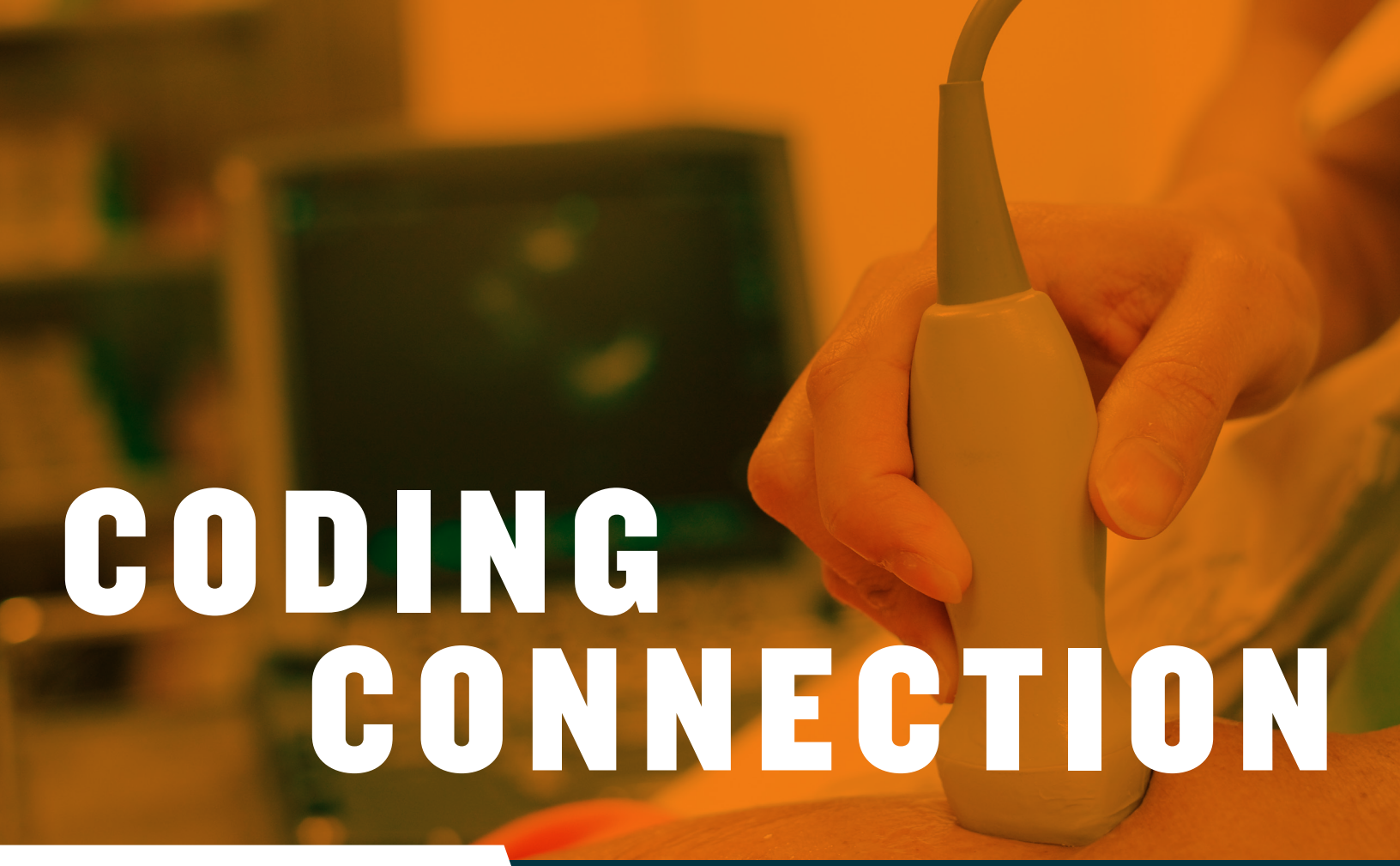

CODING CONNECTION

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 ADD-ON CODE FOR 3D ECHOCARDIOGRAPHY

ASE is committed to ensuring that echocardiography services are appropriately identified and reimbursed.

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MYOCARDIAL STRAIN IMAGING CODE +93356

CPT code +93356 should be reported for myocardial strain imaging

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MEDICARE SPLIT/SHARED VISIT CHANGES

Changes to CMS' longstanding policies for split or shared

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ASE AMERICAN SOCIETY OF ECHOCARDIOGRAPHY
Sound Saves Lives

MARCH 2022

New Add-on Code for 3D Echocardiography +93319

ASE is committed to ensuring that echocardiography services are appropriately identified and reimbursed. One such example is a new add-on CPT code for 3D echocardiography. This new CPT® code for calendar year (CY) 2022 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.

To use this new add-on code and be reimbursed properly, you must list this new CPT code **in addition** to the appropriate base echocardiography code: Congenital Transthoracic (CPT codes 93303, 93304) or Transesophageal Echocardiography (CPT codes 93312, 93314, 93315, 93317). It is important to note that this is not an add-on code for CPT code 93355 since this code already includes 3D imaging for guidance of a structural intervention. The physician work RVUs for +93319 is 0.50.

CPT/HCPCS CODE	DESCRIPTION
3D Imaging	
+93319	**3D echocardiographic imaging and postprocessing during transesophageal echocardiography, or during transthoracic echocardiography for congenital cardiac anomalies, for the assessment of cardiac structure(s) (eg, cardiac chambers and valves, left atrial appendage, interatrial septum, interventricular septum) and function, when performed (List separately in addition to code for echocardiographic imaging)**

There are two existing CPT codes for 3D imaging 76376 and 76377. These codes are for 3D rendering with image interpretation and image post-processing under concurrent physician supervision. CPT code 76376 takes place on the echo machine while CPT code 76377 should be reported if work is performed on an independent workstation.

CPT codes 76376 and 76377 are not add-on codes and are appropriate for reporting 3D-rendering services provided on a date separate from the base-imaging study. The physician work RVUs for 76376 is 0.20 and for 76377, 0.79.

CPT code +93319 is a new code for 2022, therefore coverage and reimbursement are in flux. ASE suggests that providers always verify with the payers if prior authorization must be approved in advance. Claims can be appealed based on the individual patient issue and how 3D supported their diagnosis or treatment for patients with non-coverage policies.

Myocardial Strain Imaging Code +93356

CPT code +93356 should be reported for 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, amongst other applications.

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 if strain performed. Please refer to the AMA CPT Codebook for additional details.

As always, ASE suggests that providers verify with their individual payer mix for coverage of strain imaging and if prior authorization must be approved in advance. Finally, ASE retains an expert in coding to answer individual member coding questions. This service is available by logging in to the ASE Member Portal and clicking "Ask a Coding Expert" to get an answer from the experts.

IMPORTANT INFORMATION ABOUT ADD-ON CODES

Add-on codes are CPT codes identified with the "+" symbol. These codes are eligible for payment only if it is reported with the appropriate primary procedure performed by the same physician. ***The procedure must be medically necessary and proper documentation must be submitted to explain why the procedure required more work than usual and why an add-on code is needed.*** ASE recommends periodically reviewing 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.

Modifier 93

At its September 2021 meeting, the CPT® Editorial Panel accepted the addition of Modifier 93, which allows reporting of medical services that are provided through real-time interaction between the physician or other qualified healthcare professional and a patient through audio-only technology. The use of this modifier became effective January 1, 2022. Current legislation will extend Telehealth Flexibilities beyond 151 days following the public health emergency.

MODIFIER 93 DESCRIPTOR

Synchronous telemedicine service is rendered by telephone or other real-time interactive audio-only telecommunications system.

Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified healthcare professional and a patient who is located away at a distant site from the physician or other qualified healthcare professional.

The totality of the communication of information exchanged between the physician or other qualified healthcare professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that is sufficient to meet the key components and/or requirements of the same service when rendered through a face-to-face interaction.

CPT Appendix S: AI Taxonomy for Medical Services & Procedures

At its September 2021 meeting, the CPT® Editorial Panel accepted the addition of a new Appendix S to provide guidance for classifying various artificial intelligence/augmented intelligence (AI) applications. This guidance should be consulted for code change applications (CCAs) which describe work associated with the use of AI-enabled medical services and/or procedures.

This taxonomy provides guidance for classifying various AI applications (e.g., expert systems, machine learning, algorithm-based services) for medical services and procedures into one of three categories: assistive, augmentative, or autonomous. The use of this appendix for guidance on coding was effective January 1, 2022.

THREE CATEGORIES FOR AI APPLICATIONS

AI as applied to healthcare may differ from AI in other public and private sectors (e.g., banking, energy, transportation). Note that there is no single product, procedure, or service for which the term "AI" is sufficient or necessary to describe its intended clinical use or utility; therefore, the term "AI" is not defined in the code set.

In addition, the term "AI" is not intended to encompass or constrain the full scope of innovations that are characterized as "work done by machines." Classification of AI medical services and procedures as assistive, augmentative, or autonomous is based on the clinical procedure or service provided to the patient and the work performed by the machine on behalf of the physician or other qualified healthcare professional (QHP).

1. ASSISTIVE CLASSIFICATION

The work performed by the machine for the physician or other QHP is assistive when the machine detects clinically relevant data without analysis or generated conclusions. Requires physician or other quality healthcare provider (QHP) interpretation and report.

2. AUGMENTATIVE CLASSIFICATION

The work performed by the machine for the physician or other QHP is augmentative when the machine analyzes and/or quantifies data in a clinically meaningful way. Requires physician or other QHP interpretation and report.

3. AUTONOMOUS

The work performed by the machine for the physician or other QHP is autonomous when the machine automatically interprets data and independently generates clinically relevant conclusions without concurrent physician or other QHP involvement. Autonomous medical services and procedures include interrogating and analyzing data. The work of the algorithm may or may not include acquisition, preparation, and/or transmission of data. The clinically relevant conclusion may be a characterization of data (e.g., likelihood of pathophysiology) to be used to establish a diagnosis or to implement a therapeutic intervention. There are three levels of autonomous AI medical services and procedures with varying physician or other QHP professional involvement:

- **Level I** —The autonomous AI draws conclusions and offers diagnosis and/or management options, which are contestable and require physician or other QHP action to implement.
- **Level II** — The autonomous AI draws conclusions and initiates diagnosis and/or management options with alert/opportunity for override, which may require physician or other QHP action to implement.
- **Level III** — The autonomous AI draws conclusions and initiates management, which require physician or other QHP action to contest decision.

Medicare Split/Shared Visit Changes

Changes to CMS longstanding policies for split or shared evaluation and management (E/M) visits went into effect on January 1, 2022, to better reflect the evolving role of non-physician practitioners (NPP) as members of the medical team.

CMS updated definitions, implementing new reporting rules regarding where the services are reported and who can report them, creating a new modifier, and clarifying conditions of payment that must be met to bill Medicare for these services.

SPLIT/SHARED VISIT DEFINITION

Historically, CMS has defined a split or shared visit as an encounter where both the physician and NPP perform a substantive portion of the E/M visit. However, the new definition requires the physician and NPP to be in the same group and it must be performed in the facility setting so that the E/M visit could be billed by either the physician or the NPP if it was furnished independently by only one of them.

Medicare Definition of Split/Shared Visit	
Current Definition	**New Definition for 2022 and Beyond**
A medically necessary encounter with a patient where the physician and a qualified NPP each personally perform a substantive portion of an E/M visit face to face with the same patient on the same date of service.	An E/M visit in the facility setting that is performed in part by both a physician and an NPP who are in the same group, in accordance with applicable laws and regulations. Furnished in a facility setting by a physician and an NPP in the same group. Furnished in accordance with applicable law and regulations, including conditions of coverage and payment, such that the E/M visit could be billed by either the physician or the NPP if it were furnished independently by only one of them in the facility setting (rather than as a split or shared visit).

REPORTING RULES

As of January 1, 2022, split and shared visits can be performed only in a facility setting. While office services reported with POS 11 cannot be reported as shared visits, you can still report incident-to-services in the office setting.

Previous CMS provisions were interpreted to mean split or shared visits could not be billed for new patients. However, the new rules state that they can be reported for new or established patients and for initial and subsequent encounters. Inpatient hospital services, observation services and Emergency Department visits, and critical care services can be billed as shared services.

NEW DEFINITION FOR "SUBSTANTIVE PORTION"

Beginning January 1, 2022, the practitioner who performs more than half of the total time spent on the E/M or one of the three key components in its entirety can bill the visit. Keep in mind that you cannot count duplicated time.

CMS Example: If history is used as the substantive portion and both practitioners take part of the history, the billing practitioner must perform the level of history required to select the visit level billed.

Medicare Definition of "Substantive Portion"		
Current Definition	**2022 – Transitional Year**	**2023 and beyond**
All or some portion of the history, exam, or medical decision-making key components of an E/M service.	The practitioner who performs more than 50% of the time of the visit or the practitioner who performs and documents in its entirety either the history, exam or MDM portion of the note When one of the three key components is used as the substantive portion in 2022, the practitioner who bills the visit must perform that component in its entirety in order to bill it.	The "substantive portion" of the visit is more than half of the total time spent.

Note that the cardiology societies along with other specialty societies are pressing CMS to change the 2023 requirement to allow for either time, as described here, OR medical decision-making, to be the basis of ability to bill. If the physician needs to spend more than half the total time of a split-shared visit, rather than documenting the medical decision-making summary, the ability to efficiently use advanced practice providers in hospital settings will be largely negated.

NEW -FS MODIFIER FOR SPLIT/SHARED VISITS

CMS created new mandatory claims modifier -FS to be appended to all split or shared visits beginning January 1, 2022, that will allow the agency to perform a more targeted review of services furnished by physicians and non-physician providers.

> *FS: Split (or shared) Evaluation and Management service*

NEW DOCUMENTATION REQUIREMENTS

Medicare has not previously published guidance on reporting split or shared visits. However, beginning January 1, 2022, you must identify the practitioners who performed the split/shared visit and the billing practitioner must sign and date the medical record. Check with your billing department and EHR vendor to ensure they are prepared to implement the new rules and changes expected.

ASE Top Coding Questions

Q. Is an order necessary to report strain?

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 diagnostic 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 not 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 diagnosis 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 that are filed and awareness of clinical utility increases, it moves the potential for coverage forward.

Q. Can 3D be part of an as needed protocol on TTE or must it have a specific order by a provider? The CPT codes sent to us don'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 the proper code to append.

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

A. To report 3D, you must 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 outpatient studies (by Medicare). Rather the charges that are established 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.
    1. The pre-operative planning of valve repair for mechanism and severity of valvular 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;
    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;)

Here is a link to ASE guidelines for 3D to help support (medical necessity) for denied claims on a case-by-case basis.

ASE Top Coding Questions

Q. Is there a specific CPT code for bubble studies or starting an IV? We spend a lot of time and resources to perform this service in addition to baseline echo service.

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.

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 Healthcare Common Procedure Coding System (HCPCS) codes "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 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 (TTE) with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; complete.
- C8922 Transthoracic echocardiography (TTE) with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; follow-up or limited study.
- C8923 Transthoracic echocardiography (TTE) 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 (TTE) 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 (TTE) 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.

CY2022 Medicare Payment Conversion Factor & Impact to Echocardiography

The final calendar year (CY) 2022 PFS conversion factor is $34.6062.

- As a result of advocacy efforts across the entire field of medicine, on December 10, 2021, President Biden signed the Protecting Medicare and American Farmers from Sequester Cuts Act into law. This Act mitigates the planned cut to the 2022 MPFS conversion factor by including another one-year increase to the conversion factor, this time for 3.0%.
- The severe cuts to reimbursement would have been further exacerbated if Congress had not averted two additional statutory cuts referred to as "sequestration."
  - » One sequestration reduction is a mechanism that had been in place prior to the COVID-19 public health emergency (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 sequestration 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 2023.
- **Cumulatively, these relief provisions mitigate what would have been a roughly 9.0% cut in overall payments to an approximately 2.0% reduction throughout 2022.**
- **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

- 2022 MPFS Final Rule Payment Changes

DISCLAIMER

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