AMERICAN SOCIETY OF ECHOCARDIOGRAPHY 2018 CODING NEWSLETTER

Volume 1 / Issue 1

MODERATE SEDATION CODING DENIALS

If you have received a denial for separate billing of moderate sedation services CPT (99150-99153, 99155-99157), we want to help. Please contact ASE staff if you believe an insurer has denied your moderate sedation claim in error – Irene Butler, Vice President of Health Policy ibulter@asecho.org or P (919) 297.7162.

CY2018 CODING NEWSLETTER

The American Society of Echocardiography (ASE) works closely with the American Medical Association (AMA) together to ensure that adequate methods are in place for echocardiography services. The societies' advisors continuously review Current Procedural Terminology (CPT®) and work through the AMA process to revise and add new codes, as appropriate. It is important for practices and groups to annually review and potentially update documentation in the office and facility to ensure the CPT® codes are accurate and up to date. Coding accurately for the services you provide is essential, especially in today's environment of declining reimbursement and increased scrutiny. ASE is committed to ensuring you are fairly reimbursed for your work. Reporting the most appropriate CPT® code is essential in the correct reporting of services to obtain fair and reasonable reimbursement for procedures, tests and visits.

Moderate Sedation Coding Review

Beginning January 1, 2017, moderate sedation is no longer part of the TEE service payment. Moderate sedation must be separately reported with new CPT codes and documented, when performed. This is important as the moderate sedation service was previously included in the TEE relative value units (RVUs). If moderate sedation codes are not separately reported, payment for the service will be lost.

This change in codes and reporting impacts payments from both private payers and Medicare for TEE services described by CPT 93312, 93313, 93314, 93315, 93316, 93317, and 93318.

- Physicians report moderate sedation codes with TEE when performed in the office and facility.
- Hospitals may also report moderate sedation codes with TEE when performed in the hospital outpatient setting. Note that under the CMS hospital outpatient payment system (OPPS), moderate sedation services are considered an integral part of the primary procedure and are not separately paid.

Selecting the appropriate code and units of service is important. Intra-service time of moderate sedation is used to select the appropriate code(s), not the time of the procedure the sedation supports. For these purposes, "intra-service" time of moderate sedation:

- Begins with the administration of the sedating agent(s);

- Ends when the procedure is completed, the patient is stable for recovery status, and the physician or other qualified health care professional providing the sedation ends personal continuous face-to-face time with the patient;
- Includes ordering and/or administering the initial and subsequent doses of sedating agents;
- Requires continuous face-to-face attendance of the physician or other qualified health care professional;
- Requires monitoring patient response to the sedating agents, including:
  - Periodic assessment of the patient;
  - Further administration of agent(s) as needed to maintain sedation; and
  - Monitoring of oxygen saturation, heart rate, and blood pressure.

If the physician or other qualified health care professional who provides the sedation services also performs the procedure supported by sedation (99151, 99152, 99153), the physician or other qualified health care professional will supervise and direct an independent trained observer who will assist in monitoring the patient's level of consciousness and physiological status throughout the procedure.

Moderate sedation codes 99151, 99152, 99153, 99155, 99156, and 99157 are not used to report administration of medications for pain control, minimal sedation (anxiolysis), deep sedation, or monitored anesthesia care (00100-01999). Note that propofol sedation provided by anesthesia professionals is seldom going to be reported with moderate sedation codes, since such sedation is typically deep sedation, reported presently by anesthesia codes for related procedures.

Refresher - Total Intra-service Time for Moderate Sedation Provided By Physician

CPT published a table which guides the actual minutes that distinguish 99152/G0500 from the add-on "additional 15 minutes," which reflects a CPT convention that for time-based codes, the threshold to report a unit of time is ½ the total time of the service. For 15 additional minutes of moderate sedation, at least 7 minutes of the additional service must be performed. Since the panel decided that less than 10 minutes of time should not be reported separately, the time breaks for the services wind up as follows. If moderate sedation is administered for less than 10 minutes, it not separately reportable.

- 10-22 minutes: 99152
- 23-37 minutes: 99152 + 99153
- 38-52 minutes: 99152 + 99153 x 2
- 53-67 minutes: 99152 + 99153 x 3
- 68-82 minutes: 99152 + 99153 x 4
- 83 minutes or longer: add 99153 for every 15 additional minutes to the previous line

Changes to CY2018 Echocardiography Services Physician Work RVUs

CMS identified two TTE codes (93306 and 93351) as "Potentially Misvalued Codes" as determined through a "High Expenditure" screen. ASE (as part of its role on the AMA House of Delegates) - along with American College of Cardiology - participated in the RUC review of primary transthoracic echocardiography CPT code 93306, stress transthoracic echocardiography CPT code 93351, and the related family of CPT codes.

We are pleased that CMS has accepted the RUC recommendation to increase the physician work RVUs for CPT code 93306 from 1.30 to 1.50 work RVUs. Additionally, CMS will maintain the current work RVUs values for remaining transthoracic and stress echocardiography services. Ensuring adequate reimbursement levels for echocardiography services on behalf of our ASE provider members ultimately helps provide patient access to this important technology.

Interventional Transesophageal Echocardiography Services – CPT code 93355

Transesophageal echocardiography (TEE) is an invasive technique whereby the transducer is placed at the tip of an endoscope and introduced into the patient's esophagus as guidance for procedures performed on intracardiac or other great vessels and structures. TEE provides high-quality, real-time images of the beating heart and mediastinal structures. CPT Code 93355 is used to report the guidance during the procedure(s), as well as measurements of the surrounding structures. It includes probe navigation, image acquisition, and physician's interpretation and report. Diagnostic TEE is included and contrast administration, Doppler, color flow, and 3D images, when performed, are also included.

This code became effective on January 1, 2015 and a range of intracardiac therapies may be performed with TEE guidance. Code 93355 describes TEE during advanced transcatheter structural heart procedures (eg, transcatheter aortic valve replacement [TAVR], left atrial appendage closure [LAA], or percutaneous mitral valve repair).

93355 - Echocardiography, transesophageal (TEE) for guidance of a transcatheter intracardiac or great vessel(s) structural intervention(s) (eg,TAVR, transcatheter pulmonary valve replacement, mitral valve repair, paravalvular regurgitation repair, left atrial appendage occlusion/ closure, ventricular septal defect closure) (peri-and intraprocedural), real-time image acquisition and documentation, guidance with quantitative measurements, probe manipulation, interpretation, and report, including diagnostic transesophageal echocardiography and, when performed, administration of ultrasound contrast, Doppler, color flow, and 3D

It is important to note that there are edits in place which do not permit the reporting of Interventional TEE (CPT code 93355) with anesthesia services. CMS has indicated that their position is that the delivery of the diagnostic and interventional periods of the 93355 TEE service are not to be performed simultaneously with the anesthesia service. The work involved in performing interventional TEE is provided in real time and requires the physical manipulation of the TEE probe by the provider responsible for the probe placement and management of the TEE.

Category III echocardiographic CPT codes.

While category III codes are not nationally reimbursed by CMS, these codes may be reimbursed by private payers—ASE is meeting with private payers in an effort to establish reimbursement. Additionally, CMS will track submission of these codes. There will be an opportunity for this code to progress to Category I status over the next few years based on 1) utilization and 2) additional peer reviewed publications demonstrating efficacy.

- ***CPT™ code +0399T:*** Myocardial strain imaging has emerged as a sensitive tool for assessing regional and global left ventricular systolic function. +0399T is to be reported once per encounter in addition to the appropriate echocardiography base codes 93303-93351.

- ***CPT™ code +0439T:*** Myocardial contrast perfusion echocardiography aids in the detection of myocardial ischemia and myocardial viability and is well-tolerated and safe in both ambulatory and critically ill patients. This code should be submitted whenever myocardial contrast perfusion echocardiography is performed and may be used only in conjunction with echocardiography base codes 93306, 93307, 93308, 93350, 93351.

ASE is encouraging you to *share information about these new codes* with your lab staff and business departments and *submit these codes* whenever myocardial strain imaging or myocardial perfusion echocardiography is performed.
ASE has developed a Strain Code Toolkit to assist members.

Frequently Asked Questions – Echocardiography Coding

Insert information on where to send coding questions and Judy's contact information (if appropriate)

1. What elements are included in the complete and limited TTE exam?

Per CPT Guidance in the Echocardiography Introduction Section, here are the definitions of a complete or limited echo. For further details as to how CPT describes echocardiography examinations, refer to the CPT introductory language in the Echocardiography section of the book.

- Complete echo: A complete echocardiogram is one that includes multiple 2D views of all chambers, valves, pericardium, and portions of the aorta, with appropriate measurements. The inability to visualize or measure the clinically relevant anatomy requires documentation of the attempt. Additional anatomy and M mode tracings may not be required but may also be included.

- Limited echo: A limited examination is usually a follow-up or focused study that does not evaluate all the structures required for a comprehensive or complete echocardiographic exam. The purpose of this exam is best described and documented as a focused clinical exam to answer a specific clinical question.

- Documentation: All reports should include an interpretation of the images with quantitative measurements, and clinically relevant and abnormal findings. When images are attempted but not adequately identified, it should be noted in the report. Recorded studies must be available for subsequent review.

2. How frequently can a TTE be billed?

The rules of frequency per indication/diagnosis vary by payers. In general, repeat echocardiography studies should be guided by the clinical status of the patient, which may be outlined in coverage policies. Typically, repeat studies are appropriate to monitor changes in cardiac structure or function when there are changes in the clinical status of the patient, or when disease progression is otherwise suspected.

3. How is strain imaging reported?

CPT code 0399T is reported for myocardial strain imaging.

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

The instructions are as follows: (Use 0399T in conjunction with 93303, 93304, 93306, 93307, 93308, 93312, 93314, 93315, 93317, 93350, 93351, or 93355. Report 0399T once per session)

Separate reimbursement of Category III codes is at the discretion of payers. No national relative value units (RVUs) or national payment is assigned. See ASE clinical summary that may be referenced to support a request for payment from payers. asecho.org/wordpress/wp-content/uploads/2016/01/MLM-Revised-Strain-Code-1-6-16.docx (please make this link live)

The following diagnosis codes may be reported for monitoring cardiac toxicity. Note, these codes do not guarantee coverage or payment.

Z08: Encounter for follow-up examination after completed treatment for malignant neoplasm

Z01.818: Encounter for other preprocedural examination

Z51.11: Encounter for antineoplastic chemotherapy

Code the diagnosis(es) for the initial pre-chemotherapy echo according to the patient’s condition (i.e. cancer diagnosis and other clinical conditions). Ensure there is clear documentation in the medical record supporting the necessity of the echocardiogram. If the echocardiogram occurs at the same visit that chemotherapy is initiated, report ICD-10: Z51.11: Encounter for antineoplastic chemotherapy

4. What clinical conditions are considered congenital?

CPT doesn't provide guidance as to the definition of what is considered congenital.
The selection of a congenital or non-congenital code is left to the physician. Ensure good documentation for medical

necessity and follow clinical congenital echocardiography guidelines to best support the selection of codes. See coding tips from CPT Assistant Frequently Asked Questions (May 2015)

General Reporting Tips

- If echocardiography detects any congenital abnormality, it is appropriate to use congenital echocardiography codes.
- When congenital heart disease is known to be present from other studies, the procedure should be reported using the congenital echocardiography codes.
- If echocardiography detects congenital heart disease of little or no clinical significance, it can be reported with the congenital echocardiography codes. However, if the work involved is less than usual for congenital echo imaging, the physician may choose to report the noncongenital echo codes.

5. *How is contrast echocardiography reported by the hospital (facility)?*

Medicare has established a family of HCPCS "C" echocardiography codes that describe reporting of contrast administration. These codes should be reported by the hospital when an outpatient contrast echo procedure is performed in place of the conventional CPT codes (e.g., 93306, 93351, etc.). In addition to reporting the contrast procedure, hospitasl should report the applicable contrast agent "Q" code. Per the NCCI manual and correct coding edits, Medicare does not allow separate reporting for the IV insertion or injection procedure. Private payers may or may not use these codes. Check with payers.
HCPCS "C" codes:

- C8921 Transthoracic echocardiography with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; complete
- C8922 Transthoracic echocardiography with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; follow-up or limited study
- C8923 Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography
- C8924 Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study
- C8925 Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report
- C8926 Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report
- C8927 Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis
- C8928 Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular

stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report

- C8929 Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography

- C8930 Transthoracic echocardiography, with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision

Contrast Agents:

Select the applicable HCPCS "Q" code to report the contrast agent used.

- Q9955 injection, perflexane lipid microspheres, per ml

- Q9956 injection, octafluoropropane microspheres, per ml

- Q9957 injection, perflutren lipid microspheres, per ml

- Q9950 Injection, sulfur hexafluoride lipid microspheres, per ml

This reference 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

CPT Copyright 2017 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. Applicable FARS/DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.