

Special Insert

ACC Guide to 2009 Cardiology Coding and Payment Changes

Significant changes in cardiac device monitoring codes, as well as echocardiography codes, will mark 2009 as a sentinel year for cardiology coding and payment. The ACC has prepared the following overview to help ease the transition to the new codes and better enable physicians and coders to prepare for and comply with the new coding structures.

Changes for Echocardiography

Current Procedural Terminology (CPT) codes developed over the past 15 years for many key cardiovascular services were designed to maximize flexibility and accuracy in coding by establishing separate, very specific codes for individual components of services. However, this fee-for-service (FFS) system has come under increasing fire for offering incentives to provide a greater number of services that may or may not provide improvements in health. As a result, Congress, the Centers for Medicare and Medicaid Services (CMS) and others are looking at a bundled payment system, which would offer one payment for a group of services rendered for a certain illness, as a means of ensuring more accurate payment and reducing Medicare costs. A first step in this process is creating new CPT codes to describe combinations of services frequently performed together that have been reported with multiple CPT codes.

Physicians who perform the frequent combination of transthoracic echocardiography (TTE) with spectral and color flow Doppler are among the first to see the effects of this bundling trend. In 2007, the ACC and the American Society of Echocardiography (ASE) successfully deflected an attempt by CMS to discontinue all payment for color flow Doppler, provided bundled codes were created for 2009 implementation. Since then, the ACC and ASE developed two new “bundled” echocardiography codes: CPT 93306, which is to be used for reporting resting TTE with spectral and color Doppler, and CPT 93351, which is to be used to report performance of a stress test and stress echo by the same physician. There is also a new “add-on” code for contrast administration (CPT 93352) performed in conjunction with a stress echocardiograph. In addition, there are several editorial changes to introductory language, CPT language and exclusionary comments.

The ACC worked hard to minimize the payment reductions involved in these bundling initiatives. While Medicare payment reductions for echocardiography services are significant, these reductions are attributable in large measure to modifications of CMS’ budget neutrality methodology and to the continued transition to “resource-based” practice expense payments, and not to the introduction of the new bundled codes. In other words, even if there were no coding changes for echocardiography services, Medicare payments for these services would still be cut in 2009 and 2010, although to a somewhat lesser degree.

New combined TTE/spectral Doppler/color Doppler (CPT 93306)

A complete TTE with spectral and color flow Doppler will now be reported with the new CPT code 93306. A complete TTE without spectral and color flow Doppler is to be reported with existing CPT code 93307. CMS accepted the AMA/Specialty Society RVS Update Committee (RUC) recommendations for the work RVUs (W-RVU) for the new combined TTE/spectral Doppler/color Doppler code 93306. The work RVUs for CPT 93306 are 0.07 W-RVUs less than the combined W-RVUs for the component codes (93320, 93325 and 93307). The national average payment for transthoracic echocardiography with spectral and color flow Doppler echocardiography will decrease from \$356 in 2008 to \$268 in 2009 – a 25 percent cut, while payment for stress echocardiography with stress EKG will drop 10 percent from \$302 in 2008 to \$272 in 2009.

93306	Transthoracic (2D) echocardiography with spectral Doppler and color flow Doppler
-------	--

*These are abbreviated descriptions. For complete descriptions, see AMA’s CPT 2009.

New combined stress test/stress echo code (CPT 93351)

Prior to 2009 if an individual physician performed all elements of a stress echocardiographic study (i.e., both the stress echo imaging portion and the stress EKG), he/she reported CPT codes 93350 and 93015. Under the new coding structure, a physician who performs all elements required will report CPT code 93351. However, physicians that do not perform all elements will use CPT code 93350 to report the performance and interpretation of the stress echocardiographic imaging study only with the appropriate components of the cardiovascular stress codes reported separately (93016 - 93018). For example, if a physician does not analyze, interpret and report on the cardiovascular stress test, but does supervise the performance of the stress test along with the stress echo, he/she would report 93350 and 93016.

CMS also accepted the RUC-recommended W-RVUs for the new combined stress test/stress echo code 93351 of 1.75 W-RVUs. However, CMS did not accept all elements of the RUC's practice expense recommendations, resulting in lower payments for 2009. These practice expense inputs are subject to comment. ACC will work with appropriate cardiovascular specialties to address these detailed issues with CMS.

93351 Stress echocardiography including stress ECG

New contrast add-on (CPT 93352)

For the first time, a code will be available to report administration of a contrast agent during stress echocardiography. Using CPT 93352, physicians performing contrast enhanced stress echocardiography (CPT codes 93350 or 93351) are now able to separately report services associated with contrast administration. The contrast agent is reported with the appropriate Healthcare Common Procedure Coding System (HCPCS) supply code. Total RVUs of 1.07 for CPT 93352 yields a national average Medicare payment of approximately \$36.

93352 Administration if echo contrast agent

CODE	MODIFIER	DESCRIPTION	TOTAL RVU	TOTAL NAT AVG Medicare Payment
93306		TTE w/doppler, complete	7.42	\$267.61
93306	TC	TTE w/doppler, complete	5.43	\$195.84
93306	26	TTE w/doppler, complete	1.99	\$71.77
93307		TTE w/o doppler, complete	4.91	\$177.09
93307	TC	TTE w/o doppler, complete	3.53	\$127.32
93307	26	TTE w/o doppler, complete	1.38	\$49.77
93320		Doppler echo exam, heart	1.66	\$59.87
93320		Doppler echo exam, heart	1.66	\$59.87
93320	TC	Doppler echo exam, heart	1.48	\$53.38

CODE	MODIFIER	DESCRIPTION	TOTAL RVU	TOTAL NAT AVG Medicare Payment
93320	26	Doppler echo exam, heart	.38	\$13.71
93325		Doppler color flow add-on	1.50	\$54.10
93325	TC	Doppler color flow add-on	1.39	\$50.13
93325	26	Doppler color flow add-on	0.11	\$3.97
93350		Stress TTE only	5.87	\$211.71
93350	TC	Stress TTE only	3.64	\$131.28
93350	26	Stress TTE only	2.23	\$80.43
93351		Stress TTE complete	7.68	\$276.99
93352		Admin ECG including stress ECG	1.07	\$38.59

Cardiac Device Monitoring — Then and Now

The ACC collaborated with the Heart Rhythm Society (HRS) and industry representatives for approximately two years to develop an entire new set of cardiac device monitoring codes that accurately reflect physician professional and service center components. The current CPT codes for cardiac rhythm management (CRM) device monitoring services do not reflect current practice and technology. There was a need to modernize the current codes and provide a new set of technology-relevant code descriptions, particularly in regard to evolving technology. The new codes are device dependent, independent of differences among different manufacturers' devices and applicable to all devices in a product area. The new codes are intended to establish consistency in code descriptions, simplify code language, provide uniform frequency standards, reflect current technology in remote monitoring services and to eliminate the potential for inappropriate billing.

Caution: Areas to Watch

- Reprogramming is not the determining factor for choosing the correct code
- Interrogation codes – same code for a single, dual and multi lead device
- Programming codes – codes change for single, dual and multi lead
- Don't forget to bill for the technical side of remote services if you are performing that service
- Think through how the new codes fit into existing medical policies
- Review supervision requirements
- Watch for correct coding initiative (CCI) changes
- Watch for changes in local and national medical policies
- Check whether private payers are covering services
- Track inappropriate denials from payers

What You Need to Know About the New Cardiac Device Monitoring Codes

- Codes 93279-93292 are reported per procedure.
- Codes 93293-93296 are reported not more than once every 90 days.
 - Do not report 93293-93296 if the monitoring period is less than 30 days.
- Codes 93297-93299 are reported no more than once up to every 30 days.
 - Do not report 93297-93299 if the monitoring period is less than 10 days.
- A period is established by the initiation of the remote monitoring or the 91st day of a pacemaker or ICD monitoring or the 31st day of the ILD or ICM and extends for the subsequent 30 or 90 days, respectively, for which the remote monitoring is occurring.
- Programming device evaluations and remote interrogation device evaluations may both be reported during the remote interrogation device evaluation period.
- A service center may report 93296 or 93299 during a period in which a physician performs an in-person interrogation device evaluation.
- A physician may not report an in-person and remote interrogation of the same device during the same period.
- Report only remote services when an in-person interrogation device evaluation is performed during a period of remote interrogation device evaluation.

It is imperative to review the new introductory language provided in the AMA's **CPT 2009**, which provides education on the terminology used in the descriptors, the technology and guidelines for reporting. These services are divided into two sections in the Medicine/Cardiovascular section. The first section (Cardiography) contains two new codes and 15 revisions, while the second section (Cardiovascular Device Monitoring – Implantable and Wearable Devices) contains 21 new codes. Eleven codes have been deleted.

Highlights of the new code structure include:

- A modernized set of technology-relevant code descriptions will classify future generation devices seamlessly.
- Code descriptions for the new codes have significantly changed from the existing codes, therefore detailed descriptions are provided in the introductory language to avoid ambiguity. For example, the number of leads will be based on the number of active leads and the number of chambers paced.
- Separate codes are established between implantable and wearable defibrillators to capture the difference in work for evaluation and frequency distinguished by the device technology.
- For the implantable device and wearable defibrillator codes, the major changes from current to proposed codes provide for work currently not represented in current CPT codes, including:
 - complete device analysis without parameter change;
 - remote or in-person interrogation follow-up;
 - biventricular device analysis differentiation;
 - perioperative limited programming;
 - limitations on frequency of coding for follow-up interrogations including transtelephonic pacemaker monitoring (90 days);
 - parallel codes for wearable defibrillator and implantable pacemaker/ICD;
 - separate physician and technical codes; and

- codes for implantable cardiovascular monitoring technology

Given the significant changes in the coding structure and its implications for work flow, patient scheduling and other practice issues, physicians, device clinic staff and practice administrators will all need to work together to develop an implementation strategy.

Structure for the 2009 Cardiac Device Monitoring Codes

The new codes are categorized into seven groups:

1) Programming Cardiac Implantable Electrical Device (CIED) Evaluations:

A programming evaluation is a customized evaluation in which the physician prescribes the appropriate behavior of the device for the patient and evaluates both the patient's condition and the device's function. The programming evaluation codes are used when all device functions including battery, programmable settings, and lead(s) when present, are evaluated. It is also used for assessment of capture thresholds, iterative adjustments (i.e., progressive changes in the pacing output of a lead) and programmable parameters. Evaluation allows the operator to assess and select the most appropriate parameters to provide for appropriate therapy and verify device function. The final program parameters may or may not change as a result of the evaluation.

Components to be evaluated include all of the interrogation evaluation and selection of specific programmed parameters.

- **PM** - programmed parameters, lead(s) battery capture and sensing function and heart rhythm. Often, but not always, sensor rate response, lower and upper heart rates, AV intervals, pacing voltage and pulse duration, sensing value and diagnostics will be adjusted
- **ICD** - programmed parameters, lead(s) battery capture and sensing function, presence or absence of therapy for ventricular tachyarrhythmias and underlying heart rhythm. Often but not always sensor rate response, lower and upper heart rates, AV intervals, pacing voltage and pulse

duration, sensing value, and diagnostics will be adjusted. Ventricular tachycardia detection and therapies may be altered depending on the data, patient's rhythm, symptoms, and condition.

- **Loop** - programmed parameters, heart rate and rhythm during recorded episodes from both patient initiated and device algorithm detected events. Often but not always, tachycardia and bradycardia detection criteria will be adjusted.

93279	Programming device evaluation; single lead pacemaker
93280	Programming device evaluation; dual lead pacemaker
93281	Programming device evaluation; multiple lead pacemaker
93282	Programming device evaluation; single lead ICD
93283	Programming device evaluation; dual lead ICD
93284	Programming device evaluation; multiple lead ICD
93285	Programming device evaluation; implantable loop recorder system

2) Interrogation CIED Evaluations (Remote and In-Person):

An interrogation evaluation is a less complex and a more standardized evaluation than a programming evaluation. During an interrogation CIED evaluation the physician retrieves stored and measured information from the device on the existing programmed parameters. The data obtained pertains to the lead(s) and sensor(s) when present, battery and generator function, and data stored regarding heart rhythm and heart rate. These codes should also be used when data is evaluated to assess aspects of the device's programming and function (e.g. battery voltage, lead impedance, tachycardia detection settings and rhythm treatment settings).

The remote and in-person components to be evaluated are identical and include:

- **PM** – programmed parameters, lead(s) battery capture and sensing function and heart rhythm
- **ICD** - programmed parameters, lead(s) battery capture and sensing function, presence or absence of therapy for ventricular tachyarrhythmias and underlying heart rhythm
- **ICM** – programmed parameters and analysis of at least one recorded physiologic cardiovascular data element from internal or external sensors
- **Loop** – programmed parameters, heart rate and rhythm during recorded episodes from both patient initiated and device algorithm detected events, when present

IN PERSON VS REMOTE

The previous coding structure did not recognize the value of the information obtained and presented for physician review independent of whether it is derived directly from the implanted device or from remote sensors in contact with the device and its telemetry system. Remote interrogation network systems have become important to current practice. This technology merges outpatient monitoring, device and

arrhythmia detection, wireless communications, and the internet to allow device and cardiac rhythm related problems to be quickly identified, analyzed and communicated to the prescribing physician. Correctly describing and valuing the work provided by the physician, including complex data collection and the effort of the physician, independent diagnostic testing facilities (IDTF), when present, and office personnel, required a new strategic approach to coding.

Key differences between remote and in-person codes include:

- In person codes – 93288 – 93292 are billed per incident.
- Remote services – codes 93294 – 93297 - are billed once per 90 day period.
- A physician/practice may not report an in-person and remote interrogation of the same device during the same service period.
- For patients being followed remotely, a physician/practice may pull the data as often as needed, but may bill only once per 90 day period
- A physician/practice may not report 93294 - 93297 if the service is less than 30 days
- Programming device evaluations and in-person interrogation device evaluations may not be reported on the same date of service by the same physician, as the programming device evaluation includes all elements of the interrogation device evaluation.
- Programming device evaluations and remote interrogation device evaluation may be reported during the same remote period.

In Person:	
93288	Interrogation device evaluation (in person); single, dual or multiple lead pacemaker
93289	Interrogation device evaluation (in person); single, dual or multiple lead implantable cardioverter defibrillator system
93290	Interrogation device evaluation (in person); implantable cardiovascular monitor system
93291	Interrogation device evaluation (in person); implantable loop recorder system

Key Definitions

The following are the major changes to definitions that are also outlined in the introductory language of the 2009 CPT Guide. This information aligns with the July 2008 Heart Rhythm Society (HRS) Guideline regarding remote follow-up of devices. See: www.hrsonline.org/Policy/ClinicalGuidelines/upload/cieds_guidelines.pdf.

- Device single lead – PM or ICD, pacing and sensing in one chamber
- Device dual lead – PM or ICD, pacing and sensing in two chambers
- Device multiple lead – PM or ICD, pacing and sensing in three or more chambers

In Person:	
93292	Interrogation device evaluation (in person); wearable defibrillator system

Remote:	
93294	Interrogation device evaluation(s) (remote), per 90 days; single, dual or multiple lead pacemaker
93295	Interrogation device evaluation(s) (remote), up to 90 days; single, dual or multiple lead ICD
93296	Interrogation device evaluation(s), (remote) per 30 days; implantable cardiovascular monitor system
93297	Interrogation device evaluation(s), (remote) per 30 days; implantable loop recorder system

3) Trans-telephonic Rhythm Strip Evaluations (TTM)

This code is used when an electrocardiographic rhythm strip is recorded both with and without a magnet applied over the pacemaker. It is also used when the rhythm strip is evaluated for heart rate and rhythm and atrial and ventricular sensing (if observed). In addition, the battery status of the pacemaker is determined by measurement of the paced rate on the electrocardiographic rhythm strip recorded with the magnet applied.

93293	Transtelephonic rhythm strip pacemaker evaluation(s) single, dual or multiple lead pacemaker, up to 90 days
--------------	---

4) Peri-procedural Programming Device Evaluations

In a big win for cardiology, new codes have been established to allow physicians to separately report the evaluation of PM or ICD to adjust settings prior to and after a surgery, procedure or test. No codes were previously available to report these services. They are also used when device system data are interrogated to evaluate lead(s), sensor (s) and battery and to review stored information, including patient and system measurements. In addition, physicians should use these codes when a device is programmed to a setting appropriate for surgery, procedure, or test as needed, and when a second evaluation and programming are performed after the surgery, procedure or test to re-establish the appropriate therapeutic settings post procedure.

93286	Peri-procedural device evaluation and programming; single, dual or multiple lead pacemaker
93287	Peri-procedural device evaluation and programming; single, dual or multiple lead ICD

5) Implantable Cardiac Monitors Implantable Cardiac Monitors (ICMs) are CIEDs that store cardiovascular physiologic data such as intracardiac pressure waveforms and other data in the device memory. However, instead of focusing only on heart rhythm, the hemodynamic and cardiovascular physiologic information stored in these devices is used as an aid in managing patients with chronic cardiac diseases such as heart failure. Use CPT 93290 to report an in-person interrogation of an ICM and CPT 93297 to report remote ICM interrogation.

6) Implantable Loop Recorders Implantable Loop Recorders (ILRs) are CIEDs that store in-device memory recordings of the heart rhythm and data derived from the cardiac rhythm. The data stored may be retrieved either in person or remotely. The ILR function may be the only function of the device, or it may be part of the pacemaker or implantable cardioverter defibrillator device. Use CPT 93291 for in-person ILR interrogation and CPT 93298 for remote services.

7) Mobile Cardiovascular Telemetry Mobile Cardiovascular Telemetry (MCT) continuously records the electrocardiographic rhythm from external electrodes placed on the patient's body. The system monitors the patient 24 hours a day via the wearable device as they continue with their normal daily routine. Periodically and as events occur, patient activity is automatically transmitted to a remote surveillance location. Physician analysis of the data is reported with CPT 93228. The surveillance center services are reported with CPT 93229.

Key Steps to Making the Transition to the New Cardiac Device Monitoring Codes

Successful implementation of the new cardiac monitoring codes requires careful planning and preparation. The following steps will be critical in helping practices make the transition to the new codes:

1) Identify your implementation team. This team will be a critical factor in the entire process. Start with identifying your team members. They might include a physician representative, device clinic staff, a holter/event monitoring representative, coders and billers, and perhaps Congestive Heart Failure (CHF) clinic and scheduling staff. Don't forget to keep IT in the loop. Once your team has been identified, it is critical to educate them about the changes, what to look for and the impacts (or potential impacts) on the practice. Some practices may want to create specialty "cheat sheets" on the changes.

2) Identify the services that your practice performs. Do you perform or are you planning to perform remote checks? If you provide remote services, do you provide the technical services as well? Do you have patients with devices that would qualify as an ICM? Do you perform or do you plan to incorporate MCT into your practice?

3) Complete a thorough review of your current billing practices and review your current budget. How are charges being submitted now? How will you handle an increase in the number of 30- and 90-day services? When setting your fee you'll need to consider implications of 30- or 90-day codes and keep in mind that CMS did not accept the full AMA recommended RVU on all codes. You'll also need to look at what changes will be needed for your billing forms/fee tickets. Are there implications for electronic medical record requirements? Will you want to track the

number of services actually rendered in a 90-day period? How will you ensure all billable services have been captured? In terms of the budget process, it is important to understand that the codes do not have a direct cross-walk to existing codes and this must be factored in when determining how you will conduct your financial analyses and forecasts.

4) Make sure your documentation is appropriate, accurate and accessible. Where do you keep your device check reports? Can you distinguish a remote service from an in-person interrogation? Review your reports for the key components of a programming evaluation versus an interrogation evaluation. Will you need to make any changes in your documentation? Are there implications to software that you may be using for device checks?

5) Review contracted rate implications. It is important to identify your top commercial payers and evaluate any contract implications. Do you have contracts that were negotiated per CPT code? Do you have contracts that “locked in” to a previous year of Medicare reimbursement?

6) Examine compensation models. Will your compensation model require that you track all services rendered? For example, the physician doing the first read of a 90-day service will probably be your billing provider. Do you need to credit the physician who may read other services in that 90-day period?

As with any major change, the ACC doesn’t have all the answers yet and there will likely be bumps in the road as practices adjust to the new systems. Practices are encouraged to meet early and often with their local Medicare carriers and other health plans as the changes take place. In addition, ACC regulatory affairs staff is on hand to assist with questions and issues. ACC staff continues to work with CMS for greater clarity and new items will be posted at www.acc.org and in *Cardiology* as appropriate. For more information, contact Brian Whitman at bwhitman@acc.org. For a comprehensive list of answers to frequently asked questions, visit www.acc.org and click on “regulatory.”

Codes by Device Type:

To facilitate use of the new CPT codes, the following chart groups the codes by device type together. This chart will help when determining which service is appropriate to bill.

	CPT Code		Comments
	93288	PM – Interrogation in person, – Single/dual/multi	Not billable in remote global days
	93279	PM - Programming device eval - Single	Separately billable in remote global days
	93280	PM - Programming device eval - Dual	Separately billable in remote global days
	93281	PM - Programming device eval - Multi	Separately billable in remote global days
	93286	PM - Peri-procedural - eval & program of device before or after a surgery, procedure, or test – single/dual/multi	Billed once for pre and once for post service
Phone 90 Day	93293	PM- Phone check , with & w/out magnet app, physician analysis, review/report, up to 90 days - single/dual/multi	
Remote 90 Day	93294	PM – Interrogation (remote) , up to 90 days – Single/dual/multi	
	93289	ICD – Interrogation in person – Single/dual/multi	Not billable in remote global days
	93282	ICD – Programming , Single	Separately billable in remote global days
	93283	ICD – Programming , Dual	Separately billable in remote global days
	93284	ICD – Programming , Multi	Separately billable in remote global days
	93287	ICD - Peri-procedural - eval & program of device before or after a surgery, procedure or test – single/dual/multi	Billed once for pre and once for post service
Remote 90 Day	93295	ICD - Interrogation (remote) , up to 90 days – Single/dual/multi	
	93290	ICM – Interrogation in person	Not billable in remote global period
Remote 30 Day	93297	ICM – Interrogation (remote) , up to 30 days	
	93285	Loop – Program (incl. retrieval of data, phys. review & interp and reprogramming)	
	93291	Loop – Interrogation in person	Not billable in remote global period
Remote 30 Day	93298	Loop – Interrogation (remote) , up to 30 days	
Technical Remote 90 Day	93296	PM or ICD – Interrogation (remote) , up to 90 days – single/dual/multi – technical	Can be billed by office along with interrogation code