



2013 EP Coding and Reimbursement
Frequently Asked Questions

CODING RESOURCES



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Disclaimer

The information contained in this guide is provided to assist you in understanding the reimbursement process. It is intended to assist providers in accurately obtaining reimbursement for health care services. It is not intended to increase or maximize reimbursement by any payer. We strongly suggest that you consult your payer organization with regard to local reimbursement policies. The information contained in this document is provided for information purposes only and represents no statement, promise or guarantee by Biosense Webster, Inc. concerning levels of reimbursement, payment or charge. Similarly, all CPT® & HCPCS codes are supplied for information purposes only and represent no statement, promise or guarantee by Biosense Webster, Inc. that these codes will be appropriate or that reimbursement will be made.

ABLATION PROCEDURES

Q. What changes have been made in CPT® 2013 for ablation procedures?

A. As a result of the Joint CPT / RUC screen for procedures inherently performed together, several changes have been made to bundle electrophysiological (EP) evaluation and intracardiac ablation procedures. As part of this restructuring, codes 93651 and 93652 (ablation services) were identified by CMS and the RUC as potentially misvalued since they were billed with EP studies greater than 75 percent of the time, which affects the RVUs assigned to the new codes.

2 DELETED CODES:

- 93651 – Ablation for treatment of supraventricular tachycardia
- 93652 – Ablation for treatment of ventricular tachycardia

5 NEW CODES:

- 93653 – Comprehensive EPS with atrial ablation, single focus
- 93654 – Comprehensive EPS with ventricular ablation, includes 3-D mapping, LV pacing & recording
- + 93655 – Ablate additional discrete arrhythmia focus
- 93656 – Comprehensive EPS with pulmonary vein isolation for Afib, includes transeptal access, LA pacing & recording
- + 93657 – Ablate additional left or right atrial focus for Afib

NO CHANGE:

- 93650 – AV node ablation

Q. How do the new ablation procedure codes compare with previous codes?

ABLATION FOR SVT / FLUTTER / WPW			
2012		2013	
Code	Descriptor	Code	Descriptor
93653	Comprehensive EP study with induction or attempted induction of arrhythmia	93653	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording, His recording with intracardiac catheter ablation of arrhythmogenic focus; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry
93651	Intracardiac ablation for treatment of supraventricular tachycardia		

ABLATION FOR VENTRICULAR TACHYCARDIA			
2012		2013	
Code	Descriptor	Code	Descriptor
93620	Comprehensive EP study with induction or attempted induction of arrhythmia	93654	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording, His recording with intracardiac catheter ablation of arrhythmogenic focus; treatment of ventricular tachycardia or focus of ventricular ectopy including intracardiac electrophysiologic 3-D mapping, when performed, and left ventricular pacing and recording, when performed
93622	... with left ventricular pacing & recording		
93652	Intracardiac ablation for treatment of ventricular tachycardia		
93613	Intracardiac 3-D mapping		

PULMONARY VEIN ISOLATION ABLATION FOR ATRIAL FIBRILLATION			
2012		2013	
Code	Descriptor	Code	Descriptor
93620	Comprehensive EP study with induction or attempted induction of arrhythmia	93656	Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with atrial recording and pacing, when possible, right ventricular pacing and recording, His bundle recording with intracardiac catheter ablation of arrhythmogenic focus, with treatment of atrial fibrillation by ablation by pulmonary vein isolation
93621	... with left ventricular pacing & recording		
93651	Intracardiac ablation for treatment of ventricular tachycardia		
93462	Intracardiac 3-D mapping		

Note: Unlike 93653 and 93654, the descriptor for 93656 does not specify atrial pacing and recording as “right” atrial; therefore, 93621 is also a bundled procedure, as noted in CPT™ parenthetical instruction.

ADD-ON PROCEDURES			
2012		2013	
Code	Descriptor	Code	Descriptor
N/A	No code – bundled into primary ablation procedure	93655	Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia (List separately in addition to code for primary procedure)
N/A	No code – bundled into primary ablation	93657	Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation (List separately in addition to code for primary procedure)

THERMOCOOL® Navigation Catheters are approved for drug refractory recurrent symptomatic paroxysmal atrial fibrillation, when used with CARTO® Systems (excluding NAVISTAR® RMT THERMOCOOL® Catheter).

Q. When would one of the ablation “add-on” procedures be reported?

A. There are two new codes for additional ablation performed in combination with a base procedure. These codes would be used in different situations:

93655 Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia (List separately in addition to code for primary procedure)

Code 93655 is reported in combination with any of the three “primary” ablation services, when two distinctly different arrhythmia foci are treated. This could represent:

- two different atrial pathways,
- two different ventricular mechanisms,
- one atrial and one ventricular arrhythmia, or
- a distinct arrhythmia in conjunction with paroxysmal atrial fibrillation, such as atrial flutter.

93657 Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation (List separately in addition to code for primary procedure)

Code 93657 is reported only in combination with 93656. If, subsequent to completion of pulmonary vein isolation, diagnostic measurements indicate that there are still remaining triggers for atrial fibrillation, then 93657 for further ablation of these site(s) is additionally reported.

Q. May an add-on ablation code be reported more than once during a case?

A. The CMS Medically Unlikely Edits (MUEs) indicate that 93655 is intended to be reported only once per case. However, 93657 does not have an identified limit on the number of units per day, and could be reported more than once if multiple additional atrial fibrillation triggers are identified and ablated following pulmonary vein isolation.

Q. If both atrial and ventricular tachycardia ablations are performed in a single setting, how is this reported?

A. Only one primary ablation package procedure may be reported in a single case – 93653 and 93654 may not be reported together. Therefore, the first ablation could be reported with either 93653 or 93654, and the distinct mechanism would be reported as 93655.

Q. Can an EP bill 93655 with an atrial fibrillation procedure? Can they bill it alone? Can they bill it with 93657?

A. New code 93655 can be billed in addition to any of the primary ablation services — 93653 (atrial), 93654 (ventricular), or 93656 (atrial fibrillation, pulmonary vein isolation), for treatment of a distinct arrhythmia focus. It cannot be billed stand-alone. In theory, 93655 could be reported in addition to 93657 (eg, it is not contradictory to 93657), but 93657 must be billed in addition to 93656.

Q. Ablation code revisions (93653-93657) now all include comprehensive EP study; how should one code if physician does not report complete study, but only limited sites (eg, only atrial or only ventricular)?

A. If all the elements of a comprehensive study which are included in the code descriptor are not done, then modifier 52, reduced services, is potentially appropriate. A procedure may be reported with modifier -52 when it is reduced at the physician’s discretion; it should be noted that payor policy regarding use of modifier -52 on these codes may vary, and reporting by this method may lead to a request for documentation.

Q. What if documentation describes ablation & mapping only, but there is no real discussion of any diagnostic EP study?

A. The general assumption, incorporated into these new codes, is that a physician needs to perform a diagnostic EP study in order to identify the need and location for ablation. It may be appropriate to discuss with the physician options for documentation improvement, and to confirm the full extent of services performed.

ELECTROPHYSIOLOGY STUDIES

Q. The physician did not complete all of the components for a Comprehensive EP Study. How would this be reported? Would they bill each procedure separately?

A. A comprehensive EP study (93619) is essentially comprised of 5 services, each of which does have a defined CPT® code available if performed individually:

- 93600 – Bundle of His recording
- 93602 – Intra-atrial recording
- 93610 – Intra-atrial pacing
- 93603 – Right ventricular recording
- 93612 – Right ventricular pacing

Comprehensive study 93620 adds the sixth element of induction of arrhythmia (93618).

If only 2 areas of the heart are evaluated, then the individual service codes should be reported by preference. For example, if the patient's condition is of atrial origin, and no pacing or recording is performed in the right ventricle, then use codes 93600, 93602, and 93610 (each with modifier -26 for the physician claim).

Alternatively, the comprehensive study code 93619 or 93620 may be reported with a modifier -52 as a reduced service. This may be preferable in situations where add-on procedures are also performed, such as:

- 93621 – Left atrial pacing and recording
- 93622 – Left ventricular pacing and recording
- 93623 – Programmed stimulation and pacing after IV drug infusion

These services may only be reported in conjunction with the primary procedure code 93620 - comprehensive study with induction of arrhythmia. 93623 may be reported with 93619 or 93620. They cannot be reported with the individual service codes 93600 - 93612.

Q. Due to an initially presenting arrhythmia (eg, atrial fibrillation or flutter), it was not possible to perform right atrial pacing prior to ablation. However, pacing and recording of the left atria via the coronary sinus were performed and, once the arrhythmogenic focus was mapped and ablated, programmed stimulation and pacing was performed in an attempt to induce the arrhythmia. How can the services described by 93621 and 93623 be captured?

A. As described in the scenario above, to use the electrophysiology (EP) add-on codes, a base code must first be reported, and if all the elements are not done, then modifier 52, Reduced services, is appropriate.

The 2013 ablation codes include comprehensive study in their definitions. Atrial flutter ablation would be reported as 93653, while atrial fibrillation ablation of pulmonary veins would be 93656. The descriptor for code 93656 states, "with atrial recording and pacing, when possible", which allows reporting in cases when this is not possible. Code 93653 does not include the language "when possible", and so is potentially less flexible.

However, it is usually proper to perform a complete study once a sinus rhythm is obtained after cardioversion or ablation for atrial flutter and fibrillation. This is to ensure that there is not a hidden accessory pathway or another problem. If atrial and ventricular pacing is done before or after the ablation, the complete electrophysiologic study is supported.

Q. The physician attempted to induce the patient's arrhythmia during the study, but was unable to reproduce it in the lab. Does this have to be reported as 93619?

A. Whether the induction of arrhythmia is successful is irrelevant, because the code describes the attempt at induction, not the success of the procedure, and supports the use of code 93620.

Q. Is it appropriate when performing AV node ablation, 93650, to also bill some EP study component codes such as 93602, 93610, 93600, and possibly mapping codes 93609 or 93613, if the codes are documented in the report?

A. These services are not bundled, so if documentation supports that they (a) have been performed and (b) are clinically indicated and medically necessary, then they may be reported in combination with the AV node ablation.

Q. For a diagnostic EP study without ablation, how can we code a bi-atrial study (without ventricular pacing/recording)?

A. This is reported as 93620 with add-on code 93621; and one would also report the transseptal puncture code (93462), if this is performed. However, if documentation discusses findings of atrial sites only, comprehensive study may be more appropriately reported with modifier -52. A comprehensive study code may be reported with modifier -52 when it is reduced at the physician's discretion; it should be noted that payor policy regarding use of modifier -52 on these codes may vary, and reporting by this method may lead to a request for documentation.

Confirm with physician and via ancillary documents for complete information before assigning codes or assuming study is reduced. Documentation improvement could include:

Prompts for Narrative Input of Data	Tables			
"Quad was advanced to the right atrium, His position, and RV apical position. HA interval of ____, HV interval of ____, PR interval of ____, QRS duration of ____, QT interval of ____, AV block cycle length at baseline was ____."	R-R		QT	
	PR		AH	
	QRS		HV	
	AV block cycle			
	Slow pathway ERP			
	Fast pathway ERP			

Q. What is the correct CPT® code for rapid atrial pacing to terminate atrial flutter?

A. Rapid atrial pacing, sometimes termed burst pacing or overdrive pacing, may be reported in different ways depending upon technique:

- If pacing is performed via the electrodes of an existing pacemaker:
 - 93724** Electronic analysis of antitachycardia pacemaker system (includes electrocardiographic recording, programming of device, induction and termination of tachycardia via implanted pacemaker, and interpretation of recordings)
- If pacing is performed using externally placed electrodes:
 - 92953** Temporary transcutaneous pacing
- If pacing is performed during a catheter-based EP study, then it is included in the description of 93620.

Q. Why would an electrophysiology service be denied?

A. There are many reasons why a service could be denied by an insurer:

- Certain procedures are designated add-on codes per CPT® definition, and may only be reported in conjunction with a primary procedure – it may not be reported "stand-alone." EP examples include mapping (93609 or 93613), IV drug study (93623), left atrial or ventricular pacing and recording (93621 and 93622), and intracardiac echo-cardiography (93662).
- CPT® may indicate in a parenthetical instruction that a procedure may only be reported when in conjunction with other specified services. Examples relevant to EP services include:
 - Mapping (93609 or 93613) must be reported in conjunction with 93620 or 93653; it is also appropriate with 93656;
 - Left atrial (93621) pacing and recording must be reported in conjunction with 93620 – it may also be reported with 93653;
 - Left ventricular (93622) pacing and recording must be reported in conjunction with 93620 – it may also be appropriate with 93653 or 93656;

- IV drug study (93623) must be reported in conjunction with 93619 or 93620 – it may also be reported with ablation codes 93653, 93654, and 93656, but there are limitations on circumstances, which are discussed further below;
- Intracardiac echocardiography (93662) must be reported in conjunction with 93621, 93622, 93653, 93654 or 93656;
- Transseptal puncture (93462) must be reported in conjunction with 93653 or 93654.

If none of these identified procedures are also on the claim, then the ancillary procedure will likely be denied.

The 2013 CPT® changes have several possible discrepancies or inconsistencies in the instructional notes. For example, the introductory section discussing ablation references reporting 93622 and 93623 with 93656; however, the parenthetical notes following 93622 and 93623 do not mention coding in conjunction with 93656, but only with 93620. Similarly, the note following 93621 references reporting with 93620; however, it is not identified as bundled into 93653 in the notes following this ablation code, nor is 93621 included in 93653 according to the CCI.

The first quarter 2013 National Correct Coding Initiative (CCI) includes a bundling edit of 93623 into all of the new ablation package codes, although a modifier is permitted to override when appropriate. The CCI Chapter Notes provide the following information:

“CPT code 93623 (programmed stimulation and pacing after intravenous drug infusion) is an add-on code that may be reported per CPT Manual instructions only with CPT codes 93619 or 93620 (comprehensive electrophysiologic evaluation). CPT code 93623 should not be reported for injections of a drug with stimulation and pacing following an intracardiac catheter ablation procedure (e.g., CPT codes 93650-93657) to confirm adequacy of the ablation. Per CPT Manual instructions, CPT code 93623 is not intended to be reported with the intracardiac catheter ablation procedure codes, and confirmation of the adequacy of ablation is included in the intracardiac catheter ablation procedure.”

Programmed stimulation with IV drug (93623) which is performed preceding the ablation, as part of the diagnostic evaluation of the patient rather than to confirm adequacy of the ablation, does not appear to fall under this limitation, and modifier -59 would be appropriate.

It is suggested that the CCI and the AMA website be monitored for updates, as further clarification may be forthcoming.

- Individual payors may have guidelines related to a given procedure which more specifically indicate cover age requirements – such as a list of approved diagnosis codes, frequency, submission of documentation, or other criteria.

It is important to understand and keep abreast of individual payor coverage policies. While a code may exist to describe a procedure, this is no guarantee that a payor will cover it. The FDA has approved devices which some payors still consider ‘investigational’, and may not reimburse when used, even for performance of an otherwise covered service – or may have stringent requirements for authorization, such as specific energy source, clinical indication, or other more narrow limits or interpretation.

Q. For an inpatient case, what are the ICD-9 codes that comprise the MS-DRG 250?

A. MS-DRGs 250 and 251 are defined as “Percutaneous Cardiovascular Procedure without Coronary Artery Stent”, and are the MS-DRGs most commonly related to electrophysiology procedures. MS-DRG 250 is with MCC (major complication or comorbidity); MS-DRG 251 is without MCC. In addition to several other percutaneous coronary procedures in these categories, the electrophysiology procedures which may cause an admission to be assigned to one of these MS-DRGs are:

- 37.26** Catheter based invasive electrophysiologic testing (eg, diagnostic EP study)
- 37.27** Cardiac mapping
- 37.34** Excision or destruction of other lesion or tissue of heart, endovascular approach (eg, transcatheter ablation)

Q. What diagnoses constitute an MCC, such that the admission is assigned to MS-DRG 250?

A. A list of all MCCs is included in the Medicare Inpatient Prospective Payment System Final Rule, which is published each year on or about August 1st, effective for discharges October 1st and later. This rule and the associated data tables are available at the CMS website at www.cms.gov:

- Select “Medicare”;
- Scroll down to “Medicare Fee-for-Service Payment”, select “Acute Inpatient PPS”;
- Select “FY 2013 IPPS Final Rule Home Page” at left;
- Select as desired: FY 2013 Final Rule and Correction Notices, Data Files, and Tables

For 2013, the MCC and CC diagnosis codes are included in Tables 6I-6J -- MCCs are Table 6I. MCCs listed include secondary diagnoses such as: tuberculosis, pneumonia, and certain other infectious diseases; diabetes mellitus with ketoacidosis, hyperosmolarity, or coma; acute MI; endocarditis and myocarditis; ventricular arrhythmias; cardiac arrest; acute or acute on chronic heart failure; stroke; arterial dissections; acute respiratory failure; acute kidney failure or end stage renal disease; cardiogenic and other sepsis / septic shock; and a wide range of fractures and other traumatic injuries.

Note that these diagnoses typically reflect a significant increase in patient risk of morbidity or mortality, and documentation of diagnoses needs to be as specific as possible to capture the intensity of the manifestation.

Examples of Vague Language	More Specific Documentation Which May Affect DRG Assignment
Tachycardia	Specific type of tachycardia
Diabetes poorly controlled	Uncontrolled diabetes, specific manifestations
Respiratory insufficiency	Respiratory failure, and acute vs. chronic
CHF or EF 35%	Systolic vs. diastolic heart failure, and acute vs. chronic
NA = 120	Hyponatremia, and cause if known
Renal insufficiency	Severity of chronic kidney disease, or acute failure
Obesity	Morbid obesity, and Body mass index

Additionally, the principal diagnosis (that primarily responsible for necessitating the admission) cannot also be an MCC – CCs and MCC are secondary diagnoses which increase the complexity of managing the admission for the principal diagnosis. There are also certain code pairs which are considered too similar to one another, and therefore cannot be CCs or MCCs.

MAPPING

Q. What is mapping?

A. Mapping is a distinct procedure performed in addition to a diagnostic electrophysiologic or ablation procedure. When a tachycardia is induced, the site of tachycardia origination or its electrical path through the heart is often depicted by mapping. Mapping creates a multidimensional depiction of a tachycardia by recording multiple electrograms obtained sequentially or simultaneously from multiple catheter sites in the heart. Depending upon the technique, a mapping catheter may be repositioned from point-to-point within the heart, allowing sequential recording from the various sites to construct maps. Other types of mapping catheters allow simultaneous recording from many electrodes on the same catheter and computer-assisted three dimensional (3-D) reconstruction of the tachycardia activation sequence.

Q. What code is used to report mapping?

A. There are two CPT® codes which describe mapping:

- + **93613** Intracardiac electrophysiologic three-dimensional (3-D) mapping (List separately in addition to code for primary procedure)
- + **93609** Intraventricular and/or intra-atrial mapping of tachycardia site(s) with catheter manipulation to record from multiple sites to identify origin of tachycardia (List separately in addition to code for primary procedure)

Q. What is the difference between 93609 and 93613?

A. In standard mapping (93609), the mapping catheter is moved from point to point to record endocardial activation during tachycardia or during sinus rhythm (voltage map identifying scar) to identify an early point of activation, mid-diastolic potential, Kent potential, and/or similar paced maps. The map is displayed and analyzed.

For 3-D mapping (93613), requires use of specialized catheters and an advanced three-dimensional, computer-assisted mapping system to localize the arrhythmia origin. The system is calibrated, and recordings are made during sinus rhythm to identify normal activation and the location of scar and during each distinct tachycardia. The computer-generated map is displayed, modifications in the computer parameters and display are performed, and the tachycardia origin is identified. The ablation catheter is moved to the point of early activation localized by the mapping system to identify a mid-diastolic potential, Kent potential, and/or similar paced maps. As this technology has matured, it has become the technique of choice by many electrophysiologists.

Q. Can I report both 93609 and 93613 in the same case? Also, if the physician does mapping of the left heart as well as the right, do we bill for both?

A. No. Do not report standard mapping in addition to 3D mapping – report only 93613. Either mapping code may be reported only once per case.

Q. Parenthetical notes following 93613 states to report in conjunction with 93620, 93653, and not to report with 93654 - can it be reported with 93656?

A. Yes. 93656 may be reported with either 93609 (standard mapping) or 93613 (3D mapping).

Q. How is mapping reimbursed?

A. PHYSICIAN SERVICES: Code 93613 or 93609 are reported as a distinct line item when performed. Mapping is a designated add-on service per CPT®, and is considered a distinct procedure performed in conjunction with a diagnostic electrophysiology procedure. Mapping is bundled into the ventricular ablation procedure 93654, but may be reported in addition to atrial ablation 93653 or with pulmonary vein ablation 93656. Although the parenthetical notes following the mapping codes do not reference 93656, this has been confirmed as appropriate with the AMA. Add-on codes are typically exempt from multiple procedure payment reduction, and so should be reimbursed at the full fee schedule amount identified by the payor.

HOSPITAL OUTPATIENT SERVICES: For the outpatient facility claim, there is no additional reimbursement for mapping. 93609 and 93613 are not assigned to an APC, but are considered ancillary to the primary procedures. Status indicator is “N” on these procedures; no separate APC payment is made for mapping.

HOSPITAL INPATIENT SERVICES: ICD-9-CM procedure code 37.27 is reported for any method of cardiac mapping, but typically does not affect MS-DRG assignment or change the payment amount. There is no additional payment for use of mapping. Reimbursement will be driven by the principal procedure (eg, ablation) and principal diagnosis determining the MS-DRG.

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TRANSSSEPTAL ACCESS

Q. How is a transseptal puncture reported?

A. Beginning in 2011, a new add-on CPT® code was introduced to report transseptal access:

+ **93462** Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure)

(Use 93462 in conjunction with 93452, 93453, 93458-93461, 93653, 93654)

Transseptal puncture is included in the code descriptor for 93656, and so 93462 may not be reported in combination with 93656.

Q. Do we have to perform a full left heart hemodynamic assessment (eg, left ventricular pressures) in order to report 93462?

A. No, although some pressure measurement and/or contrast injection may be performed to confirm successful access, this is not a required component of the code.

The new code, 93462, added in 2011, does not require or describe the hemodynamic assessment, but is only the puncture access service. Although used with ablation for EP procedures, the parenthetical states to also report in conjunction with a range of cardiac catheterization codes which describe left heart catheterization – the hemodynamic study – so 93462 would not capture or include that service.

Q. Can we charge for an atrial angiogram when we perform a transseptal puncture?

A. If a full diagnostic atrial angiogram is performed, and documentation supports that it is clinically indicated, then it may potentially be reported. However, it is more likely that a small amount of contrast is injected to confirm completion of transseptal access, rather than to evaluate atrial function, in which case it is included in 93462.

Q. Can we still use CPT® code 93462 for a transseptal puncture if they are not going via the right heart?

A. The definition of 93462 states that it reflects access to the left heart by either by transseptal puncture (eg, starting from the right heart) **or** by a transapical puncture.

Q. Do you need a -26 modifier for 93462?

A. No, the concept of technical and professional component is not applicable to this code.

Q. If the physician performs more than one transseptal puncture in the same procedure, can he bill for it more than once?

A. No, the code may be billed only one time per case.

Q. Can the physician report 93462 additionally whenever left atrial pacing and recording (93621) or left ventricular pacing and recording (93622) is performed?

A. Code 93462 may be reported in conjunction with ablation procedure codes 93653 or 93654; it is included in the definition of 93656. CPT® instructional notes do not indicate that 93462 may be reported in conjunction with a diagnostic electrophysiology study in the absence of ablation, but specifically references only 93653 and 93654 within the electrophysiology codes; therefore, it should not be expected that payors would consider it appropriate to report except in conjunction with 93653 or 93654.

Q. Is CPT® 93462 an add-on code?

A. Yes, it is a designated add-on code, as indicated by the symbol “+” preceding the code. Add-on codes are always performed in conjunction with a primary service or procedure and should not be reported as a stand-alone code.

Q. How is the transseptal access procedure reimbursed?

A. PHYSICIAN SERVICES: Code 93462 is reported as a distinct line item when performed with 93653 or 93654; it may not be reported in addition to 93656. Add-on codes are typically exempt from multiple procedure payment reduction, and so should be reimbursed at the full fee schedule amount identified by the payor.

HOSPITAL OUTPATIENT SERVICES: Code 93462 is also additionally reported with 93653 or 93654, and should lead to reimbursement under APC 0080. Note that code 93656 includes transseptal access in its descriptor, and therefore 93462 may not be reported additionally. The descriptor for APC 0080 is “Diagnostic Cardiac Catheterization”; however, it is important to remember that these titles do not necessarily reflect everything within an APC category, or limit its applicability.

APC 0080 is reimbursed separately from the electrophysiology composite APC 8000, when it is reported in conjunction with 93653 or 93654. APC 0080 has a status indicator of “T”, which means that the hospital outpatient reimbursement for this procedure is subject to a 50% multiple procedure payment reduction from the fee schedule rate. For commercial plans reimbursement will vary by contract, which may or may not utilize the APC payment methodology.

HOSPITAL INPATIENT SERVICES: There is not a similar ICD-9-CM procedure code for transseptal access. Reimbursement will be driven by the principal procedure and principal diagnosis determining the MS-DRG, and transseptal access has no effect on MS-DRG assignment. There is no additional payment for transseptal access.

ECHOCARDIOGRAPHY (TEE AND ICE)

Q. What types of echocardiogram services might be provided in conjunction with electrophysiology procedures?

A. The most likely services will be transesophageal echo (TEE) or intracardiac echo (ICE) procedures.

Q. What codes are used to report transesophageal echocardiogram (TEE)?

A. Transesophageal echocardiography has two families of codes — standard “adult” patients, and congenital cardiac anomalies. The usual service codes are:

93312	Transesophageal echocardiogram; complete
93313	placement of transesophageal probe only
93314	image acquisition, interpretation and report only

93312 is used most often. Codes 93313 and 93314 are reported on the infrequent situation where the physician obtaining and interpreting the image is different from the person who places the transesophageal probe — these codes were introduced into CPT® when the service was a new technology, and sometimes the cardiologist was not comfortable with this placement and asked a gastroenterologist or anesthesiologist to place the probe. Also, if an anesthesiologist has been using TEE for intraoperative monitoring (93318) and observes something of concern, he/she may request a cardiologist to review and interpret the TEE diagnostically, then 93314-26 would apply for the cardiologist, as the probe is already in place.

When the procedure is performed in a facility setting, the physician would report with modifier –26 (professional component) on either 93312 or 93314, indicating interpretation without ownership of the equipment. Modifier –TC (technical component), indicates the equipment and supplies but not interpretation, is most often used by independent diagnostic testing facilities [IDTFs]; hospitals usually report without modifiers for APC reimbursement.

For patients with congenital cardiac anomalies, TEE codes are:

93315	Transesophageal echocardiogram for congenital cardiac anomalies; complete
93316	placement of transesophageal probe only
93317	image acquisition, interpretation and report only

These procedures would more typically be related to evaluations for patients who subsequently undergo percutaneous atrial or ventricular septal defect closure procedures.

Q. Why would a transesophageal echo be performed with an EP procedure?

A. Transesophageal echo may be commonly performed in conjunction with an atrial fibrillation ablation procedure, to ensure patient does not have left atrial appendage thrombus present prior to performing the case. If a full evaluation of cardiac structures is not performed and documented, but only evaluation of this single issue, then it may be appropriate to report as a reduced study with modifier -52. Although transthoracic echos have a CPT® code option for limited study, there is not one for TEE.

Q. Is TEE before the case billable as a separate procedure or is it lumped into the total charges for an ablation?

A. Transesophageal echo is not defined as included in the ablation procedure, and may be reported additionally. However, please note that a formal written interpretation report is required for any diagnostic echocardiography procedure, distinct from the EP service report. If no formal interpretation report is documented, then the TEE is not distinctly reported.

Q. How are TEE procedures paid?

A. **PHYSICIAN SERVICES:** Transesophageal echocardiography (TEE) may be reimbursed separately from an EP procedure when a distinct diagnostic TEE is performed. This would be reported with either 93312, 93314, 93315, or 93317, as appropriate. These physician services are coded as facility-based procedures (eg, performed in a hospital inpatient or outpatient setting), which would be reported with modifier -26. Please note that a formal written interpretation report is required for this procedure, separate from the EP service report.

If transthoracic or transesophageal ultrasound is used solely for guidance, it is not separately reportable. Physicians should not report CPT® codes 76942, 76998, 93318, or other ultrasound procedural codes if the ultrasound procedure is performed for guidance during one of the procedures described by CPT® codes 93600 - 93662.

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HOSPITAL OUTPATIENT SERVICES: Transesophageal echocardiography (TEE) may be reimbursed separately from an EP procedure when a distinct diagnostic TEE is performed. Code 93312 is assigned to APC 270; code 93315 is assigned to APC 269 – both TEE procedures have an APC status of “S” (Significant procedure – APC paid separately, not subject to multiple procedure discount)

HOSPITAL INPATIENT SERVICES: ICD-9-CM procedure code 88.72 describes either transthoracic or transesophageal ultrasound. Echocardiography typically does not affect MS-DRG assignment, as it would not be the principal procedure for an admission. There is no additional payment for use of TEE in conjunction with EP procedures. Reimbursement will be driven by the principal procedure (eg, ablation), and principal and secondary diagnoses determining the MS-DRG.

Q. How is intracardiac echocardiography (ICE) reported?

A. Intracardiac echocardiography has only one code, which might be reported in conjunction with either ablation or septal defect closure procedures, or to guide transseptal access.

93662 Intracardiac echocardiography during therapeutic/diagnostic intervention

The CPT® definition of the service also indicates it may be reported when used for purely diagnostic evaluation, without ablation or other treatment at the same session - report in conjunction with 92987, 93453, 93460-93462, 93532, 93580, 93581, 93621, 93622, 93653, 93654, 93656 as appropriate. However, payor policy may vary on coverage for diagnostic-only situations.

In a facility setting, the physician would report ICE with modifier –26 (professional component), indicating interpretation without ownership of the equipment.

Q. When physicians use an ICE catheter that is capable of both 3D mapping and intracardiac echocardiography, can they still bill for both 93613 and 93662?

A. As long as both procedures are being performed, it is appropriate to bill for both – separate devices are not required. Please note that these are both add-on codes and would need to be billed with a primary procedure, as well.

Q. How are ICE procedures paid?

A. **PHYSICIAN SERVICES:** Intracardiac echo (ICE) may be reimbursed separately from an EP procedure when performed, and is reported with 93662-26. Intracardiac echo may be reported when used for guidance to perform another procedure, such as a transseptal puncture, or for diagnostic purposes.

HOSPITAL OUTPATIENT SERVICES: Intracardiac echo (ICE) is not assigned to an APC for the hospital – it is considered ancillary to the primary procedures, and no additional payment will be made by Medicare or other payors who follow APC methodology.

HOSPITAL INPATIENT SERVICES: ICD-9-CM procedure code 37.28 is reported for intracardiac echocardiography. ICE typically does not affect MS-DRG assignment, as it would not be the principal procedure for an admission. There is no additional payment for use of ICE in conjunction with EP procedures. Reimbursement will be driven by the principal procedure (eg, ablation), and principal and secondary diagnoses determining the MS-DRG.

Q. How is a transesophageal temperature probe reported?

A. There is no distinct CPT or ICD-9-CM procedure code for insertion of an esophageal temperature probe. Esophageal temperature monitoring of a patient during an ablation procedure is included in the primary procedure; when performed by an anesthesiologist, it is included in the primary anesthesia service.

HCPCS CODES (C-CODES)

Q. What are C-codes, and when would they be used?

A. C-codes are part of the HCPCS Level II coding system, and are used to describe various supplies and devices which may be used in a case, such as particular types of electrode catheters.

C-codes may only be reported on outpatient hospital facility claims – they do not apply to inpatient cases or to physician billing.

Q. How do C-codes affect reimbursement?

A. No additional reimbursement will be provided to the facility for a C-code on an individual claim. However, Medicare uses C-codes to track device cost information for future APC rate-setting purposes, so they have an indirect and statistical impact on future payment rates.

To insure this information is received, a number of CPT® procedure codes have been “linked” to one or more C-codes, without which the procedure presumptively cannot be performed. Reporting the appropriate C-code is mandatory and CMS will reject a hospital claim if the appropriate tracking code is not identified on the claim when a device-dependent procedure is performed.

Q. Does every device used have to be reported with a C-code?

A. No, not all devices will have an associated C-code. If none is defined, then the facility will assign its own internal charge code, associated with an appropriate revenue code, to record the cost of the device or supply.

For example, please note that there is no C-code for the REFSTAR® Catheter with QWIKPATCH® External Reference Patch, COOLFLOW® Pump Tubing, PERRY® Exchange Dilator, or HEARTSPAN® Transseptal Needle, MOBICATH™ Transseptal Needle as they are considered by CMS to be accessory items.

Q. How do I find a C-code for the device which has been used?

A. The HCPCS Level II codes are updated annually, and a current list may be obtained from CMS or several private publishers. These codes tend to be fairly generic and are intended to reflect a broad range of devices with similar capabilities.

- C-Codes for Biosense Webster products may be found:
 - On line at <http://www.afiballiance.com/reimbursement.php>.
Enter Biosense Webster product number into On-line C-Code Finder.
 - 2013 Reimbursement and Coding Guide for Physicians and Facilities.
Request a guide from your Biosense Webster territory manager or download a copy at <http://www.afiballiance.com/reimbursement.php>
- For other products, review the HCPCS Level II codebook or contact the manufacturer.

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MISCELLANEOUS

Q. Is it appropriate to charge cardioversion (92960) during an AFIB ablation when the patient enters the procedure room in normal sinus rhythm (NSR) but during the procedure AFIB is induced.

A. It is generally not considered appropriate to report cardioversion for a patient in whom an arrhythmia has been induced as part of an EP study.

However, if the patient had initially presented in active atrial fibrillation or other arrhythmia, it may be necessary to cardiovert the patient prior to the study, so that a baseline may be obtained. In this instance, it is considered distinct, and 92960 would be reported additionally, with modifier -59 to indicate a separate procedure.

Q. If there are CCI edits, can we submit using the codes anyway?

A. Any CCI edits must be honored – submission of two codes which are identified as bundled or mutually exclusive will lead to a denial. Sometimes exceptions can be identified with a billing modifier, if appropriately performed and supported by documentation. The CCI code pair will identify if exceptions are made to allow both codes for a distinct and separately performed procedure with a superscript modifier indicator of "1". However, edits should not be routinely overridden.

Q. How do we code for percutaneous patent foramen ovale (PFO) and septal defect closures?

A. If septal defect closure is performed via a transcatheter / percutaneous approach, appropriate CPT® codes would be:

93580 Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant

93581 Percutaneous transcatheter closure of a congenital ventricular septal defect with implant

Both of these codes include right heart catheterization and any right atrial or ventricular angiography, so many of the cardiac catheterization services are bundled.

Intracardiac echocardiography guidance (**93662**) may be reported additionally.

The ICD-9-CM procedure codes for septal defect closures are differentiated by anatomic site, and either open or closed. Percutaneous repairs would therefore be reported as one of the following, with intracardiac echocardiography as a secondary procedure:

35.52 Repair of atrial septal defect with prosthesis, closed technique

35.55 Repair of ventricular septal defect with prosthesis, closed technique

37.28 Intracardiac echocardiography

Q. Does it matter what order the procedure codes are listed on the claim?

A. It is generally recommended that the primary / most significant procedure be listed first, and then additional or ancillary services in descending order. However, most payors employ software which applies their payment policies and reimburse accordingly, regardless of the sequence in which the codes appear on a physician or outpatient claim.

For hospital inpatient claims, however, it is necessary to identify the principal procedure, as well as principal diagnosis, in specific fields. The principal procedure is the procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or which is necessary to take care of a complication.

PROCEDURE VIGNETTES

HOSPITAL OUTPATIENT SERVICES

EP procedures may be performed as either inpatient or outpatient services. If outpatient, the hospital reports CPT® codes and is reimbursed by Ambulatory Payment Classifications (APCs). Sometimes multiple APC payments may be allowed, at other times services are packaged into a composite (additional APC discussion is found in the Resources section). Physician CPT® codes are reimbursed individually.

Atrial Fibrillation Ablation, Pulmonary Vein Isolation	2012 CPT® Codes	2013 CPT® Codes	2013 APC Status	2013 APC
Transesophageal echocardiogram (eg, to evaluate for possible thrombus prior to procedure); comprehensive diagnostic EP study with induction of arrhythmia; left atrial pacing and recording; transseptal puncture; 3-D mapping; intracardiac ultrasound; left atrial pulmonary vein isolation ablation – for treatment of drug refractory paroxysmal atrial fibrillation	93312-26	93312-26	S	0270
	93620	93656	Q3	8000
	93642			
	93621			
	93651	93613	N	N/A
	93662	93662	N	N/A

Atrial Fibrillation Ablation, Extensive	2012 CPT® Codes	2013 CPT® Codes	2013 APC Status	2013 APC	
Transesophageal echocardiogram (eg, to evaluate for possible thrombus prior to procedure); comprehensive diagnostic EP study with induction of arrhythmia; left atrial pacing and recording; transseptal puncture; 3-D mapping; intracardiac ultrasound; left atrial pulmonary vein isolation ablation – for treatment of drug refractory paroxysmal atrial fibrillation; additional linear or focal left or right atrial ablation(s) for remaining atrial fibrillation at two distinct triggering sites	93312-26	93312-26	S	0270	
	93620	93656	Q3	8000	
	93642				
	93621				
	93651	N/A	93657 x2	N	N/A
	93613	93613	N	N/A	
	93662	93662	N	N/A	

Atrial Flutter or Tachycardia Ablation, Right Sided	2012 CPT® Codes	2013 CPT® Codes	2013 APC Status	2013 APC
Comprehensive EP study with induction of arrhythmia; 3-D mapping; isoproterenol infusion; ablation of atrial tachycardia or atrial flutter	93620	93653	Q3	8000
	93651	93613	N	N/A
	93613			
	93623	93623	N	N/A

Atrial Flutter or Tachycardia Ablation, Left Sided	2012 CPT® Codes	2013 CPT® Codes	2013 APC Status	2013 APC
Comprehensive EP study with induction of arrhythmia; left atrial pacing and recording; transseptal puncture; 3-D mapping; isoproterenol infusion; ablation of atrial tachycardia or atrial flutter	93620	93653	Q3	8000
	93651	93621	N	N/A
	93621			
	93462	93462	T	0080 (@ 50%)
	93613	93613	N	N/A
	93623	93623	N	N/A

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Atrial Flutter or Tachycardia Ablation, Dual Mechanisms, Right Sided	2012 CPT® Codes	2013 CPT® Codes	2013 APC Status	2013 APC
Comprehensive EP study with induction of arrhythmia; 3-D mapping; isoproterenol infusion; ablation of atrial tachycardia or atrial flutter; atrial ablation for identified distinct arrhythmia mechanism	93620	93653	Q3	8000
	93651			
	N/A	93655	N	N/A
	93613	93613	N	N/A
	93623	93623	N	N/A

Atrial Fibrillation + Atrial Flutter Ablation	2012 CPT® Codes	2013 CPT® Codes	2013 APC Status	2013 APC
Transesophageal echocardiogram (eg, to evaluate for possible thrombus prior to procedure); comprehensive diagnostic EP study with induction of arrhythmia; left atrial pacing and recording; transseptal puncture; 3-D mapping; intracardiac ultrasound; left atrial pulmonary vein isolation ablation – for treatment of drug refractory paroxysmal atrial fibrillation; additional ablation for atrial flutter	93312-26	93312-26	S	0270
	93620	93656	Q3	8000
	93642			
	93621			
	93651	93655	N	N/A
	N/A			
	93613			
	93662			

Extended Atrial Fibrillation Ablation + Atrial Flutter Ablation	2012 CPT® Codes	2013 CPT® Codes	2013 APC Status	2013 APC
Transesophageal echocardiogram (eg, to evaluate for possible thrombus prior to procedure); comprehensive diagnostic EP study with induction of arrhythmia; left atrial pacing and recording; transseptal puncture; 3-D mapping; intracardiac ultrasound; left atrial pulmonary vein isolation ablation – for treatment of drug refractory paroxysmal atrial fibrillation; additional linear or focal left or right atrial ablation(s) for remaining atrial fibrillation; additional ablation for atrial flutter	93312-26	93312-26	S	0270
	93620	93656	Q3	8000
	93642			
	93621			
	93651	93657	N	N/A
	N/A			
	N/A			
	93613			
	93662	93662	N	N/A

Ventricular Tachycardia Ablation, Right Sided	2012 CPT® Codes	2013 CPT® Codes	2013 APC Status	2013 APC
Comprehensive EP study with induction of arrhythmia; 3-D mapping; isoproterenol infusion; ventricular ablation	93620	93654	Q3	8000
	93652			
	93613			
	93623	93623	N	N/A

Ventricular Tachycardia Ablation, Left Sided	2012 CPT® Codes	2013 CPT® Codes	2013 APC Status	2013 APC
Comprehensive EP study with induction of arrhythmia; left ventricular pacing & recording; transeptal puncture; 3-D mapping; isoproterenol infusion; ventricular ablation.	93620	93654	Q3	8000
	93622			
	93652			
	93613			
	93462	93462	T	0080 (@ 50%)
	93623	93623	N	N/A

Ventricular Tachycardia Ablation, Dual Mechanisms	2012 CPT® Codes	2013 CPT® Codes	2013 APC Status	2013 APC
Comprehensive EP study with induction of arrhythmia; 3-D mapping; isoproterenol infusion; ventricular ablation; ablation of distinct arrhythmia mechanism.	93620	93654	Q3	8000
	93652			
	93613			
	N/A	93655	N	N/A
	93623	93623	N	N/A

AV Node Ablation	2012 CPT® Codes	2013 CPT® Codes	2013 APC Status	2013 APC
Limited diagnostic EP study - His bundle recording; ablate AV node.	93600	93600	S	0084
	93650	93650	S	0084

Limited Diagnostic Study with Ablation	2012 CPT® Codes	2013 CPT® Codes	2013 APC Status	2013 APC
Limited diagnostic EP study comprised of His bundle recording and atrial pacing and recording; atrial ablation.	93600	93653-52	Q3	8000
	93602			
	93610			
	93651			

HOSPITAL INPATIENT SERVICES

For transcatheter ablation procedures performed on an inpatient basis, the hospital will typically be reimbursed under MS-DRG 250 or 251; which one is determined by presence of significant underlying comorbidities or complications, not the extent of the EP services as above. MS-DRG payment amounts may be adjusted by multiple hospital-specific factors.

MS-DRG	Descriptor
250	Percutaneous Cardiovascular Procedure without Coronary Artery Stent with MCC
251	Percutaneous Cardiovascular Procedure without Coronary Artery Stent without MCC

GLOSSARY AND ACRONYMS

There are many key terms and acronyms used in medical reimbursement literature. There can be varying definitions of terms per insurance contract. Note: This list contains some key terms and is not meant to be all-inclusive.

Actual Charge: The charge actually submitted by a physician or hospital for a service rendered.

Allowable / Approved Amount: An insurer-determined amount for a service per CPT® code. Medicare's payment methodology often can be part of this determination. See Medicare Fee Schedule (MFS).

Appeal / Review: Mechanism for contact with a payor for denied claims when there appears to be a possible oversight in determining benefits.

Audit: The act of comparing a physician's or facility's medical documentation against the billing records and claims submitted to verify accuracy and appropriateness. Audits may be conducted by a variety of payors, or internally by the entity as part of compliance activities. Note: Prepayment or prospective audit appears to be a growing trend among payors, including Medicare.

- **Prospective Review (Prepayment Audit):** Where documentation is requested for review prior to reimbursing a claim. Many facilities and practices conduct internal audit as a preventive tool to improve accuracy and reduce the possibility of unintended overpayment.

With a goal of efficiency overall and accuracy in the initial payment of claims, Medicare now engages private entities regionally to serve as recovery audit contractors (RACs), in addition to its internal audit staff. Commercial plans may also outsource review functions to third parties.

- **Retrospective Review (Postpayment Audit):** This original method of payor audit reviews paid claims. This is the method most likely performed by a payor investigating the possibility of overpayments.

Audit can result in overpayments to be refunded, and also in potential fines, penalties and sanctions such as loss of provider status in government-based insurance programs. Commercial payors may also conduct some form of audit.

CMS: Centers for Medicare and Medicaid Services, part of the federal Department of Health and Human Services (HHS), division overseeing these programs.

Coding and Billing Compliance Guidance: Published by the HHS Office of Inspector General to encourage coding and billing accuracy in claims submitted on behalf of Medicare and Medicaid beneficiaries. While adoption of a 'corporate compliance program' is stated as voluntary, most facilities and physicians implement at least some of the program elements. To verify compliant billing and coding, a facility or physician can be identified for review (audit).

Cost Sharing: Common payor methodology in which the insured individual must pay out-of-pocket a portion of the costs associated with receiving care, e.g., copayment, coinsurance and deductible.

Covered Service / Medical Necessity: A service or supply that is part of the benefit plan and eligible for reimbursement. Criteria are set forth by payors per CPT® code to determine parameters of coverage. Frequently, these involve medical conditions identified with ICD-9 diagnosis codes.

Coding: A "language" of numeric and alpha-numeric code sets intended to translate medical conditions and medical services for electronic submission of claims data by physicians and facilities on behalf of the insured individual:

CPT® Current Procedural Terminology (CPT®) is the primary codebook for reporting physician or outpatient facility services. Published annually by the American Medical Association, it is structured to report physician services.

HCPCS Healthcare Common Procedural Coding System. The HCPCS system includes the CPT® as Level I codes, and also the Level II National Codes – which are commonly referred to as "HCPCS codes." CMS maintains Level II codes, to report a diverse range of services and items not included in CPT® – supplies, devices, injectable drugs, ambulance transport, DME, etc. Level II National codes are often more limited in use, applying only to a specific payor or provider type; for example, C-codes for devices may only be reported with outpatient hospital claims. Not every supply or device will have a specific assigned HCPCS code, and multiple products may fall into a single code descriptor.

ICD-9-CM International Classification of Diseases, 9th Revision, Clinical Modification. Maintained by the National Center for Health Statistics, this code set is required for reporting diagnoses. Volume III of the ICD-9-CM is used by hospitals to report inpatient procedure codes, instead of the CPT® or HCPCS Level II codes. It should be noted that there is not a one-to-one correlation between these two procedural coding systems.

ICD-10 The next iteration of the International Classification of Diseases, 10th Revision. ICD-10-CM is planned as the replacement for ICD-9-CM, Volumes 1 and 2; ICD-10-PCS is being developed by CMS to replace ICD-9-CM Volume III. Specific revisions in ICD-10 include: the addition of information relevant to ambulatory and managed care encounters; expanded injury codes; the creation of combination diagnosis/symptom codes to reduce the number of codes needed to fully describe a condition; the addition of sixth and seventh characters; incorporation of common 4th and 5th digit subclassifications; laterality; and greater specificity in code assignment. The new structure will allow further expansion than was possible with ICD-9-CM. On January 16, 2009 HHS published a final rule adopting ICD-10-CM and ICD-10-PCS to replace ICD-9-CM in HIPAA transactions, with an implementation date of October 1, 2013; which was delayed from October 1, 2013 to October 1, 2014 by final rule CMS-0040-F issued on August 24, 2012. Until that transition, the codes in ICD-10-CM are not valid for any purpose or use.

CCI National Correct Coding Initiative (also NCCI). These are claims processing edits implemented by the Medicare program and also sometimes used by commercial plans.

There are two types: Comprehensive/component, or Column 1/Column 2 edits, indicate bundling – the procedure in column 2 is a component of the more comprehensive procedure in column 1, and not typically reimbursed separately. Mutually Exclusive edits indicate that either service may be reported, but usually not both together, as the procedure descriptors are contradictory (eg, “with” vs. “without”; “unilateral” vs. “bilateral”; or “limited” vs. “complete”). CCI edits apply to physician claims, and are also incorporated into the Outpatient Code Editor (OCE) for outpatient facility services.

Edits: Payors’ prepayment “screens” used to identify potential conflicts affecting coverage, e.g., CCI.

Place of Service (POS): CMS has designated a series of two-digit indicators for the place of service. The place of service may affect reimbursement of certain procedures.

Prior Authorization: Permission may be required by insurers prior to scheduling or paying for particular medical services recommended by providers. May be referred to as precertification or prior approval.

REIMBURSEMENT METHODOLOGIES

A payor's mechanism for determining payment rates. Many of these acronyms used relate to the Medicare program. While a number have been adopted by commercial insurance plans, some utilize other reimbursement methods according to contractual agreement and/or state statutes. Actual reimbursement will vary based on geographic adjustments and other facility-specific variables, and for commercial insurance plans according to contract.

MS-DRG Medicare reimburses inpatient hospital services under the Inpatient Prospective Payment System (IPPS), which bases payment on diagnosis-related groups (DRGs), now MS-DRGs (Medicare Severity Diagnosis Related Group). The MS-DRG payment system groups similar diagnoses into a single payment level, and reimburses the hospital according to the extent of resources typically required to treat patients with similar diagnoses undergoing similar treatments. All services and supplies provided during the inpatient admission are bundled into a single MS-DRG reimbursement rate, regardless of the length of the inpatient stay, the intensity of treatments, or the number of procedures performed for the specific individual. Hospitals will receive one global MS-DRG payment rate per patient admission, and the MS-DRG assignment is primarily determined by the patient's principle diagnosis and/or principal procedure performed.

MS-DRGs categories and payment amounts are published annually in the Medicare Inpatient Prospective Payment System Final Rule, which is effective October 1st of each year. Each MS-DRG is assigned a relative weight, which is multiplied by each hospital's blended rate. Actual payment will vary based on multiple hospital-specific factors, including geographic wage indices; disproportionate share hospitals (DSH) who provide a large amount of indigent care; graduate medical education (GME) programs; and individual hospital cost reports. Some providers may be paid based on a methodology which differs from the standard MS-DRG calculation (i.e., rural referral centers, hospitals in the state of Maryland).

CC or MCC The MS-DRG reimbursement methodology identifies many secondary diagnoses as either complications and comorbidities (CCs) or major complications and comorbidities (MCCs).

Complications – conditions that develop after inpatient admission
Comorbidities – conditions which pre-exist at the time of admission.

Presence of CCs or MCCs may lead to a different MS-DRG assignment, which are stratified to better recognize increased hospital resource use based on secondary diagnoses. These conditions generally correspond to longer and more complicated inpatient stays due to a need for services such as intensive monitoring, expensive and technically complex procedures, and/or extensive nursing care. Secondary conditions documented in a patient's medical record may impact the reimbursement a hospital receives, if the diagnosis is considered to be either a CC or MCC.

HACs / POAs CMS has identified a list of Hospital-Acquired Conditions (HACs) to provide financial incentives for hospitals to reduce the incidence of serious adverse events during inpatient stays that are reasonably preventable. Since October 1, 2008, these identified secondary conditions, which would normally be considered a CC or MCC for MS-DRG assignment, will not qualify for the higher reimbursement level if the patient acquires them after admission. With a few specified exceptions, all secondary diagnoses must be reported with a Present on Admission (POA) indicator to state whether or not this diagnosis was already present. This concept presently only applies to hospital inpatient stays, but may be expanded to outpatient services in future.

APC Ambulatory Payment Classification is the Medicare reimbursement methodology under the Hospital Outpatient Prospective Payment System (HOPPS). Similar to MS-DRGs, procedures which require similar resources are assigned to an APC category for a lump sum payment. However, multiple outpatient APCs may potentially be paid to a facility on a single case. CMS publishes national average payment amounts for each APC annually in the Medicare Hospital Outpatient Prospective Payment System Final Rule, Addendums A and B. These national base rates are then adjusted geographically according to the hospital wage index for the area.

MFS or MPFS Medicare Fee Schedule or Medicare Physician Fee Schedule – the payment amounts for physician services under the Medicare program. These amounts are revised at least annually, and can also be a component included in payment calculation by commercial insurance plans.

RBRVS Resource-Based Relative Value Scale. The methodology by which the Medicare physician fee schedule is calculated. RBRVS has been in use since 1992. Instead of basing payments on charges, the federal government established a standardized physician payment schedule based on a resource-based relative value scale (RBRVS). In the RBRVS system, payments for services are determined by the resource costs needed to provide them.

RVU Relative value unit. The numeric relative weights assigned to each CPT® code in RBRVS. Each procedure code is assigned a relative weight based upon resources needed to provide it, which has three components: physician work, practice expense, and malpractice liability. Although CMS indicates an average percentage of the total RVU for each of these components (physician work 52%, practice expense 44%, malpractice liability 4%), this is not a fixed ratio, and will vary according to the specific resources relevant for different types of procedures. Each of these component relative weights may be adjusted geographically, and then the sum multiplied by a dollar-per-unit conversion factor to arrive at the final allowed amount.

ASSIGNMENT OF CPT® CODES TO APC CATEGORIES

The descriptors applied to each Ambulatory Payment Classification are brief and intentionally generic, indicating that these categories may reflect the reimbursement level for one, a few, or a large number of individual services; the names of the APCs do not necessarily identify everything which may be included in them. See the Table below for relationships of CPT® code to APC for electrophysiology procedures. This reference is intended to assist in “matching” APCs to their relevant CPT® procedure codes. The HOPPS payments are updated at least annually, and adjusted geographically. All procedures reported with CPT® codes must be clinically appropriate for the individual patient, and documented accordingly.

APC	Official Descriptor	Status	Related CPT® Codes	Notes
0080	<i>Diagnostic Cardiac Catheterization</i>	S	<ul style="list-style-type: none"> ■ Transseptal puncture (93462) 	This APC includes a range of diagnostic cardiac catheterization codes. Code 93462 for transseptal access may be reported in combination with ablations codes 93653 or 93654, so this APC is relevant to EP.
0084	<i>Level I Electrophysiologic Procedures</i>	S	<ul style="list-style-type: none"> ■ Individual diagnostic EP services (93600 – 93618) 	This APC is assigned for individual diagnostic EP services 93600 – 93618 (except for 93609 and 93613) when performed either stand-alone or in combinations with each other.
0085	<i>Level II Electrophysiologic Procedures</i>	T	<ul style="list-style-type: none"> ■ Comprehensive EP studies (93619, 93620, or 93624) without ablation ■ AV node ablation (93650) 	This APC is assigned for comprehensive EP studies 93619 or 93620 when performed as a stand-alone procedure (eg, without ablation), or AV node ablation 93650 when performed without a comprehensive study. APC 0085 is also assigned to 93624.
0086	<i>Level III Electrophysiologic Procedures</i>	T	<ul style="list-style-type: none"> ■ None 	With the restructuring of CPT ablation procedures in 2013, there are no CPT codes which are assigned to APC 0086.
8000	<i>Cardiac Electrophysiologic Evaluation and Ablation Composite</i>	T	<ul style="list-style-type: none"> ■ Ablation procedures (93653, 93654, 93656) ■ Comprehensive diagnostic EP study (93619 or 93620) and ■ AV node ablation (93650) 	APC 8000 is assigned when a comprehensive study (93619, 93620) is combined with AV node ablation (93650), as well as for the new 2013 codes 93653, 93654, 93656. The codes which are reimbursed according to EP composite APC 8000 all have a status indicator of “Q3”.

APC	Official Descriptor	Status	Related CPT® Codes	Notes
0434	<i>Cardiac Defect Repair</i>	T	<ul style="list-style-type: none"> ■ Septal defect closures (93580, 93581) 	This APC is assigned for percutaneous atrial or ventricular septal defect closures (93580, 93581).
0269	<i>Level III Echocardiogram Without Contrast</i>	S	<ul style="list-style-type: none"> ■ Transesophageal echo, congenital anomaly (93315) 	This APC is assigned additionally if a transesophageal echo is performed on a patient with congenital cardiac anomaly (eg, septal defect).
0270	<i>Level II Echocardiogram Without Contrast</i>	S	<ul style="list-style-type: none"> ■ Transesophageal echo (93312) 	This APC is assigned additionally if a transesophageal echo is performed (eg, preceding an atrial fibrillation ablation).
N/A		N	<ul style="list-style-type: none"> ■ Mapping (93609, 93613) ■ Left heart EP (93621, 93622) ■ Drug study (93623) ■ Intracardiac echo (93662) 	93609 and 93613 (mapping), 93621, 93622, and 93623 (add-on codes), and 93662 (intracardiac echocardiography) are not assigned to an APC, but are ancillary to the primary procedures.

Status Indicators referenced identify a payment mechanism under the Ambulatory payment classifications. Definitions for status indicators and national average HOPPS allowables are derived from the Medicare Hospital Outpatient Prospective Payment System Final Rule [CMS-1589-FC] issued by CMS on 11/1/12 and published in the Federal Register (Vol. 77, Issue 221) on 11/15/12.

- S - Paid separately in full
- T - Paid separately; 50% multiple procedure discount applies
- N - No separate APC payment is made
- Q3 - Composite APC – specified combinations of CPT® codes are reimbursed as a “package”, rather than as individual APCs

CODING RESOURCES AND REFERENCES

The following are some of the coding resources which are available to assist in accurately reporting electrophysiology services, procedures, and devices. These resources also informed the responses to the FAQs in this document.

Biosense Webster, Inc. Resources:

- C-Codes for Biosense Webster products may be found:
 - On line at <http://www.afiballiance.com/reimbursement.php>.
Enter Biosense Webster product number into On-line C-Code Finder.
 - 2013 Reimbursement and Coding Guide for Physicians and Facilities.
Request a guide from your Biosense Webster territory manager or download a copy at <http://www.afiballiance.com/reimbursement.php>
- For other products, review the HCPCS Level II codebook or contact the manufacturer.

Other Resources:

- The Heart Rhythm Society publishes a resource book and offers additional educational information on their website: www.HRSonline.org
 - *Coding Guide for Heart Rhythm Procedures and Services* (published annually)
- American Medical Association: www.ama-assn.org
 - 2013 Current Procedural Terminology (CPT®), Professional Edition, copyright 2012 American Medical Association (AMA). All Rights Reserved.
 - CPT® Network: An online, subscription based service for coding information: www.cptnetwork.com
 - CPT® Assistant: A monthly coding publication of the American Medical Association.
- *Hospital ICD-9-CM 2013 Standard, Volumes 1, 2, & 3, 9th Revision, Clinical Modification*. AMA copyright 2012 OptumInsight. Please note that the ICD-9-CM is maintained by the National Center for Health Statistics (www.nchs.cdc.gov) and is available from multiple publishers.

In preparation for transition to ICD-10-CM and ICD-10-PCS in October 2014, the ICD-9-CM system is in a partial code freeze and there are no relevant changes for FY 2013.
- Medicare Program website: www.cms.gov
Provides a wide range of information and resources, including:
 - 2013 Medicare Physician Fee Schedule (MPFS).
 - APC payment amounts and CPT® assignment -- Medicare Hospital Outpatient Prospective Payment System Final Rule, Addendums A and B.
 - MS-DRG categories and payment amounts -- Medicare Inpatient Prospective Payment System Final Rule. Actual payment will vary based on various hospital-specific factors. Some providers may be paid based on a methodology which differs from the standard MS-DRG calculation reflected in the amount shown (i.e., rural referral centers, hospitals in the state of Maryland).
 - Medicare Coverage Database

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