

American Society of Echocardiography Coding Newsletter

The American Society of Echocardiography (ASE) works closely with the American Medical Association (AMA) to ensure that adequate reimbursement methods are in place for echocardiography services. ASE's advisors continuously review the 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 their 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. Using the most appropriate CPT® code is essential in the correct reporting of services to obtain fair and reasonable reimbursement for procedures, tests, and visits.

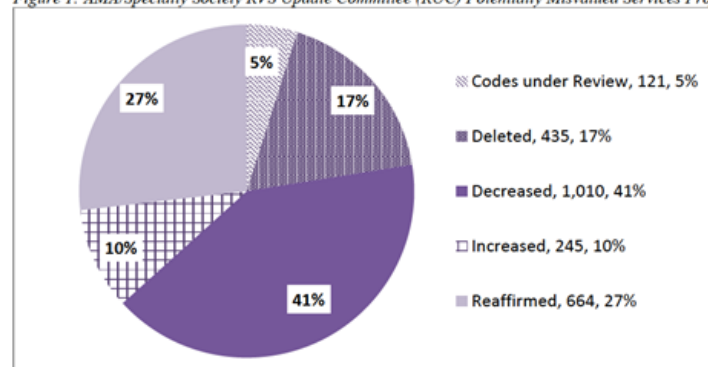
CPT Code 93306 to be Reviewed by the RUC – Again

In an unprecedented move, CMS accepted Anthem, Inc.'s nomination of seven CPT codes including 93306 – Transthoracic Echocardiography (TTE) – as potentially "misvalued." This occurred despite the fact that the work RVUs for CPT code 93306 were just revised and published in CY2018 Medicare Fee Schedule (MPFS). That recent review, for publication in CY2018 MPFS, included a robust survey response rate of over 170 responses, which

far exceeded the minimum number of responses required by the RUC for this service. Such strong and compelling RUC survey participation makes it unlikely that pre-, post-, and intra-service time data are inaccurate.

Returning to the RUC is very challenging. Per AMA data, the majority of codes undergoing RUC review see a decrease in value or are deleted, as shown in this chart.

Figure 1: AMA/Specialty Society RVS Update Committee (RUC) Potentially Misvalued Services Project



The RUC survey for 93306 was released in late February for presentation in April 2019. If you participated in the RUC survey process – we greatly appreciate your feedback. Member engagement is key in the assessment of the time, complexity, and physician work value for these procedures.

ASE is committed to ensuring that this code is fairly valued, but we will need your help! Contact [Irene Butler](#) if you have any questions.

Reminder - TEE Sedation must be billed separately

Moderate sedation for TEE will not be included and must be billed separately under new CPT codes. Moderate (or conscious) sedation is defined by CPT as drug-induced depression of consciousness in which the patient maintains the ability to purposefully respond to verbal commands (either alone or with light tactile stimulation). No interventions are necessary to maintain cardiovascular and airway function

without support and spontaneous ventilation is adequate. If moderate sedation is not billed separately, payment will be lost.

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 five years of age

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.

99152 patient age 5 years or older

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)

Additional codes 99155, 99156 and 99157 are used when someone other than the physician performing the TEE performs the moderate sedation service.

When to Bill 93306 vs. 93308

Recently there have been questions about when to report either complete TTE (93306) vs. limited or follow-up TTE studies (93308).

Carefully review the CPT descriptors –

CPT code 93306 Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography describes a complete transthoracic echo with Doppler and color flow.

CPT® introductory language criteria clarify: a complete transthoracic echocardiogram requires 2-dimensional and, when performed, selected M-mode examination of the left and right atria, left and right ventricles, the aortic, mitral and tricuspid valves, the pericardium and adjacent portions of the aorta. (Note that while M-mode exam is sometimes performed, it is not required in order to assign a complete echo code.) If it is impossible to image all of the listed structures, the report must indicate the reason. A limited transthoracic echocardiogram should be billed if the report does not evaluate or attempt to evaluate all of the structures listed above.

CPT code 93308 Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study. When Doppler is performed and color Doppler is performed on a limited echo study, 93321 and 93325 should be billed.

To clarify, this does not evaluate (or document the attempt to evaluate) all the structures that comprise the complete echocardiographic exam, as outlined in the CPT® criteria, above. A limited study is typically confined to, or performed in follow-up of a focused clinical concern.

Further, CPT Assistant (September 2005) further advises:

[echo] whether complete or limited, includes an interpretation of all obtained information,

documentation of all clinically relevant findings including quantitative measurements obtained, plus a description of any recognized abnormalities. Pertinent images, videotape, and/or digital data are archived for permanent storage and are available for subsequent review. Use of echocardiography not meeting these criteria is not separately reportable.

Finally, 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.

LVAD Ramp Studies

Recently questions have come up on how to code for a left ventricular assist device (LVAD) ramp study performed during a diagnostic right heart catheterization.

Currently, there is no specific CPT code for an LVAD ramp study. CPT code 93750, Interrogation of ventricular assist device (VAD), in person, with physician or other qualified healthcare professional, analysis of device parameters (e.g. drivelines, alarms, power surges), review of device function (e.g. flow and volume status, septum status, recovery), with programming, if performed, and report, may be reported only if **all** service components of the code are performed. These services include: a) interrogation of VAD, in person, with physician or other qualified health care professional; b) analysis of device parameters (e.g. drivelines, alarms, power surges); c) review of device function (e.g. flow and volume status, septum status, recovery); and d) with programming, if performed. If all the services described in code 93750 are not performed, then code 93799, unlisted cardiovascular service or procedure, should be reported. Right heart catheterization is reported with code 93451, Right heart catheterization including measurement(s) of oxygen saturation and

cardiac output, when performed. The services described by code 93750 are not included with a right heart catheterization procedure. When a TTE is performed and documented, the appropriate code (93306, echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography, or 93308, Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study) may also be reported. If performed, limited Doppler (93321) and color Doppler (93325) should be added services billed with 93308.

Myocardial Contrast Perfusion Imaging

Coding accurately for the services you provide is essential, especially in today's environment when you are facing declining reimbursement and increased scrutiny. ASE is committed to ensuring you are fairly reimbursed for your work. In this effort, the Society was able to establish a Category III echocardiographic CPT® code for perfusion imaging, and we encourage members to use this code when appropriate.

While Category III codes are not reimbursed by the Centers for Medicare and Medicaid Services (CMS), these codes are sometimes 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 +0439T: Myocardial contrast perfusion echocardiography imaging code 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 but may be used only in conjunction with echocardiography base codes 93306, 93307, 93308, 93350, and 93351.

There is a time frame for utilization. If the codes are not used they may “sunset” after five years, eliminating the opportunity to establish reimbursement and limiting patients’ access to the technology. Therefore, ASE is encouraging you to **share information about these new codes** with your staff and business departments, and **submit these codes** whenever myocardial perfusion echocardiography is performed.

CMS Modifies LCD Process and Policies

Did you know? CMS recently implemented a revised process for the promulgation and consideration of local coverage determination (LCD) policies. CMS has stated that effective immediately, it will no longer be appropriate to routinely include Current Procedure Terminology (CPT) codes or International Classification of Diseases Tenth Revision-Clinical Modification (ICD-10-CM) codes in the LCDs. All codes will be removed from LCDs and placed in billing & coding articles that are linked to the LCD.

For additional information please see - <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10901.pdf>