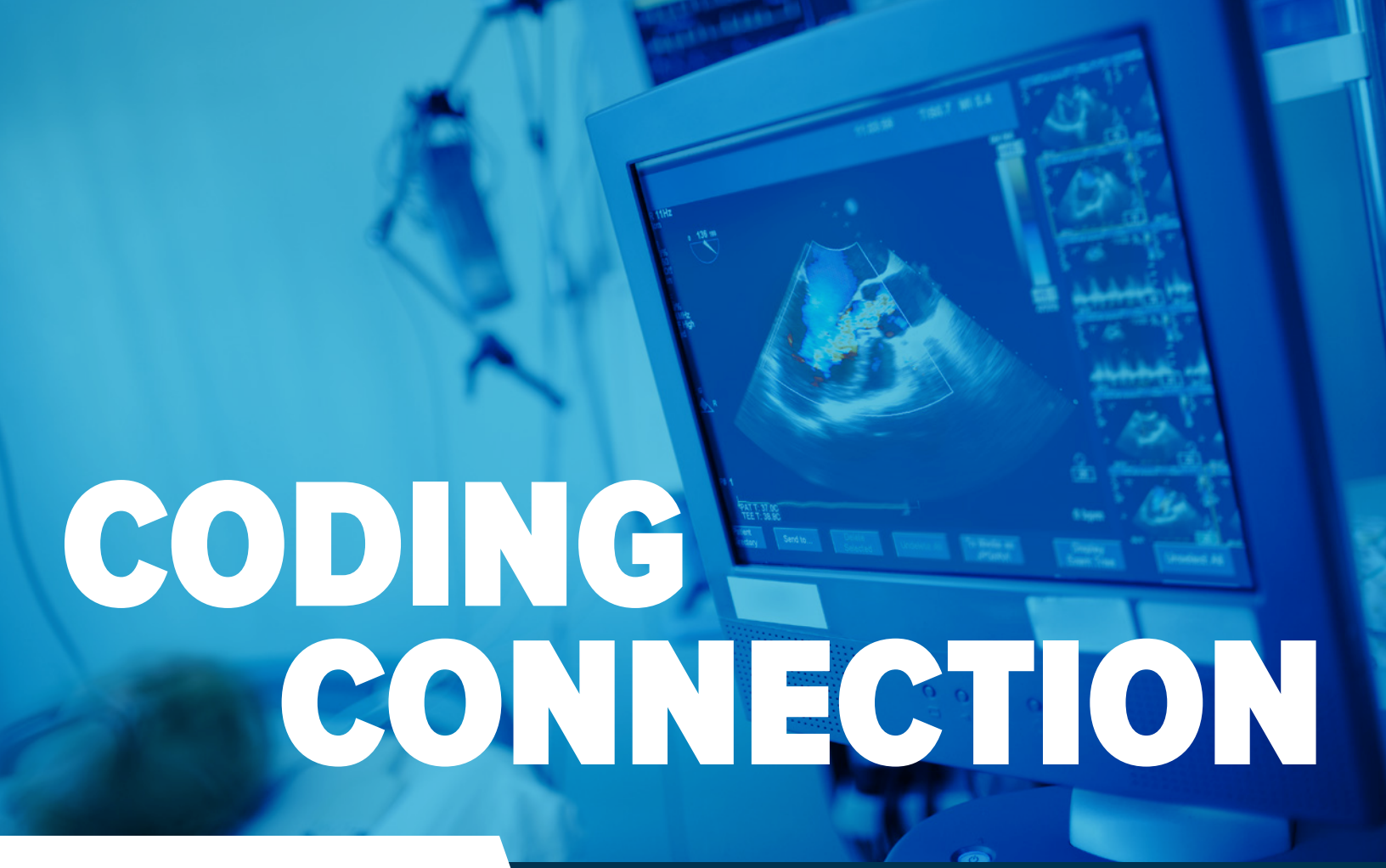

CODING CONNECTION

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.

ASE American Society of Echocardiography
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MAY 2024

AMA Coding Updates: Strain Imaging

There has been a rising interest in the use of strain imaging in echocardiography to better qualify left and right ventricular function and help diagnose various types of cardiomyopathies. The ability of strain to detect those subtle differences in cardiac function is leading to earlier detection or confirmation of numerous disease states, including heart failure, hypertrophic cardiomyopathy (HCM), cardiac amyloidosis, myocardial infarction, left bundle branch block (LBBB), post infarction aneurism, and other conditions.

CPT code **+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 is committed to ensuring that echocardiography services are appropriately identified and reimbursed. We encourage providers to verify with their individual payer mix for coverage of strain imaging (+93356) and if prior authorization must be approved in advance. Claims can be appealed based on the individual patient issue and how 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.

ASE ARTIFICIAL INTELLIGENCE STATEMENT

The use of artificial intelligence (AI) in echocardiography is big topic of interest to members and industry alike. ASE is a strong proponent for innovation in the field of ultrasound and has been actively engaged in fostering AI) to assist guidance of optimal image acquisition for cardiovascular ultrasound. We believe this type of innovation could be an ally to help meet the demands of a growing number of people who need cardiovascular care as obesity and diabetes levels continue to rise around the world. The Society believes vigorous scientific protocols are needed when creating these AI algorithms as the end products need to consider many factors including gender, ethnicity, age, etc. that research has shown can dramatically change the testing outcomes. ASE will continue to set the standards for image analysis, including the quantitative parameters required, expected reliability of measurements, and how these measures are integrated to provide clinical insight. A link to the full policy statement can be found here: ASE AI Policy

CY2024 CATEGORY

CPT Code Update

CPT CLARIFIES GUIDANCE ON ACCURATELY SELECTING CPT CODES AND UNBUNDLING

Revisions have been made to the first and last paragraphs of the "Instructions for Use of the CPT Code Book" section of the preamble to the CPT book to clarify guidance on accurately selecting and assigning CPT codes.

The last paragraph provides clarification on appropriate code assignment to avoid inappropriate unbundling of CPT codes. According to the AMA, "Unbundling refers to using multiple CPT codes for the individual parts of the procedure, either due to misunderstanding or in an effort to increase payment."[1] The CPT manual clarifies that unbundling is inappropriate and offers examples for situations involving Category I and Category III codes. New language states that Category I and Category III codes can be reported together to accurately describe the complete service or procedure "if they represent separately reportable services."

OFFICE VISIT EVALUATION AND MANAGEMENT (E/M) CODE REVISIONS

CPT revised E/M office visit codes 99202-99205 and 99212-99215 to remove the time "range" in minutes from each code. When reporting based on time, clinicians must meet or exceed a single "minimum time threshold" of total time on the dates of the encounter for each code.

SPLIT (OR SHARED) VISITS REVISIONS

CPT has clarified that a split (or shared visit) is defined by the substantive portion of the evaluation and management (E/M) service provided, which can be determined in two ways:

- based on the majority (over half) of the total clinical care time invested in the visit by both the physician and the accompanying qualified healthcare professional (QHP), or
- by a substantive portion of the medical decision making (MDM) process

CPT	2023 Total Time Range in Minutes	2024 "Meet or Exceed" Total Time in Minutes
99202	15–29	15
99203	30–44	30
99204	45–59	45
99205	60–74	60
99212	10–19	10
99213	20–29	20
99214	30–39	30
99215	40–54	40

For the physician to be reported as the billing provider for a shared E/M service, the 2024 CPT Split or Shared Visits Guidelines require the physician to make or approve the management plan for the number and complexity of problems addressed at the encounter for the patient and take responsibility for that plan with its inherent risk of complications, morbidity, or mortality. CPT states, "By doing so, a physician or other QHP has performed two of the three elements used in the selection of the code level based on MDM."

Further, when determining the code level, the physician does not need to interview the independent historian personally or order and/or review tests or external documents. However, the physician must personally perform any independent interpretations and external discussions when these are used in determining the reported E/M level.

In recent years, there has been confusion as the Centers for Medicare and Medicaid Sevices (CMS) considered how to define split or shared visits. In the 2024 Medicare Physician Fee Schedule final rule, CMS announced the adoption of the CPT definition of the "substantive portion" as of January 1, 2024, finally bringing permanent consistency between the agency's rules for physicians and CPT's guidance for split and shared visits.

1 https://www.ama-assn.org/practice-management/cpt/8-medical-coding-mistakes-could-cost-you#:~:text=Unbundling%20refers%20to%20using%20multiple,an%20effort%20to%20increase%20payment.

HCPCS Code Update

NEW G2211 ADD-ON CODE FOR VISIT COMPLEXITY

The Centers for Medicare & Medicaid Services (CMS) created HCPCS add on code G2211 to better account for the resource costs associated with visit complexity inherent to primary care and other longitudinal care. Code G2211 is payable beginning January 1, 2024, and may be submitted with Evaluation and Management (E/M) office or outpatient (O/O) visits, 99202-99215.

CMS Code Descriptor: G2211 – Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)

Per CMS, the relationship between the patient and the physician is the determining factor of when the add-on code should be billed. Documentation would support furnishing services to patients on an ongoing basis that result in care personalized to the patient. The services result in a comprehensive, longitudinal, and continuous relationship with the patient and involve delivery of team-based care that is accessible, coordinated with other practitioners and providers, and integrated with the broader health care landscape.

Do not use G2211 when your relationship with the patient is of a discrete, routine, or time-limited nature, the associated office visit E/M is reported with modifier 25 appended or when reporting CPT code 99211.

Edits to Prevent Payment of G2211 with Office/Outpatient Evaluation and Management Visit and Modifier 25

How to Use the Office & Outpatient Evaluation and Management Visit Complexity Add-on Code G2211

SOCIAL DETERMINATES OF HEALTH RISK ASSESSMENT ESTABLISHED FOR 2024

For 2024, CMS has established a G-code to provide reimbursement for conducting a social risk assessment of a patient: G0136 (Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment tool, 5–15 minutes). The code requires at least five minutes of assessment time and an SDOH-specific screening tool. It cannot be provided more often than every six months. It has been added to the Medicare Telehealth Services list.

Physician Practice Information Survey

The American Medical Association (AMA) has contracted with Mathematica, an independent research company, to conduct the AMA Physician Practice Information Survey. The input from physician practices and individual physicians that are randomly selected to participate in this study is critical for its success and will help shape the future of Medicare physician pay. Participation will ensure that practice expenses and patient-care hours are accurately reflected.

The survey is being administered currently and ASE strongly urges all physicians who are selected for the surveys to respond as soon as possible. It is very important that we get enough responses to have accurate and statistically valid physician cost data. There are two elements to the PPI survey—a financial survey and a physician hours survey. This is particularly important for physicians to ensure the survey results reflect our providers higher practice expenses.

Practices are encouraged to watch their emails for survey invitations. The subject line for the PPI Survey invitation email will read, “American Medical Association requests your input on physician practice expense and patient care hours.” The subject line for the Physician Hours Survey invitation email will read, “Please help to update accurate physician payments.”

Invitations and reminders about the PPI Survey will be sent to financial experts in the practice and will come from PPISurvey@mathematica-mpr.com. Invitations and reminders about the Physician Hours Survey will be distributed to physicians and will come from PhysicianHoursSurvey@mathematica-mpr.com or from the practice directly. If you should have any questions, please contact Sherry Smith, the AMA’s director of physician payment policy and systems.

How the AMA RUC Survey Process Works

The Relative Value Scale Update Committee (RUC) is a multi-specialty committee that provides medicine with a powerful voice in describing the resources required to provide physician services. Since 1991 the RUC has submitted numerous recommendations to the Centers for Medicare & Medicaid Services (CMS) that enhance the underlying data used to create relative values units (RVUs). The RUC, in conjunction with the Current Procedural Terminology (CPT) Editorial Panel, has created a process where specialty societies can develop relative value recommendations for new, revised and potentially misvalued codes as well as update RVUs to reflect changes in medical practice.

The AMA manages the RUC although its activities are a collaborative venture between the AMA, national medical specialty societies, limited license and allied health provider organizations and the Centers for Medicare and Medicaid Services (CMS). It is critical if new or revised echocardiography services are up for review that members who receive the survey respond.

This survey process utilizes provider expertise to ensure that the AMA RUC obtains valid accurate data to evaluate the service and develop recommendations to CMS, the federal agenda responsible for determining the payment schedule for medical services under the Medicare program. Learn more: AMA RUC Process and RUC Booklet.

Top 10 Coding Questions

Q: Please clarify when to code 3D with CPT 93319, and when to code CPT 76376,76377.

A: CPT code +93319 must be utilized with a base echocardiography code: Congenital Transthoracic (CPT codes 93303, 93304) ***or*** Transesophageal Echocardiography (CPT codes 93312, 93314, 93315, 93317). CPT code +93319 should be appended when 3D imaging is provided during the imaging capture portion of the congenital study. If 3D rendering with image interpretation and image post-processing is performed post image capture, then utilize CPT codes 76376 and 76377.

Q: Why is CPT code 93325 (color Doppler) not reimbursed with 93319?

A: The AMA CPT published a new add on CPT code +93319 for CY2022. As part of the discussion during the CPT Panel meeting, there were multiple stakeholders who provided suggested edits and modifications as part of the review process. The outcome from the AMA CPT Panel was to establish a new add-on code which must be utilized with a base echocardiography code: Congenital Transthoracic (CPT codes 93303, 93304) or Transesophageal Echocardiography (CPT codes 93312, 93314, 93315, 93317). During the iterative process noted above, a third party included Color Doppler CPT code +93325 in the exclusionary parenthetical.

ASE worked in conjunction with the pediatric echocardiography community and ACC to request an editorial edit to remove +93325 from the exclusionary parenthetical. Unfortunately, the Panel's interpretation of how Color Flow Doppler is utilized in the performance of +93319 placed in question the viability of this submission. While ASE has a different interpretation, it was concluded that there is not a viable path forward to change to the code.

Q: Are CPT codes 3D 76376, 76377 reimbursed by payers?

A: Sample language in some Medicare coverage policies are below. Private payers may have different or similar clinical indications. Ensure documentation supports the medical necessity (clinically relevant) for 3D, and ensure the ICD-10 codes reflect the clinical indications and/or findings. This documentation will support appeals if claims are denied. Payers/Medicare may or may not separately reimburse depending upon their individual policies.

Possible medical necessity for 3D CPT codes 76376/76377:

1. The pre-operative planning of valve repair for multiple etiologies of mitral regurgitation;
2. In the assessment of mitral stenosis and in the accurate calculation of mitral valve area;
3. Pre-operative planning for diagnosis and treatment of atrial septal defects; and
4. 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;
5. Intraoperative mapping for atrial ablation procedure.

Top 10 Coding Questions (cont.)

Medicare expects there will be a primary diagnosis code(s) that is representative of the patient's medical condition, which supports the need for the base imaging procedure. Use the secondary diagnosis that most closely represents the body area that is to be 3-D imaged (implies medical necessity for 3-D rendering and interpretation). Example for secondary diagnosis is:

R93.1 Abnormal findings on diagnostic imaging of heart and coronary circulation.

Q: Are there billable ICD-10 codes to report medical necessity when strain is performed?

A: Medical necessity for strain varies among payers. There isn't one list and often the codes are not listed in policies. Here is a sample of a UHC guideline policy and a partial component.

Myocardial strain imaging (CPT® 93356, speckle tracking longitudinal strain) is indicated for the initial evaluation of LVH, in addition to the primary echocardiogram, when there is documentation of both:

» Unclear etiology

» Concern for infiltrative cardiomyopathy

Myocardial strain imaging (CPT® 93356) in addition to the primary echocardiogram in individuals receiving therapy with cardiotoxic agents for ANY of the following:

» Initial evaluation-prior to treatment with EITHER:

- Medications that could result in cardiotoxicity/heart failure.
- Radiation that could result in cardiotoxicity/heart failure.
- Re-evaluation of an individual previously or currently undergoing therapy as per echocardiogram parameters. See Cardiotoxic agent/Cancer Therapeutics-Related Cardiac Dysfunction (CD-12.1).
- Re-evaluation of an individual undergoing therapy with worsening symptoms.

Q: What CPT codes are used for a complete fetal echo with color, Doppler, M mode, and umbilical vein and artery?

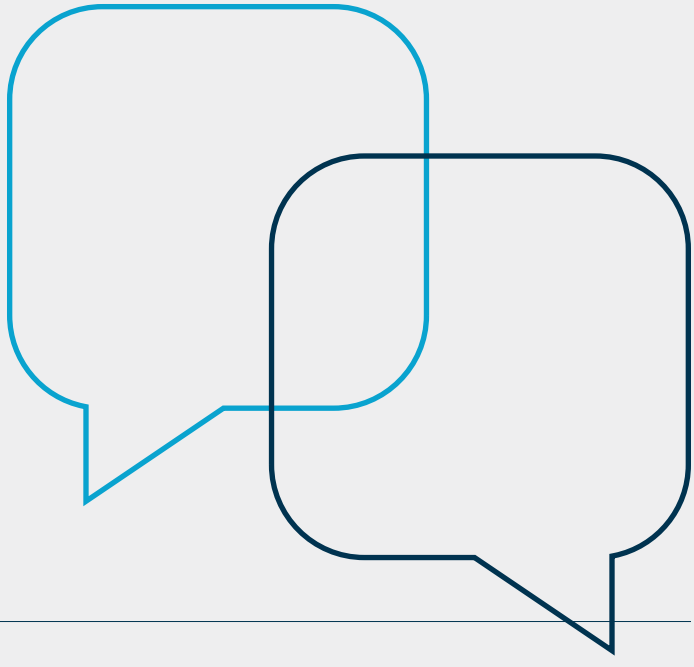
A: Report CPT codes 76825 (complete 2D echo, with or without M mode), 76827 (Doppler), 93325 (color Doppler).

Q: Is there a code for outpatient bubble study besides the 93306 for the professional component?

A: There is not a specific code for reporting saline echo. For a complete echo, report CPT code 93306. For a limited echo, report CPT 93308 and if limited.

Doppler and color Doppler are performed, report CPT codes 93321(Doppler) and 93325(color Doppler).

Per CMS NCCI billing edits, for procedures requiring intravenous injection of dye or other diagnostic agent, CMS considers the Introduction of a needle (36000) and IV push injection (96374-96376) integral to the procedure and not separately reportable. IV insertion is not separately paid.



Top 10 Coding Questions (cont.)

Q: Does 93355 (interventional TEE code) include the Doppler exam (93320 and 93325), and 3D codes (76376 or 76377)?

A: Doppler and 3D are included in the code and should not be reported separately. This is the description and guidance from CPT for code 93355.

Interventional TEE Code 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 intra-procedural), 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**.

Code 93355 includes the work of passing the endoscopic ultrasound transducer through the mouth into the esophagus, when performed by the individual performing the TEE, diagnostic transesophageal echocardiography and ongoing manipulation of the transducer to guide sizing and/or placement of implants, determination of adequacy of the intervention, and assessment for potential complications. Real-time image acquisition, measurements, and interpretation of image(s), documentation of completion of the intervention, and final written report are included in this code. A range of intracardiac therapies may be performed with TEE guidance.

Q: Can a TTE and stress echo be performed on the same day?

A: Per CPT Assistant guidance (January 2010) Transthoracic echocardiography (code 93303, 93304, 93306, 93307 or 93308) may be reported on the same date of service as a stress echo (code 93350-93352) for a different clinical circumstance. Modifier-59, Distinct Procedural Service, should be appended to the applicable transthoracic echo code to indicate that a separate and distinct transthoracic echocardiography was performed on the same date of service as the stress echocardiography.

Payers may or may not reimburse for both procedures. Confirm documentation is comprehensive to support the medical necessity for both a TTE and stress echo on the same date of service. Ensure the ICD-10 dx codes reflect this information.

Q: What elements of the exam need to be placed into a report in order to receive reimbursement for both complete or limited echoes?

A: Per the CPT Echocardiography Introduction Section of the CPT book, here are the definitions of a complete or limited echo that must be met.

- **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**.

Top 10 Coding Questions (cont.)

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.

Q: Please clarify the use of congenital CPT echo codes.

A: CPT Education and Information services has referenced that CPT Codes 93303, Transthoracic echocardiography for congenital cardiac anomalies, complete and 93304, follow-up or limited study should NOT be used for “simple” congenital anomalies such as patent foramen ovale (PFO) or bicuspid aortic valve. In these cases, the non-congenital echocardiography codes (93306-93308) should be used.

CPT has issued multiple guidance articles since 2013 with various coding tips about the use of congenital echo codes. Regarding guidance about “simple” or “complex” congenital procedures, we note that since the AMA CPT code book does not have a definition of congenital it does allow for latitude; CPT codes 93303 and 93304 are defined as congenital complete or limited - not simple or complex. There are no vignettes or descriptions of the services as these codes have not been reviewed or updated since 1996.

Physician selection of coding may be based on findings and the medical record/report. Ensure clinical and technical documentation are comprehensive. For reference, see the definitions of a complete or limited echocardiograms from the AMA CPT code book that are described in Question 9 above.

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