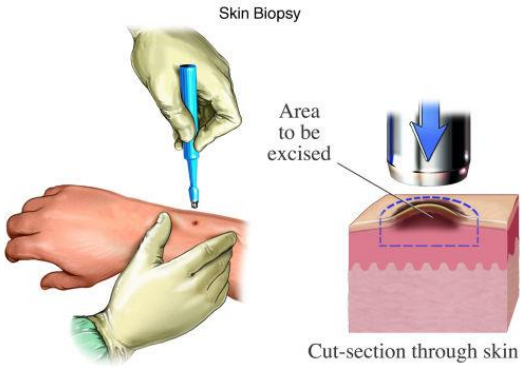


Biopsies are the removal and examination of tissue in order to establish a diagnosis. There are a number of different types of biopsy procedures, the most common of which are defined below.

Aspiration biopsy- biopsy in which tissue is obtained by application of suction through a needle attached to a syringe.
Brush biopsy- biopsy in which cells or tissue are obtained by manipulating tiny brushes against the tissue or lesion in question (e.g., through a bronchoscope) at the desired site.

Cone biopsy-biopsy in which an inverted cone of tissue is excised, as from the uterine cervix.
Core biopsy, **core needle biopsy-** needle biopsy with a large hollow needle that extracts a core of tissue.
Endoscopic biopsy- removal of tissue by appropriate instruments through an endoscope.
Excisional biopsy- biopsy of tissue removed by surgical cutting.
Incisional biopsy- biopsy of a selected portion of a lesion.
Needle biopsy- biopsy in which tissue is obtained by puncture of a tumor, the tissue within the lumen of the needle being detached by rotation, and the needle withdrawn. Also called percutaneous biopsy.
Punch biopsy- biopsy in which tissue is obtained by a punch.
Shave biopsy- biopsy of a skin lesion in which the sample is excised using a cut parallel to the surface of the surrounding skin.
Stereotactic biopsy- biopsy of the brain using stereotactic surgery to locate the biopsy site.





Lesion removal procedures are reported by adding the size of the lesion itself plus the margins around the lesion that require surgical removal to excise the lesion. Closure of the surrounding tissue may be reported separately if the closure requires intermediate or complex repair. Simple repairs are considered inclusive of the removal process and therefore are not reported separately. Providers must document the diameter and margins in order to code lesion removal procedures.

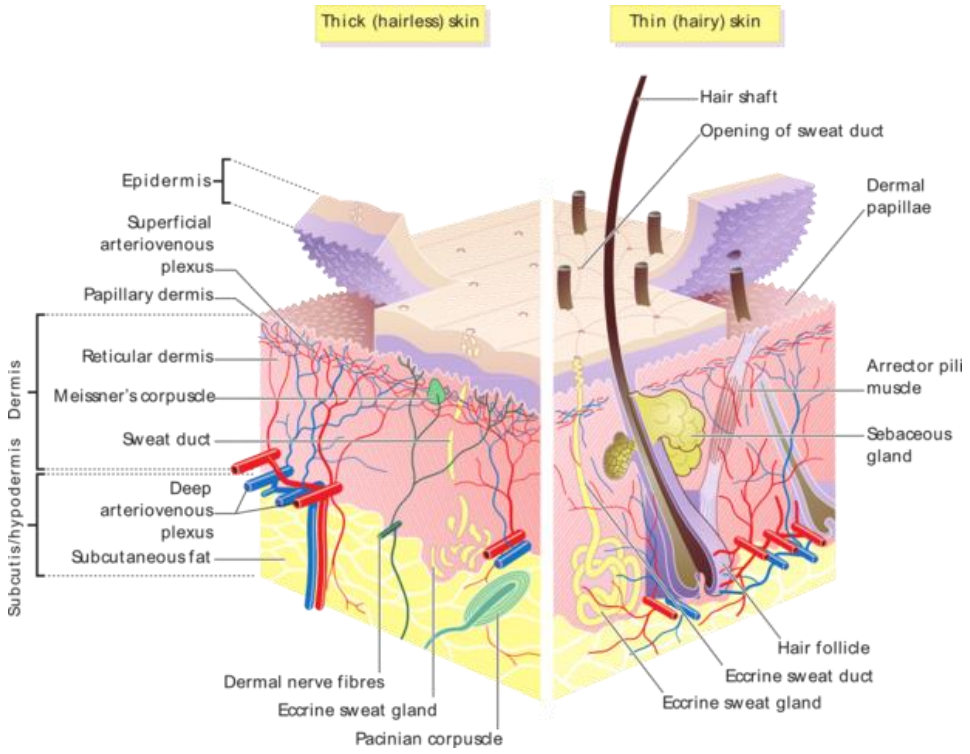
Wound repairs are reported by anatomic site, the length of the wound and the type of repair. There are three types of repairs defined by the complexity level of the repair performed. Simple repairs are considered an integral part of the procedure being performed and therefore are not reported separately from another procedure; however, if the repair is the only procedure being performed, simple repairs are reported. The repair types are defined below.

Simple repairs are reported when a single layered closure is performed that involves the epidermis, dermis or subcutaneous layers of the skin where there is no deeper layer involvement required to perform the repair. Local anesthesia, chemical and electro cauterization procedures are considered inclusive of the simple repair procedure and are **not** reported separately. Simple ligation of vessels and simple exploration of nerves, blood vessels, or tendons is included in the wound repair procedure. Simple repair (closure) is bundled into the excision codes.

Intermediate repairs are reported when the repair involves layered closure of the deeper layers of the skin and the connective tissue (called fascia) that supports muscle and other tissues. Intermediate layer closure may also be reported when a single layer closure is infected and requires extensive cleaning and removal of foreign body or infection before closing the wound.

Complex repairs are reported when the repair involves multiple layered closures beyond skin and connective tissue (into muscle and other tissues). Complex wounds include wounds that require extensive undermining, debridement, stents or retention sutures before closing the wound.

The top (single layer) layer of the skin, the secondary or intermediate layers of the skin and the deeper layers of the skin are shown in the illustration below. By comparing a provider's documentation verbiage to the layers shown below, the coder can better understand which repair code to assign.



The lengths of the wound repairs that are in the same category (simple, intermediate or complex) and body area should be added together to determine total size of the repair.

Example: *Documentation states that the physician performed a simple repair of a 2.5 cm abrasion on the* ***neck*** *and a simple repair of a 3.4 cm laceration on the* ***back****; the length of these wounds may be added up and billed as one simple repair. The correct code would be 12002 since the neck and back are included in the procedure code definition.*

Example: *The documentation in this scenario states that the physician performed a simple repair of a 2.5 cm abrasion on the* ***lip*** *and a simple repair of a 3.4 cm laceration on the* ***back****. Notice the category of the wounds has not changed, but the anatomic sites have; therefore two codes would be used to code the simple repair in two different anatomic sites. The correct codes would be 12002 and 12011.*

The lengths of the wound repairs in different categories or classifications should always be reported separately. For example, a complex repair and a simple repair must be coded using two separate codes. The more complex classification should be reported as the primary procedure as it requires more time and effort. The -51 modifier would be applied to the second and subsequent codes.

Example: *Documentation states that the physician performed a 2.5 cm complex repair of the forearm and a much larger 10.7 cm intermediate repair to the forearm. The case would be coded* 13120, 12034 – 51

Wound repairs involving nerves, blood vessels and tendons should be reported under the appropriate body system.

Example: *Documentation states that a physician repairs a blood vessel in the heart would be coded in code series 35201, 35206 and 35226 (direct repair) or 35261, 35266 and 35286 (repair with graft).*

Skin replacement surgery codes include surgical preparation and placement of autograft (skin from patient) or homograft, allograft and xenograft (skin source other than patient or substitute skin source) procedures.

Skin replacement codes are reported using location and size of resultant defect. Defects in same anatomic area should be added together while defects in different anatomic sites should be reported separately.

In some cases, repairs may be coded separately (i.e. for intermediate or complex repairs). Adjacent tissue transfer codes are also reported separately (14000-14061).

Mohs Micrographic Surgery is reported using code series 17311-17315 and is performed when complex skin cancer requires removal and is reported only when the surgeon and pathologist functions are performed by the ***same individual***. If two separate providers are providing services; one as surgeon and one as pathologists, the surgeon reports the surgery and the pathologists from the lab/path code series.
Repairs and biopsies performed on the same day as a Mohs procedure should be reported separately. Modifier -59 should be reported on any subsequent procedures performed to report that services are distinct and separate per documentation.
Breast biopsies and other procedures of the breast are reported using codes 19000-19499.

Musculoskeletal System Surgery Guidelines

Surgeries performed on bones, muscles, tendons, joints, ligaments and bursae are reported in this section. Procedures related to fractured or broken bones are reported utilizing the appropriate type of surgery classification used to repair the bone. These classifications are defined below.

Open treatment procedures are reported when the surgery requires open procedure to repair the bone. The open procedure allows the bone to be seen by the surgeon so that repairs can be performed. The open treatment may be performed at the actual site or may be indirectly visualized by performing a remote repair away from the site where the bone is not directly visualized through the actual site.

Closed treatment procedures are reported when the fracture treatment does not require open surgery to repair. Closed treatment procedures may be performed with manipulation, without manipulation or with traction, without traction.

Manipulation is when the bone is moved back into its original place after separation without the need to perform an open procedure. Frozen shoulders, neck, back and knee replacements can also be "manipulated" back into place when popped out of joint or out of line.

Traction is used to apply force to draw two adjacent bones apart from one another so the joint space in-between can be expanded. Traction can also stretch the soft tissue around the joint. Traction is provided manually or by means of a device.

Percutaneous fixation is used to treat a fracture by placing fixation devices such as pins across the fracture site, usually under x-ray imaging.

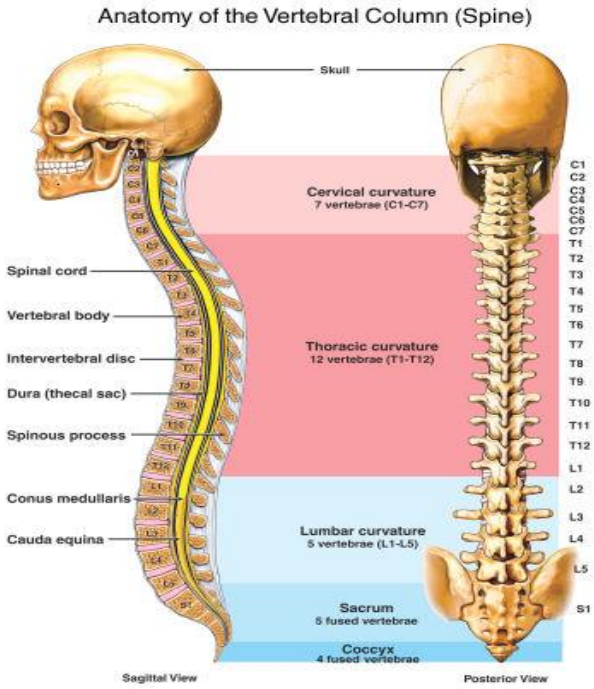
Spine procedures are reported by anatomical site and by vertebral categories including cervical, thoracic and lumbar, sacrum and coccyx areas. Each spinal column has a certain number of vertebrae within each code classification.

Cervical – 7 vertebrae (C1-C7)
Thoracic – 12 vertebrae (T1-T12)
Lumbar – 5 vertebrae (L1-L5)
Sacrum – 5 fused vertebrae (S1-S5)
Coccyx – 4 fused vertebrae (Coccyx)

When coding for these procedures, each vertebra is counted as one individual vertebra. For example, a procedure performed on C7-T3 would be a total of four individual vertebrae, a procedure performed on L1-L3 would be three total vertebrae, and so on. The total number of vertebrae within each classification and the designation for each as described within the CPT procedure code descriptions are shown in the diagram on the next page.

Interspaces are counted and reported as one interspace between each vertebra. Interspaces will be discussed in more detail within the neurosurgery section.

The Spine

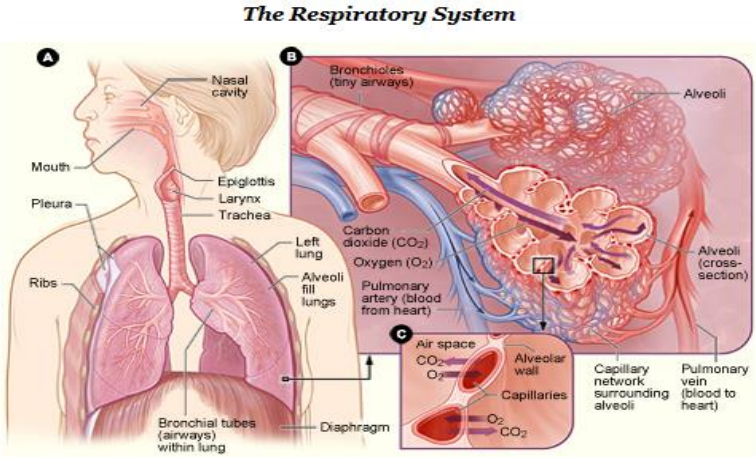


Osteotomy codes are used to report procedures involving cutting of a bone or removal of a piece of bone. When performing osteotomy procedures, arthrodesis, instrumentation and bone graft procedures are all reported separately.

Arthrodesis is the fusion of joints by surgical intervention performed for the purpose of reducing or eliminating pain. Other procedures performed and reported within the musculoskeletal section include arthroscopies and injections.

Respiratory System Surgery Guidelines

Respiratory procedures include procedures performed on the lungs, trachea, bronchi, alveoli, nose, and mouth.

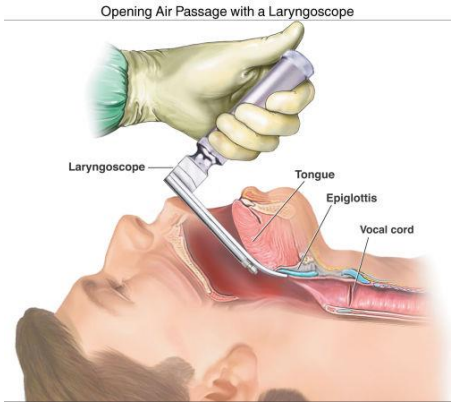


Procedures in this section include repairs, foreign body removals, biopsies and endoscopies (i.e. bronchoscopies, laryngoscopies). When reporting diagnostic procedures, it is important to remember that the diagnostic procedure code is included in the primary surgery

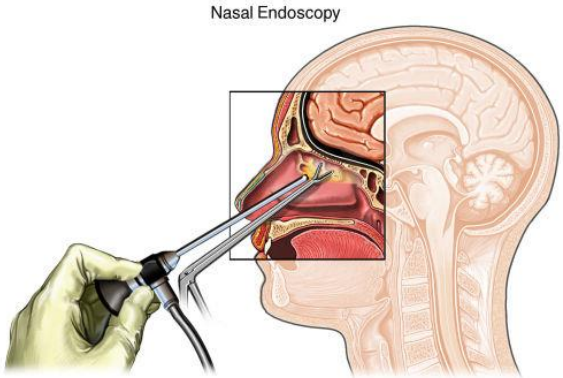
endoscopy when performed within the same session. Diagnostic procedures should only be reported separately if the diagnostic procedure is the only procedure performed and no additional surgical intervention is required.

Endoscopic surgery refers to looking inside the body for medical reasons using an endoscope. An endoscope is an instrument used to examine the interior of a hollow organ or cavity of the body. The instrument and video equipment used to provide live images are displayed. Images are produced from the camera on the end of the scope. Below are pictures of respiratory endoscopic procedures performed utilizing the scope for the larynx and the nose. Note that the patients are generally awake during these procedures and are able to communicate with the physician.

Laryngoscopy



Nasal Scope



Cardiovascular System Surgery Guidelines

Invasive surgery within the cardiovascular system is reported using code series 33010-37799. The radiology section of CPT is used to report the images that are produced when invasive procedures are performed. Diagnostic procedures on the cardiovascular system are reported in the Medicine section and will be reviewed in detail in Chapter 10 of this manual.

The cardiovascular system includes the **heart** and two **vascular** systems: the arterial and vascular. These systems are responsible for blood transportation throughout the body. The arterial system transports blood to lungs and peripheral (away from center or outside) organs of the body. The vascular system transports blood back to the heart and from the lungs to the heart. CPT procedure descriptions for the cardiovascular system reported by the type of surgery performed (repair, excision, incision) and the anatomical area where the surgery is being performed (heart, vein, artery).

The heart's two upper chambers, called the atria, contract. This contraction pumps blood into the heart's two lower chambers, the ventricles. The ventricles then contract and pump blood to the rest of the body. The combined contraction of the atria and ventricles produces a heartbeat.