ASE American Society of Echocardiography

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2017 Coding and Reimbursement Newsletter

The ASE Coding and Reimbursement Newsletter is a resource for cardiovascular ultrasound procedures provided in the facility and office settings. The Newsletter is provided exclusively to members of ASE.

2017 Physician Fee Schedule (PFS) Cardiovascular Ultrasound Services

In General: Medicare payments for physicians' services (including payment for the interpretation of cardiovascular ultrasound studies (professional component or "PC")) and payment for physicians' office overhead, clinical staff, equipment and supplies in non-facility settings (technical component or "TC")) are determined by the relative value units (RVUs) accorded to each service, multiplied by the national conversion factor, adjusted based on the Geographic Practice Cost Indices, and further modified under various billing and payment policies.

- **Relative Value Units (RVU):** For each procedure/service represented by a code, three RVU components are assigned to account for the relative resource costs used to provide a service/procedure.
    - *Physician work:* Reflects relative levels of physician time/ intensity associated with furnishing a service
    - *Practice expense (PE)*: Reflects practice costs (e.g., office space, supplies and equipment, and staff)
    - *Malpractice expense (MP):* Represents payment for the professional liability expenses
- **Conversion Factor (CF)**: The CF is a dollar amount used to convert RVUs into a payment amount. For the period from January 1, 2017 through December 31, 2017, the CF is **$35.887**
- **Geographic Practice Cost Indices (GPCI)** account for the geographic differences in the cost of practice across the country. CMS calculates an individual GPCI for each of the RVU components.

National Average Physician Fee Schedule Payment Amounts: The national average Medicare Physician Fee Schedule amounts are the product of three factors: Total RVUs x Conversion Factor (CF) = National Average Payment. See Table 1 for the national average Medicare PFS amounts through December 31, 2017. Please note that the payment amounts provided on Table 1 are not geographically adjusted.

What's New for 2017:

- Medicare payment for the professional and technical components of most echocardiography services under the Physician Fee Schedule will remain essentially unchanged in 2017, except that the Medicare allowances for TEE will no longer include payment for moderate sedation, which will be separately billable under new CPT codes.

- If you perform moderate sedation in conjunction with the TEE or other procedures that you provide, use the following new CPT codes, as applicable:

CPT[1]/ HCPCS	Description	2017 PFS Rate (non-hospital)	2017 PFS Rate (hospital)
99151	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intra-service time, patient younger than 5 years of age	$78.23	$24.04
99152	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intra-service time, patient younger than 5 years of age	$52.04	$12.56
99153	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes of intra- service time (List separately in addition to code for primary service)	$11.12	NA

- If an anesthesiologist or a physician other than the physician performing the procedure provides the anesthesia, that physician will bill separately using different new CPT codes. (new CPT codes 99155, 99156, or 99157, as applicable.)

- In 2017, a number of payment adjustments may apply to Medicare payment under the Physician Fee Schedule, depending on the physician's (or his or her group's) performance under Medicare incentive programs.

- In 2017, a penalty of 2% of Medicare PFS allowances may apply if the physician (or group) failed to meet Medicare's Physician Quality Reporting System requirements in 2015. For information on the 2015 PQRS Feedback Reports and how to request them, individual EPs and group practices should visit the PQRS Analysis and Payment webpage and access the "2015 PQRS Feedback Report User Guide" and the "Quick Reference Guide for Accessing 2015 PQRS Feedback Reports".
- In 2017, a penalty of -2% of Medicare allowances may apply if the physician failed to meet requirements related to Meaningful Use of Electronic Health Records (EHR), during an EHR reporting period in 2015.
- In CY 2017, Medicare will apply the Value Modifier to physician payments under the Medicare Physician Fee Schedule for all physicians, regardless of practice size.
  - Under this program, in order to avoid an automatic negative two percent (-2.0%) (for solo physicians and physician groups with between 2 to 9 physicians or other eligible professionals) or negative four percent (-4.0%) (for physician groups with 10 or more eligible professionals) adjustment in CY 2017, physicians must have participated satisfactorily in the PQRS in CY 2015.
  - Quality-tiering is mandatory for groups and solo practitioners subject to the Value Modifier in CY 2017. Groups with 10 or more EPs are subject to upward, neutral, or downward adjustment under quality-tiering, and solo practitioners groups with fewer than 10 physicians and eligible professionals EPs are subject to only upward or neutral adjustment in 2017.

- CY will serve as the performance year for PFS payment adjustments that will be implemented in 2019, under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).
  - Under MACRA, the payment adjustment that will apply will depend upon whether you qualify for the Advanced Alternative Payment Model (AAPM) or Merit-based Payment System (MIPS) "track."
  - For the 2017 performance year, virtually all ASE members likely will fall under the MIPS payment track
  - Under MIPS, Medicare PFS adjustments for physicians and certain other clinicians are adjusted up or down based on how they perform with respect to four performance categories:
    - ✓ Quality (currently PQRS),
    - ✓ Advancing Care Information (ACI)(currently Meaningful Use of Certified Electronic Health Records (CEHRT)),
    - ✓ Clinical Practice Improvement Activities (CPIA) (new), and
    - ✓ Cost (currently Value-Based Modifier).
  - However, for the 2017 performance year, special MIPS transition rules will be in effect. Under these rules:
    - ✓ MIPS-eligible clinicians who fail to report into the new system at all will incur a payment reduction in 2019 (based on 2017 performance) (-2%).
    - ✓ Clinicians who report one measure in the quality performance category **OR** one activity in the improvement activities performance category; **OR** report the required measures of the advancing care information performance category can avoid a negative MIPS payment adjustment in 2019.
    - ✓ Those who report more than one measure for the full 90 day reporting period will be eligible for positive adjustments.

2017 Hospital Outpatient Cardiovascular Ultrasound Services

Hospitals are paid by Medicare for outpatient procedures and services under the Outpatient Prospective Payment System (OPPS), which utilizes the Ambulatory Payment Classification (APC) system. Services are reported with CPT codes and/or HCPCS codes; each payable code is classified into an APC group.

Each APC is assigned a Medicare payment rate that applies to all of the procedures in the APC. This APC rate is intended to cover all of the hospital resources involved in the provision of the service (such as equipment, supplies, and staff), with the exception of physicians' services, which are separately billable and separately payable to Medicare under the Physician Fee Schedule.

What's New for 2017:

- For 2017, CMS restructured the APCs applicable to all imaging studies, including echocardiography. For the first time, many echocardiography procedures are included in the same APCs as imaging studies that use imaging modalities such x-ray, CT, and MRI.
- While Medicare payment for the most commonly performed echocardiography procedures will remain relatively stable for 2017 (+8%), the restructured echocardiography APCs will result in the following significant changes in the national 2017 APC rates, as compared with those in effect in 2016:

    - HOPPS rates for TEE will be reduced by 36%.
    - HOPPS rates for congenital echocardiography (CPT 93303) will be reduced by 36%.
    - HOPPS rates for limited echocardiography (CPT 93308) will increase by 47%.
    - HOPPS rates for complete bilateral duplex studies will increase by 47%, but the HOPPS rate for limited bilateral duplex studies will be reduced by 27%.

- Hospitals may report moderate sedation codes (CPT 99151-99157, as applicable) with TEE and other services when performed in the hospital outpatient setting. However, under HOPPS, moderate sedation services are considered an integral part of the primary procedure and are not separately paid.

- Special Rules applicable to off-campus hospital outpatient facilities.

    - The Bipartisan Budget Act of 2015, enacted at the end of 2015, includes a provision that will result in a 50% reduction in the HOPPS rates payable for virtually all services (including echocardiography) provided by new "off campus" hospital outpatient facilities (i.e. those located 250 yards or more from the main hospital campus or a hospital satellite).
        - Off campus non-emergency hospital outpatient facilities that that were not billing Medicare as of the date of enactment of the law (November 2, 2015) will incur the 50% reduction in otherwise applicable HOPPS rates, effective January 1, 2017.
        - All services (including but limited to cardiovascular ultrasound) provided by these new off-campus hospital facilities must be billed using modifier "PN".

- Under this same law, those off-campus hospital outpatient facilities that were billing Medicare as of the November 2, 2015 deadline will be subject to a reduction of 50% of their HOPPS rates if they change location or ownership (with certain limited exceptions).

- Effective January 1, 2017. CMS will package services based on hospital claim rather than the date of service. It is anticipated that this change will result in packaging of more ancillary and other services and a reduction in the number of services that will be separately payable; however, echocardiography and most other ultrasound services will remain separately payable.

BOTH 2017 (PFS) AND 2017 Hospital OPPS Cardiovascular Ultrasound Services

- ICD-10 Diagnosis Codes went into effect on October 1, 2015. A "crosswalk" between ICD-9 and ICD-10 diagnosis codes is available at: http://asecho.org/icd-10-resources/.
- At the request of the ASE , the AMA CPT™ Panel has approved two new Category III (tracking) CPT™ add-on codes, for **myocardial strain imaging** (published July 1, 2015, active for reporting January 1, 2106) and **myocardial perfusion contrast echocardiography** (published January 1, 2016, active for reporting July 1, 2016).

    - The code descriptors are:

      CPT +0399T: Myocardial strain imaging (quantitative assessment of myocardial mechanics using image-based analysis of local myocardial dynamics)

      → Use 0339T in conjunction with 93303, 93304, 93306, 93307, 93308, 93312, 93314, 93315, 93317, 93350, 93351, and 93355

      → (Report 0399T once per session)

      CPT ™ +0439T: Myocardial contrast perfusion echocardiography, at rest or with stress, for assessment of myocardial ischemia or viability

      → Use +0439T in conjunction with CPT™ codes 93306, 93307, 93308, 93350, or 93351

      → (Report +0439T once per session)

    - Both of these new codes are "Category III" or "tracking" codes. This code type is used to describe "emerging technologies." While both Medicare and non-Medicare payers have the discretion to cover Category III codes, coverage generally must be sought on a payer by payer basis.

    - ASE has discussed coverage of myocardial strain imaging with both private payers and Medicare Administrative Contractors (MACs) and is seeking limited coverage for myocardial strain imaging when it is performed to aid in detection of cardiotoxicity in

patients who are receiving potentially cardiotoxic chemotherapy or radiation therapy. ASE has developed a strain code payer "toolkit" which is available for you to use to seek payment, at ASEcho.org/Advocacy. ASE also plans to work with private payers and MACs in 2017 to seek reimbursement for myocardial contrast perfusion imaging.

- Category III codes ultimately may be reclassified as Category I codes (which are typically covered by Medicare and private payers) if (1) the Category III code demonstrates significant utilization in clinical practice and (2) additional peer-reviewed literature is published which demonstrates the utility of the new service To help obtain coverage, ensure that your echo lab staff and business department are familiar with these new CPT™ add-on codes, and submit these codes when you perform myocardial strain imaging or myocardial perfusion echocardiography. This will allow national utilization tracking, which is a critical first step towards establishing reimbursement for these services.

Multiple Procedure Payment Reduction: Technical Component of Diagnostic Cardiovascular Procedures

Physician/Office Payments

Under the Medicare Physician Fee Schedule, the Multiple Procedure Payment Reduction (MPPR) on diagnostic cardiovascular procedures applies when multiple services are furnished to the same patient on the same day. The MPPRs apply to technical component only (TC) services, and to the TC of global services for those procedures assigned a status indicator of "6." Echocardiography and vascular ultrasound procedures are designated as status indicator "6" and are subject to this reduction.

Full payment is made for the TC service with the highest payment under the Medicare Physician Fee Schedule. Payment is made at 75% for subsequent TC services furnished by the same physician (or by multiple physicians in the same group practice) to the same patient on the same day.

- The MPPRs do not apply to echocardiography professional component (PC) services.
- This Medicare policy does not apply to hospital outpatient services.

Note: Some insurance companies may adopt a similar policy for their non-Medicare health plans.

Coding Tips

Physicians' Services

- **Modifiers to Report Technical and Professional Components:** These modifiers are used with diagnostic testing codes (including cardiovascular ultrasound. The acquisition of the image is the technical component, and the professional component is the physician interpretation of the exam.

***-TC Technical component*:** The technical component provided in ambulatory settings such as doctors' offices and IDTFs is reported by adding modifier TC to the CPT code. The TC modifier is reported by the entity that only provides the technical service. Institutions such as hospitals do not append the TC modifier. The use of this modifier affects payment.

-26 Professional Component: The physician service only is reported separately by adding modifier -26 to the CPT code. The use of this modifier affects payment.

No modifier: When both components are furnished by one provider, Medicare makes a single global payment that is equal to the sum of the payment for the components. No modifier is necessary.
Note that some codes such as stress test codes (93015-93018) and stress echocardiography contrast administration (93352) are designated as global codes and are never reported with -26 or TC modifiers.

The following codes may be reported with these modifiers: 93312-93314, 93315, 93317, 93318, 93320, 93321, 93325, 93350, and 93351.

-22 Increased Procedural Services: This modifier is used to identify that the work required to provide a service is substantially greater than typically required. Modifier -22 is not a hospital-approved modifier. The appropriate use of this modifier is subject to payer discretion and typically will trigger individual claim review. Specifically, CMS restricts the use of modifier -22 to only surgical procedures that have a global period of 0, 10, or 90 days. **For Medicare claims, it is inappropriate to append modifier -22 to cardiovascular ultrasound procedures.**

- The following modifiers may be appropriate for cardiovascular ultrasound codes, depending upon the circumstances:

-51 Multiple Procedures:
When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (e.g. vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier -51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes.

-52 Reduced Services

This modifier is used to describe a service or procedure that is partially reduced or eliminated. It is approved for physician and hospital use. As an example, this modifier can be used to report an arterial extremity study (93922-52) on a patient with an above the knee amputation, since the procedure was not performed in its entirety.

-59 Distinct Procedural Service:

This modifier is used to report procedures that are not normally reported together but are appropriate under the circumstances. Modifier -59 is used to clearly designate non- routine instances when distinct and separate multiple services are provided to a patient on a single date of service. It is approved for physician and hospital use. Modifier -59 should only be used if no other modifier more appropriately describes the relationships of the two or more procedure codes. As an example, if a transthoracic echo (93306) is done for a particular indication, and based on the result, a TEE is also performed; the -59 modifier would be appended to the TEE (93312).

-77 Repeat Procedure by Another Physician:

This modifier defines a repeat procedure by another physician during the same patient encounter. It is approved for physician and hospital use. As an example, when a TEE procedure is repeated by another physician, the second exam would require use of the -77 modifier and assumes that the second physician was aware this was a repeat procedure. For example, if a different physician acquires

additional images, interprets, and prepares a report in addition to the preoperative TEE, then 93314 (image acquisition, interp/report) or 93317 (congenital image acquisition, interp/report) can be reported with modifier -77. This indicates that the additional image acquisition and interpretation was provided by a different physician. The medical record should reflect the medical necessity for repeating these procedures.

Hospital Outpatient Services

- Even though add-on codes are not separately paid under the OPPS, make sure that these codes are reported when performed, and a separate charge is included on the claim.
- Please note that special "C" codes (rather than CPT codes) apply to contrast-enhanced echocardiography procedures. In addition, the contrast agent should be reported, along with a separate contrast agent charge, using the appropriate "Q" code.

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This newsletter is for information purposes only. No guarantee of payment is stated or implied. It is the responsibility of the health care provider to properly code and to seek reimbursement for rendered medically appropriate and necessary services.

2016-2017 Physician Fee Schedule and HOPPS Rates for Echo

CPT1/ HCPCS	Mod	Description	2016 PFS rate	2017 PFS rate	Diff $	Diff %	2016 APC	2017 APC	Diff $	Diff %
93303		Echo transthoracic	$ 240.96	$ 240.08	$ (0.88)	0%				
93303	TC	Echo transthoracic	$ 176.16	$ 175.13	$ (1.03)	-1%	$ 698.65	$ 449.68	($248.97)	-36%
93303	26	Echo transthoracic	$ 64.81	$ 64.96	$ 0.15	0%				
93304		Echo transthoracic	$ 157.54	$ 157.54	$ 0.01	0%				
93304	TC	Echo transthoracic	$ 120.30	$ 120.22	$ (0.08)	0%	$ 416.80	$ 449.68	$ 32.88	8%
93304	26	Echo transthoracic	$ 37.24	$ 37.32	$ 0.09	0%				
93306		TTE w/doppler complete	$ 230.22	$ 231.47	$ 1.25	1%				
93306	TC	TTE w/doppler complete	$ 165.77	$ 166.52	$ 0.74	0%	$ 416.80	$ 449.68	$ 32.88	8%
93306	26	TTE w/doppler complete	$ 64.45	$ 64.96	$ 0.51	1%				
93307		TTE w/o doppler complete	$ 131.76	$ 131.71	$ (0.05)	0%				

93307	TC	TTE w/o doppler complete	$ 85.93	$ 85.77	$ (0.16)	0%	$ 416.80	$ 449.68	$ 32.88	8%
93307	26	TTE w/o doppler complete	$ 45.83	$ 45.94	$ 0.11	0%				
93308		TTE f-up or lmtd	$ 126.03	$ 126.68	$ 0.65	1%				
93308	TC	TTE f-up or lmtd	$ 99.89	$ 100.48	$ 0.59	1%	$ 153.58	$ 225.91	$ 72.33	47%
93308	26	TTE f-up or lmtd	$ 26.14	$ 26.20	$ 0.06	0%				
93312		Echo transesophageal	$ 309.35	$ 249.77	$(59.58)	-19%				
93312	TC	Echo transesophageal	$ 186.18	$ 138.16	$(48.02)	-26%	$ 698.65	$ 449.68	($ 248.97)	-36%
93312	26	Echo transesophageal	$ 123.17	$ 111.61	$(11.56)	-9%				
93313		Echo transesophageal	$ 22.92	$ 11.84	$(11.07)	-48%	$ 698.65	$ 449.68	($ 248.97)	-36%
93314		Echo transesophageal	$ 303.26	$ 240.08	$(63.18)	-21%				
93314	TC	Echo transesophageal	$ 197.64	$ 146.78	$(50.86)	-26%	n/a	n/a		
93314	26	Echo transesophageal	$ 105.62	$ 93.31	$(12.32)	-12%				
93315		Echo transesophageal	$ -	$ -	$ -					
93315	TC	Echo transesophageal	$ -	$ -	$ -		$ 698.65	$ 449.68	($ 248.97)	-36%
93315	26	Echo transesophageal	$ 143.93	$131.71	$(12.23)	-8%				
93316		Echo transesophageal	$ 39.03	$ 27.63	$(11.39)	-29%				
93317		Echo transesophageal	$ -	$ -	$ -					
93317	TC	Echo transesophageal	$ -	$ -	$ -		-			
93317	26	Echo transesophageal	$ 107.77	$ 95.46	$(12.31)	-11%				
93318		Echo transesophageal intraop	$ -	$ -	$ -					
93318	TC	Echo transesophageal intraop	$ -	$ -	$ -		$ 698.65	$ 449.68	($ 248.97)	-36%
93318	26	Echo transesophageal intraop	$ 118.51	$107.30	$(11.21)	-9%				
93320		Doppler echo exam heart	$ 54.78	$ 54.91	$ 0.13	0%				
93320	TC	Doppler echo exam heart	$ 36.16	$ 36.25	$ 0.08	0%	n/a	n/a	n/a	
93320	26	Doppler echo exam heart	$ 18.62	$ 18.66	$ 0.04	0%				
93321		Doppler echo exam heart	$ 27.57	$ 27.63	$ 0.06	0%				
93321	TC	Doppler echo exam heart	$ 20.05	$ 20.10	$ 0.05	0%	n/a	n/a	n/a	
93321	26	Doppler echo exam heart	$ 7.52	$ 7.54	$ 0.02	0%				
93325		Doppler color flow add-on	$ 25.78	$ 25.84	$ 0.06	0%				
93325	TC	Doppler color flow add-on	$ 22.56	$ 22.61	$ 0.05	0%	n/a	n/a	n/a	

93325	26	Doppler color flow add-on	$ 3.22	$ 3.23	$ 0.01	0%				
93350		Stress TTE only	$ 243.47	$ 244.03	$ 0.56	0%				
93350	TC	Stress TTE only	$ 171.14	$ 171.54	$ 0.40	0%	$ 416.80	$ 449.68	$ 32.88	8%
93350	26	Stress TTE only	$ 72.32	$ 72.49	$ 0.17	0%				
93351		Stress TTE complete	$ 273.90	$ 274.89	$ 0.99	0%				
93351	TC	Stress TTE complete	$ 187.61	$ 188.05	$ 0.43	0%	$ 416.80	$ 449.68	$ 32.88	8%
93351	26	Stress TTE complete	$ 86.29	$ 86.85	$ 0.56	1%				
93352		Admin ECG contrast agent	$ 34.37	$ 34.45	$ 0.08	0%				
93355		Echo transesophageal (TEE)	$ 230.22	$ 232.19	$ 1.97	1%	n/a	n/a	n/a	

Contrast Echo APC rates, 2016-2017

HCPCS Code	Short Descriptor	APC Payment Rate 2016	APC Payment Rate 2017	Diff $	**% Diff**
C8921	TTE w or w/o fol w/cont, com	$ 670.96	$ 656.91	-$ 14.05	-2%
C8922	TTE w or w/o fol w/cont, f/u	$ 454.05	$ 656.91	$ 202.86	45%
C8923	2D TTE w or w/o fol w/con,co	$ 454.05	$ 656.91	$ 202.86	45%
C8924	2D TTE w or w/o fol w/con,fu	$ 454.05	$ 426.52	-$ 27.53	-6%
C8925	2D TEE w or w/o fol w/con,in	$ 670.96	$ 656.91	-$ 14.05	-2%
C8926	TEE w or w/o fol w/cont,cong	$ 670.96	$ 656.91	-$ 14.05	-2%
C8927	TEE w or w/o fol w/cont, mon*	$ 670.96	$ 656.91	-$ 14.05	-2%
C8928	TTE w or w/o fol w/con,stres	$ 670.96	$ 656.91	-$ 14.05	-2%
C8929	TTE w or wo fol wcon,Doppler	$ 670.96	$ 656.91	-$ 14.05	-2%
C8930	TTE w or w/o contr, cont ECG	$ 670.96	$ 656.91	-$ 14.05	-2%

CPT[1]/ HCPCS	Mod	Description	2016 PFS $	2017 PFS $	Diff $	% Diff	HOPPS Rate 2016	HOPPS Rate 2017	$ Diff	% Diff
Duplex Studies										
93880		Extracranial bilat study	$ 205.52	$ 205.63	$ 0.12	0%				
93880	TC	Extracranial bilat study	$ 164.70	$ 164.72	$ 0.02	0%	$ 153.58	$ 225.91	$ 72.33	47%
93880	26	Extracranial bilat study	$ 40.82	$ 40.91	$ 0.09	0%				
93882		Extracranial uni/ltd study	$ 131.40	$ 130.99	$ (0.41)	0%				
93882	TC	Extracranial uni/ltd study	$ 105.62	$ 105.15	$ (0.47)	0%	$ 153.58	$ 112.73	-$ 40.85	-27%
93882	26	Extracranial uni/ltd study	$ 25.78	$ 25.84	$ 0.06	0%				