CODING CONNECTION

ASE works closely with other stakeholders to ensure that adequate coding, coverage, and reimbursement processes are in place for echocardiography services. 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. Our goal is that this newsletter will assist in that process.

RECENT CODING UPDATES FOR ECHOCARDIOGRAPHY SERVICES

ASE is committed to ensuring that echocardiography services are ...

FINISH READING ON PAGE 2

EVALUATION AND MANAGEMENT SERVICES

Changes to evaluation-and-management (E/M) services continue to evolve to parallel the changes made in recent years for ...

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MEDICARE SPLIT/SHARED VISIT CHANGES

For CY 2023, CMS finalized a year-long delay of the split (or shared) visits policy they established in rulemaking for 2022.

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ASE TOP 10 CODING QUESTIONS

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ASE American Society of Echocardiography
Sound Saves Lives

MAY 2023

Recent Coding Updates for Echocardiography Services

+93319 AND +93356

ASE is committed to ensuring that echocardiography services are appropriately identified and reimbursed. Examples include the development of add-on CPT code for 3D echocardiography CPT® code +93319 and +93356 for myocardial strain imaging.

+93319 describes the clinical work involved in 3D echocardiographic imaging and post-processing during transesophageal echocardiography, or during transthoracic echocardiography for congenital cardiac anomalies and includes the assessment of cardiac structures and function (cardiac chambers, valves, left atrial appendage, interatrial septum, and function for example), when performed.

+93356 describes the clinical work involved in myocardial strain imaging using speckle tracking-derived assessment of myocardial mechanics. Strain imaging is used for the quantitative assessment of myocardial mechanics using image-based analysis of local myocardial dynamics. This technology helps with early detection of decreased ventricular function.

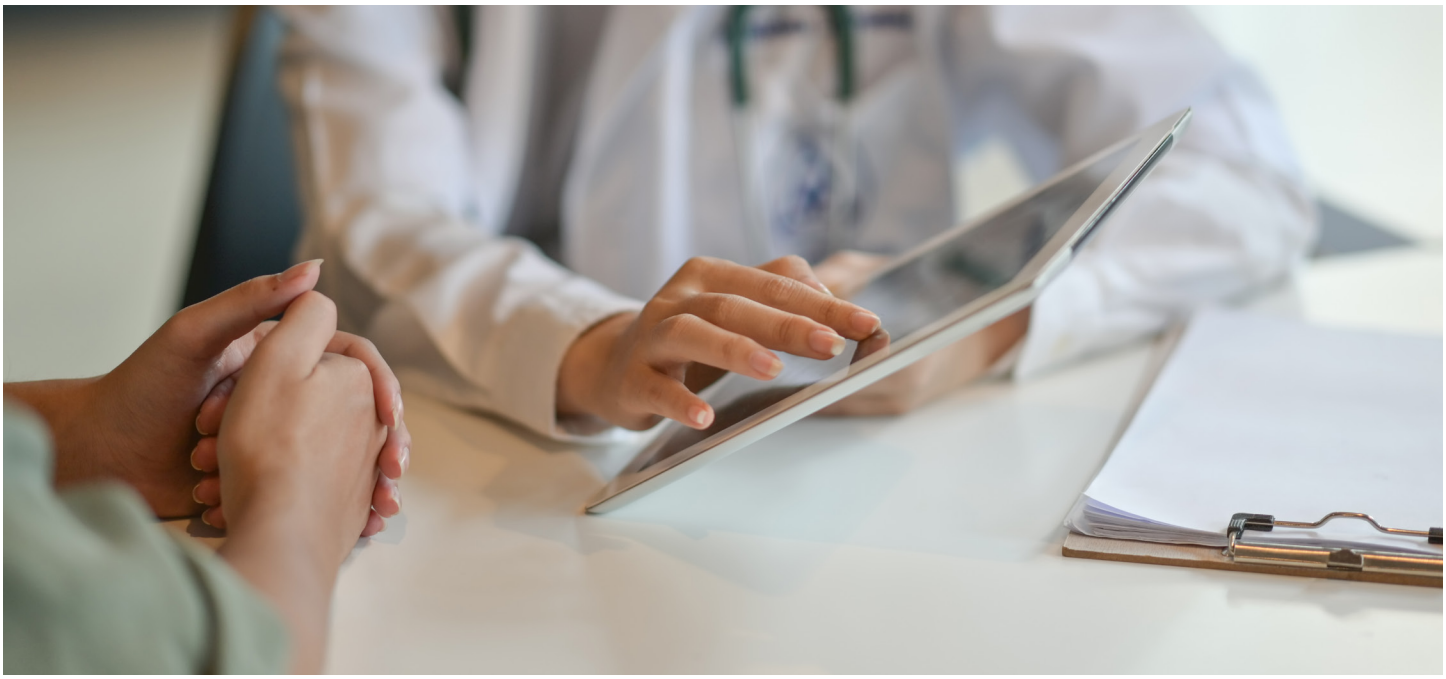
ASE encourages providers to verify with their individual payer mix for coverage of 3D echocardiography (+93319) and strain imaging (+93356) and if prior authorization must be approved in advance. Claims can be appealed based on the individual patient issue and how 3D and/or stain supported their diagnosis or treatment for patients with denials or non-coverage policies.

Finally, ASE retains an expert in coding to answer individual member coding questions. This service is available by logging in the ASE Member Portal, clicking on Advocacy, and clicking “Ask a Coding Expert” to get an answer from the experts.

ADD ON CODES

Add-on codes are Current Procedural Terminology (CPT) codes set and Healthcare Common Procedure Coding System (HCPCS) codes that describe a service always performed in conjunction with the primary service. These codes are identified in CPT with the “+” symbol and are eligible for payment only if it is reported with the appropriate primary procedure performed by the same physician. ***They must be medically necessary and proper documentation to explain why the procedure requires more work than usual, and why an add on code is needed, should be submitted.*** ASE recommends periodically checking explanation of benefits carefully for claims with add-on codes to be sure the payer is reimbursing you the appropriate fee schedule rate for the billed procedures or services.

Evaluation and Management Services



Changes to evaluation-and-management (E/M) services continue to evolve to parallel the changes made in recent years for office/outpatient E/M visit coding and payment. The intention is that coding and documentation for E/M services will carry fewer administrative burdens in 2023 as reforms that were implemented last year for E/M services performed in outpatient and office settings will be carried over across all healthcare settings.

The previous revisions covered E/M outpatient office-visit Current Procedural Terminology (CPT®) codes 99201 through 99215 and the corresponding code descriptors and documentation standards. For 2023, several E/M codes and their descriptors have been revised, consolidated or deleted. The revisions are also meant to track with E/M changes for 2023 implemented by the Centers for Medicare and Medicaid Services (CMS).

Changes for 2023 cover E/M services such as hospital observation care, E/M consultations, and prolonged services. Specific changes include deleting hospital observation codes CPT codes 99217 through 99220 and removing “domiciliary” or “rest home” as a setting for home care. This revised coding and documentation framework includes CPT code definition changes (revisions to the Other E/M code descriptors), including:

- New descriptor times (where relevant).
- Revised interpretive guidelines for levels of medical decision making.
- Choice of medical decision making or time to select code level (except for a few families like emergency department visits and cognitive impairment assessment, which are not timed services).
- Eliminated use of history and exam to determine code level (instead there would be a requirement for a medically appropriate history and exam).

CMS finalized the proposal to maintain the current billing policies that apply to the E/Ms while they consider potential revisions that might be necessary in future rulemaking. The AMA has additional resources on implementing the E/M outpatient and office-visit revisions, including step-by-step videos. Summaries of the revisions and explanations of how they will reduce administrative burdens are also available.

Medicare Split/Shared Visit Changes

For CY 2023, CMS finalized a year-long delay of the split (or shared) visits policy they established in rulemaking for 2022. This policy determines which professional should bill for a shared visit by defining the "substantive portion," of the service as more than half of the total time. Therefore, for CY 2023, as in CY 2022, the substantive portion of a visit is comprised of any of the following elements:

- History
- Performing a physical exam
- Medical Decision Making
- Spending time (more than half of the total time spent by the practitioner who bills the visit)

As finalized, clinicians who furnish split (or shared) visits will continue to have a choice of history, or physical exam, or medical decision making, or more than half of the total practitioner time spent to define the "substantive portion" instead of using total time to determine the substantive portion, until CY 2024.

TELEHEALTH SERVICES

For CY 2023, CMS finalized a number of policies related to Medicare telehealth services, including making several services that are temporarily available as telehealth services for the Public Health Emergency (PHE) available at least through CY 2023 in order to allow additional time for the collection of data that may support their inclusion as permanent additions to the Medicare Telehealth Services List. They also finalized the proposal to extend the duration of time that services are temporarily included on the telehealth services list during the PHE for at least a period of 151 days following the end of the PHE, in alignment with the Consolidated Appropriations Act, 2022 (CAA, 2022).

Continued from page 4:

MEDICARE SPLIT/SHARED VISIT CHANGES

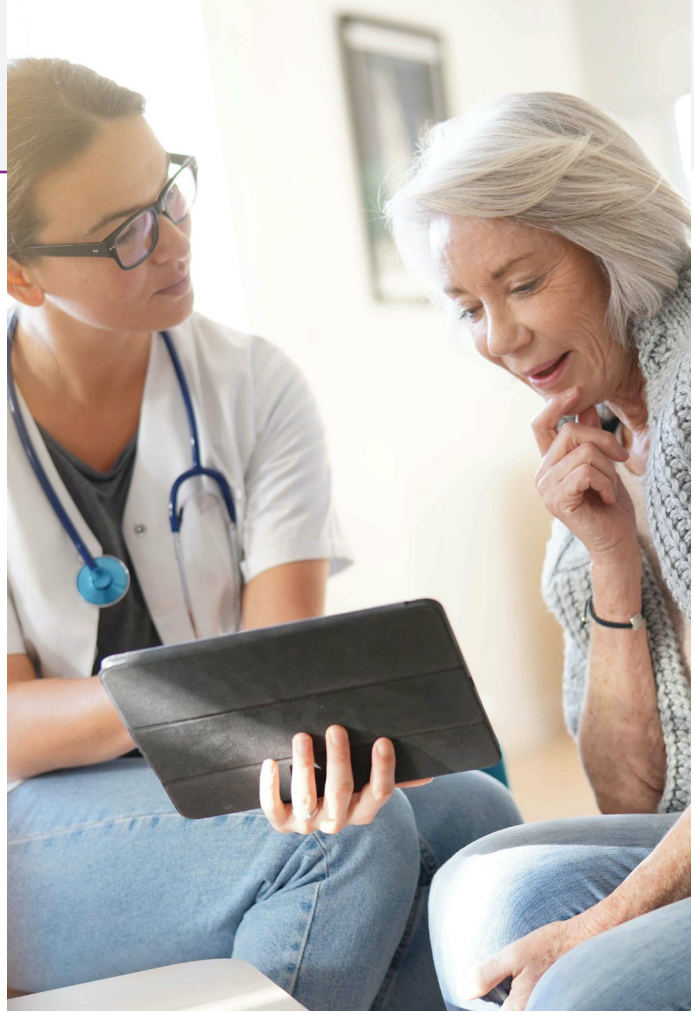
CMS confirmed their intention to implement the telehealth provisions in sections 301 through 305 of the CAA, 2022, via program instruction or other subregulatory guidance to ensure a smooth transition after the end of the PHE. These policies, such as allowing telehealth services to be furnished in any geographic area and in any originating site setting (including the beneficiary's home); allowing certain services to be furnished via audio-only telecommunications systems; and allowing physical therapists, occupational therapists, speech-language pathologists, and audiologists to furnish telehealth services, will remain in place during the PHE for 151 days after the PHE ends. The CAA, 2022, also delays the in-person visit requirements for mental health services furnished via telehealth until 152 days after the end of the PHE.

CMS finalized the proposal to allow physicians and practitioners to continue to bill with the place of service (POS) indicator that would have been reported had the service been furnished in-person. These claims will require the modifier "95" to identify them as services furnished as telehealth services. Claims can continue to be billed with the place of service code that would be used if the telehealth service had been furnished in-person through the later of the end of CY 2023 or end of the year in which the PHE ends.

END OF THE PUBLIC HEALTH EMERGENCY

Based on current COVID-19 trends, the Department of Health and Human Services is planning for the federal PHE for COVID-19, declared under Section 319 of the Public Health Service Act, to expire at the end of the day on May 11, 2023. The emergency declarations, legislative actions by Congress, and regulatory actions across government, including by the Centers for Medicare & Medicaid Services (CMS), allowed for changes to many aspects of healthcare delivery during the COVID-19 PHE. Healthcare providers received maximum flexibility to streamline delivery and allow access to care during the PHE.

While some of these changes will be permanent or extended due to Congressional action, some waivers



and flexibilities will expire, as they were intended to respond to the rapidly evolving pandemic, not to permanently replace standing rules. This fact sheet will help you know what to expect at the end of the PHE. Please note that this information is not intended to cover every possible scenario.

This fact sheet covers the following:

- COVID-19 vaccines, testing, and treatments;
- Telehealth services;
- Healthcare Access: Continuing flexibilities for health care professionals; and
- Inpatient Hospital Care at Home: Expanded hospital capacity by providing inpatient care in a patient's home.

It is important to note that as part of its end-of-year spending package, Congress included a two-year Medicare extension of telehealth flexibilities currently in place under the COVID-19 PHE. The two-year extension also applies to certain telehealth services furnished by audio-only (HCPCS codes 99241–99275, 99201–99215, 90804–90809,

and 90862). As called for in the legislation, the extension allows for the collection of greater claims data as the Administration evaluates, the impact of telehealth services on the future utilization of healthcare services.

The Administration, states, and private insurance plans will continue to provide guidance in the coming months. As described in previous communications, the Administration's continued response is not entirely dependent on the COVID-19 PHE. There are significant flexibilities and actions that will not be affected as we transition from the current phase. Click here for more information on what changes and does not change across HHS.

ADDITIONAL INFORMATION

CY2023 Medicare Payment Conversion Factor & Impact to Echocardiography

The final CY 2022 PFS conversion factor is $34.6062.

» As a result of advocacy efforts across the entire field of medicine, an end-of-year spending deal that provided modest relief to a 2023 Medicare physician fee schedule cut. This mitigated the planned cut to the conversion factor and for CY 2023, Congress has provided a 2.50 percent positive adjustment. That adjustment will be halved in 2024. Even with that relief, physicians will still receive a payment cut, and likely in 2024 as well. The spending deal does push off the threat of an added four percent Medicare reduction for another two years.

» As noted above, the severe cuts to reimbursement would have been further exacerbated if Congress had not averted two additional statutory cuts.

- One reduction is a mechanism that had been in place prior to the COVID-19 PHE and is capped at -2.0% as it applies to Medicare payments. In COVID response legislation, Congress lifted this sequestration cut temporarily. Until the passage of the Protecting Medicare and American Farmers from Sequester Cuts Act, the cut was scheduled to return for claims for services furnished beginning January 1, 2022. The statute now leaves a moratorium in place on the -2.0% sequester for the first quarter of 2022. A sequester will then begin to be phased in, with a 1.0% reduction to Medicare payments for Q2 2022. The full sequester will return for the rest of 2022, starting on July 1, 2022.
- A second reduction is triggered by federal "pay-as-you-go" (PAYGO) rules requiring cuts in spending when legislation is enacted that does not raise enough revenue to fund the increased spending it brings. As a result of the passage of the American Rescue Plan, Congressional action was needed to waive this additional -4.0% sequestration of Medicare payments. The Protecting Medicare and American Farmers from Sequester Cuts Act addressed this by postponing the PAYGO sequestration for a year. However, additional Congressional action could be needed to avoid these cuts in CY 2023.

» Cumulatively, these relief provisions mitigate what would have been a roughly 10.1% cut in overall payments to an approximately 2.08% reduction throughout 2023.

» Keeping in mind that the sequestration relief is different at different points in the year. Sequestration reduction is applied after the fee schedule amount is calculated by the Medicare contractor. This is not a further cut to the conversion factor

MEDICARE PAYMENT CHARTS

» 2023 MPFS Final Rule Payment Changes: PFS/HOPPS Final Rules and Comparison of CY2022 FINAL – CY2023 FINAL MPFS Rates for Echocardiography

ASE Top Coding Questions

Q: Can 3D be part of a as needed protocol on transthoracic echos or must it have a specific order by a provider? The CPT codes sent to us doesn't specify adult TTE codes only congenital exams. is there a code for adult TTE?

A: 3D must be in the documentation showing medical necessity. As it is being reported as an additional procedure to the base, there must be a clinical condition that warrants billing for it. As to a separate order, that would be a question for your compliance department. Many facilities have their own policy about requiring a separate order for an add-on code.

CPT code +93319 is specific to Congenital Transthoracic (CPT codes 93303, 93304) or Transesophageal Echocardiography (CPT codes 93312, 93314, 93315, 93317). Additionally, there are two existing CPT codes for 3D imaging 76376 and 76377 and it would be up to the individual claim to determine proper the proper code to append.

Q: Is an order necessary to report myocardial train?

A: Physicians must document the intent to order the diagnostic test, and the medical necessity supporting the ordered service. Provider and facility policies may vary and suggest checking with the compliance office if there is concern.

Q: Why is strain being rejected by most payers for routine use with or without diagnosis indication of cardiac toxicity and when used with contrast.

A: There are currently no coding edits prohibiting the reporting of +93356 (strain) with the Medicare contrast codes (e.g., C8929)

As strain was a Category III code in the past and often non-covered, it usually takes private payers about a year or so to review and/or to support new technology codes/policies and the associated literature. Due to the body of clinical evidence about using strain for cardiac toxicity, payers may be more willing to reimburse for that medical necessity. The critical piece for payers to reimburse for other conditions is the body of evidence for the particular conditions identified. In the interim, ensure that prior authorization has been approved in advance with those payers that require echo prior authorizations. Appeal claims based on the individual patient issue and how the strain supported your dx or treatment. If you have a peer reviewed article about that particular condition and how strain supports management, send with an appeal. Reimbursement for new codes and technologies are a process and now that there is a Category I code, the more claims are filed and awareness of clinical utility increases, it moves the potential for coverage forward.

Q: What is the CPT for add on 3D imaging associated with TEE and TTE and is there certain phrasing report that is recommended, for instance do we need to document medical necessity?

A: To report 3D, code the primary echo codes (e.g., TTE, TEE, limited TTE, etc.) in addition to one of the following codes, as applicable. 3D codes are not paid separately for hospital OP studies (by Medicare). Rather the charges that are established

ASE Top Coding Questions

for the 3D procedure are captured on the claim form by hospital billing departments, so longer term, echocardiography payments could be adjusted to accommodate the costs associated with 3D.

Note that the 3D codes also describe CT and MRI and most billing guidelines or coverage policies from payers are focused on those procedures. See below, common clinical indications that payers may allow for echo reimbursement.

» Ensure documentation supports the medical necessity for 3D, which should also be reflected in the ICD-10 diagnosis codes that are reported. Payers/Medicare may or may not separately reimburse depending upon their individual policies.

» Sample language in some Medicare coverage policies for medical necessity. Private payers may have different or similar indications. Check for prior authorization policies as well.

- The pre-operative planning of valve repair for multiple etiologies of mitral regurgitation;
- In the assessment of mitral stenosis and in the accurate calculation of mitral valve area;
- Pre-operative planning for diagnosis and treatment of atrial septal defects; and
- Pre-operative and intraoperative planning for interventional cardiac procedures (e.g., transcatheter placement of occluders for atrial septal defects or patent foramen ovales, or paravalvular dehiscence or leaks;
- Intraoperative mapping for atrial ablation procedure.

Click here to access ASE's guideline for 3D to help support (medical necessity) for denied claims on a case-by-case basis.

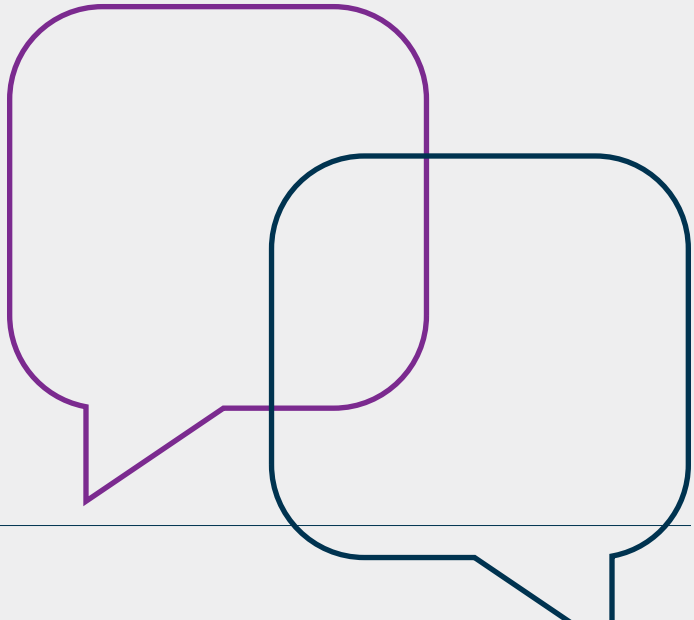
Q: Is there a specific CPT code for bubble studies or IV starts? We spend a lot of resources to perform this addition to our tests only to be able to charge a 93306.

A: The CPT code for IV injections is 96374. There isn't a specific echocardiography administration CPT code for saline injection for echo studies. While the code is available payer payment policies vary and may or may not reimburse for 96374.

Q: What is the difference in 93320 and 93321 and when do I use them?

A: Report 93321 if a limited Doppler exam is performed. This would typically be reported if a limited echo is performed. Report 93320 when a complete Doppler exam is performed except when reporting a complete echo with 93306 as the Doppler components are inclusive with the complete echo exam.

CPT doesn't specifically state what constitutes a limited Doppler vs complete. The selection of the code is to describe intent (is the Doppler answering a specific question) and what was done. The physician selects the code at his/her discretion. Ensure medical necessity documentation supports the code selected (answering a specific question or a need to examine all valves) and that there is rationale should the claim/record be audited. Refer to clinical guidelines if necessary to support decision-making.



ASE Top Coding Questions

Q: What is the proper 993XX TTE CPT code for a TTE with or without contrast?

A: There are two coding methods to report a TTE with contrast. The differentiator is if the patient has Medicare vs non-Medicare. See below a comprehensive explanation of the Medicare "C" Codes. Simply put the hospital outpatient reporting:

- TTE with contrast for non-Medicare patients is 93306+Q9957
- TTE with contrast for Medicare patients 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 plus Q9957

Medicare has established a family of HCPCS "C" echocardiography codes that describe reporting of contrast administration. These codes are 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, the applicable contrast agent "Q" is reported.

Per the National Correct Coding Initiative (NCCI) manual and correct coding edits, Medicare does not allow separate reporting for the IV insertion or injection procedure. Private payers may/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 2D 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

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