



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.



NEW CODE ALERT - MYOCARDIAL STRAIN

ASE is pleased to announce CPT code +93356. This code is to be used when reporting myocardial strain imaging.

FINISH READING ON PAGE 2

E/M CHANGES

CY2021 will bring sweeping changes to the way Evaluation and Management services are reported.

FINISH READING ON PAGE 3

ASE TOP QUESTIONS

We will review the most recent queries to the ASE Coding Hotline and provide responses for our members.

FINISH READING ON PAGE 4

New Code Alert - Myocardial Strain



ASE is pleased to announce the establishment of Current Procedural Terminology (CPT) add-on code +93356® to report myocardial strain imaging using speckle tracking derived assessment of myocardial mechanics. ASE was pleased to collaborate with the American College of Cardiology (ACC) on this successful CPT application. Code +93356 was effective for Medicare claims processing January 1, 2020 or later.

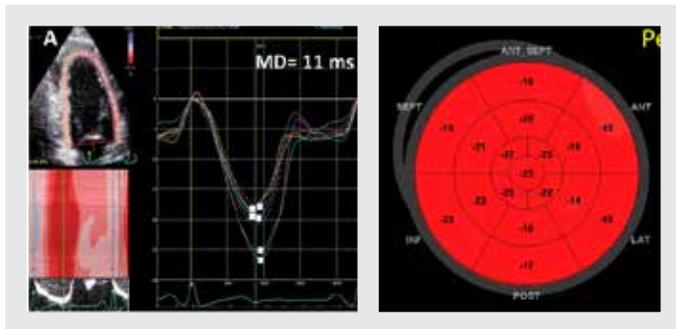
Myocardial strain imaging is used for the quantitative assessment of myocardial mechanics using image-based analysis of local myocardial dynamics. This technology helps with early detection of decreased

ventricular function allowing modification in the chemotherapy regimen, either by increasing the interval between doses or reducing the total cumulative dose of a potentially toxic agent.

Early identification of cardiotoxicity leads to initiation of cardioprotective agents such as beta-blockers and angiotensin converting enzyme inhibitors which improve prognosis. Patients can receive treatment of their cancer while simultaneously addressing and evaluating for cardiotoxicity.

It is intended to report +93356 in conjunction various transthoracic echocardiography procedures 93303, 93304, 93306 and 93308 in addition to stress echocardiography services 93350 and 93351. Additionally, the intent is for this code to be reported once per imaging session. Please refer to the AMA CPT Codebook for additional details.

ASE is pleased that myocardial strain imaging has transitioned from a category III (tracking) CPT code to a category I (Medicare reimbursable) CPT code.



+93356 Myocardial Strain Imaging Speckle Tracking

Non-Facility - CY2020							
wRVU	Payment	PE RVU	Payment	MIP	Payment	Total RVU	Total Payment
0.24	\$8.66	0.87	\$31.40	0.02	\$0.72	1.13	\$40.78
Facility - CY2020							
wRVU	Payment	PE RVU	Payment	MIP	Payment	Total RVU	Total Payment
0.24	\$8.66	0.08	\$2.86	0.01	\$0.36	0.34	\$12.27

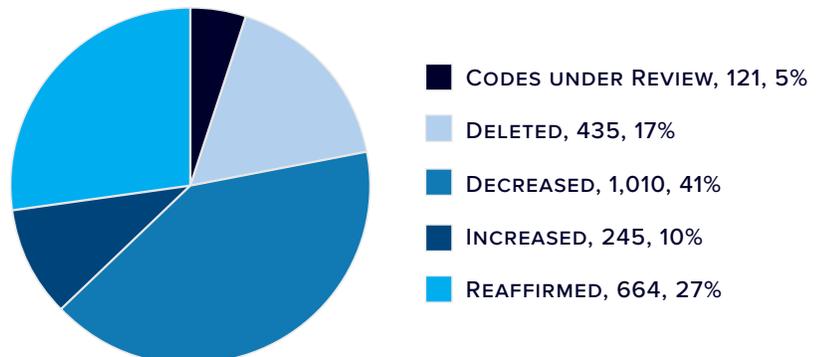
ASE CODING IN ACTION

ASE's CPT advisors continuously review Current Procedural Terminology (CPT®) and work through the AMA process to revise and add new codes, as appropriate. Coding accurately for the services you provide is essential, especially in today's environment of declining reimbursement and increased scrutiny.

Additionally, ASE participates in the AMA RUC (Relative Value Update Committee). This is the group who will review proposed valuations and submit recommendations to CMS on valuation. Presenting at the RUC is challenging and we are pleased to have such a seasoned and respected team representing ASE interests. As you will note in the grid to the left – over 50% of the existing CPT codes taken to the RUC for review are either deleted or decreased in value.

Reporting the accurate CPT codes for services performed in your practice and ensuring the valuation of those services is fair and reasonable reimbursement is paramount to ASE. We are committed to ensuring you are fairly compensated for your work.

FIGURE 1: AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE (RUC) POTENTIALLY MISVALUED SERVICES PROJECT



Evaluation and Management Coding Changes

CMS finalizes plan to adopt Evaluation and Management (E/M) coding and reimbursement changes proposed by the American Medical Association (AMA) beginning 2021. As announced, CMS accepted a plan to align with recent changes laid out by the AMA Current Procedural Terminology (CPT) Editorial Panel, which retains five levels of coding for established patients, reduced the number of levels to four for new patients, and revised the code definitions.

The revised coding definitions is paired with a decision to pay for each level of service rather than use a blended rate. Additionally, CMS is incorporating recommendations to revise work and practice expense (PE) inputs for E/M services.



TABLE 1

HCCPS Code	2019 Work RVU	2021 Work RVU
New Patient Office Visit		
99201	0.48	N/A
99202	0.93	0.93
99203	1.42	1.60
99204	2.43	2.60
99205	3.17	3.50
Established Patient Office Visit		
99211	0.18	0.18
99212	0.48	0.70
99213	0.97	1.30
99214	1.50	1.92
99215	2.11	2.80
Prolonged Services Add-On (Extended Visits)		
99XXX	N/A	0.61

NOTE: TABLE 125 OF FINAL RULE (IMPACT ANALYSIS SECTION), ON PAGE 1971

The CPT code changes allow clinicians to choose the E/M visit level based on either medical decision making or time. Finally, CMS is not adopting changes to the global surgery codes for CY2021, as they continue to evaluate data. CMS finalized this plan for implementation January 1, 2021.

The impact on specialties or individual practices will be driven by the mix of E/M services they bill. Specialties and practices that bill higher level established patient visits will see the greatest increases, as those codes were revalued higher relative to the rest of the office/outpatient E/M code set. Specialties and practices that do not generally bill office/outpatient E/M visits may experience greater decreases. In the final rule, CMS acknowledged the “redistributive impact” of the finalized E/M changes as well as commenter concerns but indicated that it is premature to discuss strategies for mitigating the impact of these changes. CMS intends to further consider these concerns and address them in future rule making.

ASE will continue to monitor and provide additional educational materials for our members as these changes are finalized in the CY2021 MPFS.



ASE Top Coding Questions

Q1. What are the parameters for billing either a complete or limited/follow up echocardiogram whether it's for congenital or non-congenital echoes? If you are performing a limited echo to answer a specific question but then the tech finds a different source for the problem that is causing the patient's change in symptoms does that still answer the focused question and a limited/follow up study should still be billed?

A. 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 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.

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. 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.

As the ordering provider requested a limited/follow up study, a limited echo 93308 should still be billed. If a complete echo is required, the ordering provider should be contacted and discussion as to need for a complete study so the order can be changed to a complete echo.

Q2. Is CPT code 0399T payable by Medicare in 2020?

A. CPT Code 0399T has been deleted for services on or after January 1, 2020. For services January 1, 2020 or post please report CPT code +93556.

Q3. Why do we use C-codes in the Hospital and CPT codes in the office?

A. C-codes or HCPCS codes were created to include the contrast for echocardiography services. CPT codes in the office setting reflect the echocardiography service only. Report the applicable contrast agent codes (Q9955, Q9956, Q9957, or Q9950). Per the NCCI manual and correct coding edits, Medicare does not allow separate reporting for the IV insertion or injection procedure.

Q4. How are contrast echocardiography procedures reported by the hospital?

A. Medicare has established an entire family of "HCPCS" echocardiography "C" codes for reporting by the hospital when an outpatient contrast echo procedure is performed (see Table 1 on previous page). In addition to reporting the contrast procedure, the hospital should report the applicable contrast agent "Q" codes (Q9955, Q9956, Q9957, or Q9950. 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 "HCPCS" echocardiography "C" codes. Check with payers.

Q5. What is the code for myocardial contrast perfusion?

A. 0439T myocardial contrast perfusion echocardiography, at rest or with stress, for assessment of myocardial ischemia or viability (list separately in addition to code for primary procedure). The CPT instruction allows reporting with TTE and stress echo primary procedures.

Use 0439T in conjunction with 93306, 93307, 93308, 93350, and 93351. Code 0439T is an add-on Category III CPT code, which does not have any assigned relative value units (RVU's). Physician payment is at the discretion of the payer. Medicare does not separately pay for this procedure when done in the hospital setting.

If contrast is used, a separate HCPCS code is appended.