Electrophysiology

Jim Collins, CPC, CCC
President, CardiologyCoder.Com, Inc.

Two Types of Diagnostic EP Studies

93619 Basic, Comprehensive Study
- RA Record
- His Record
- RV Record
- RA Pace
- RV Pace

93620 Comprehensive Study + Stimulation
- Includes all of the components of a comprehensive study PLUS Induction or attempted induction of an arrhythmia

“A comprehensive diagnostic electrophysiologic evaluation must include those services used to derive diagnostic information as described by codes 93600, 93602, 93603, 93610, and 93612. For 93620, an attempted arrhythmia induction must also be included with all of the above.” HRSOnLine.Org

“Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52.”

Infusion & Induction

93623-26 – Programmed stimulation and pacing after intravenous drug infusion (List separately in addition to code for primary procedure)

- This is an “add-on” code that must be reported with a primary procedure:
  - 93610 – RA pacing
  - 93612 – RV pacing
  - 93619 – Basic comprehensive EPS
  - 93620 – EPS with induction attempt
  - 93653 – SVT ablation
  - 93654 – VT ablation
  - 93656 – PVI ablation

- Billable when drugs are used to induce & diagnosis an arrhythmia
- Not billable when used to confirm the success of an ablation
  - “To screen for arrhythmias, Isuprel was infused…”

*29. CPT code 93623 (programmed stimulation and pacing after intravenous drug infusion) is an add-on code that may be reported per CPT Manual instructions only with CPT codes 93619 or 93620 (comprehensive electrophysiologic evaluation). CPT code 93623 should not be reported for injections of a drug with stimulation and pacing following an intracardiac catheter ablation procedure (e.g., CPT codes 93650-93657) to confirm adequacy of the ablation. Per CPT Manual instructions, CPT code 93623 is not intended to be reported with the intracardiac catheter ablation procedure codes, an confirmation of the adequacy of ablation is included in the intracardiac catheter ablation procedure.”

Mapping

- 93609-26 – 2D Mapping
  - Standard catheter mapping
- 93613 - 3D Mapping
  - Medical necessity guidelines have not yet been published

Only one form of mapping may be reported during any given procedure.

Mapping should not be reported in conjunction with AV node ablations.

*2017 Medicare Physician Fee schedule – National Average payment
Left Sided Pacing & Recording

93621-26 – Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left atrial pacing and recording from coronary sinus or left atrium (List separately in addition to code for primary procedure)

- Note must establish pacing AND recording was performed
  - Without both – add the reduced service modifier (52)
- This is an “add-on” code that must be reported with a primary procedure:
  - 93620 – Comprehensive EPS with induction attempt
  - 93653 – SVT ablation
  - 93654 – VT ablation
- This service is bundled into pulmonary vein isolation

93622-26 – LV pacing & recording

- Note must establish pacing AND recording was performed
- This is an “add-on” code that must be reported with a primary procedure:
  - 93620 – Comprehensive EPS with induction attempt
  - 93653 – SVT ablation
  - 93656 – pulmonary vein isolation
- This service is bundled into VT ablation

Pulmonary Vein Isolation

- 93656 – Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with atrial recording and pacing, when possible, right ventricular pacing and recording, His bundle recording with intracardiac catheter ablation of arrhythmogenic focus, with treatment of atrial fibrillation by pulmonary vein isolation.
  - All 6 components of a comprehensive study with induction:
    - Right atrial pacing
    - Right atrial recording
    - Right ventricular pacing
    - Right ventricular recording
    - His bundle recording
    - Induction or attempted induction of an arrhythmia
  - Pulmonary vein isolation
  - Multiple trans-septal catheterizations
    - Don’t report 93462
  - Left atrial pacing & recording
    - Don’t report 93621

“Code 93656 includes each of left atrial pacing/recording, right ventricular pacing/recording, and His bundle recording when clinically indicated. When performance of one or more components is not possible or indicated, document the reason for not performing.” CPR
Add-on Ablation Procedures

Sequence & documentation matters:
1. Pulmonary vein isolation complete (93656)
2. Patient remains in atrial fibrillation
3. Additional lesions are created to treat AF (93657)
4. Patient converts to atrial flutter
5. Additional lesions are created to treat atrial flutter (93655)

- 93657 – Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation
  - Only reported with 93656 (A-Fib ablation)
- 93655 – Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia
  - Reported with 93653 (SVT), 93654 (VT), or 93656 (AF)
  - MUE: 93655 is typically only billed 1X
    - MUE: Medically Unlikely Edit

Atrial Fibrillation Ablation Hot Topic

- “insufficient evidence to draw conclusions regarding the efficacy, effectiveness, and safety of catheter ablation”
  - CMS Technology Assessment of AF Ablation, April, 2015
- Potential coverage and regulatory focus like PMs & ICDs
  - Quantified symptom severity & AF burden
  - Medical management standards (drug & dosage)
  - First-line treatment for OSA and obesity
- Centers of Excellence
  - Safety and effectiveness of treatment
  - Not currently quantified or tracked
SVT Ablation

- 93653 - Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording, His recording with intracardiac catheter ablation of arrhythmogenic focus; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry.

- Included Services:
  - All 6 components of a comprehensive study:
    - Right atrial pacing (when possible) (right and/or left)
    - Right atrial recording (when possible) (right and/or left)
    - Right ventricular pacing
    - Right ventricular recording
    - His bundle recording
    - Induction or attempted induction of an arrhythmia

VT Ablation

- 93654 - Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording (when necessary), and His bundle recording (when necessary) with intracardiac catheter ablation of arrhythmogenic focus; with treatment of ventricular tachycardia or focus of ventricular ectopy including intracardiac electrophysiologic 3D mapping, when performed, and left ventricular pacing and recording, when performed

- Included Services:
  - All 6 components of a comprehensive study:
    - Right atrial pacing (when possible) (right and/or left)
    - Right atrial recording (when possible) (right and/or left)
    - Right ventricular pacing
    - Right ventricular recording
    - His bundle recording
    - Induction or attempted induction of an arrhythmia
AV Node Ablation, Arterial Line, ICE, Peri-Procedural

- AV Node Ablation
  93650 – Intracardiac ablation of atrioventricular node function, atrioventricular conduction for creation of complete heart block, with or without temporary pacemaker placement.

- ICE
  93662 – Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)
  - This is an “add-on” code that must be reported with a primary procedure:
    - Use 93662 in conjunction with 92987, 93453, 93460-93462, 93532, 93580, 93581, 93620, 93621, 93622, 93653, 93654, 93656 as appropriate – CPT

- Arterial Line Placement
  36620-59 - Arterial catheterization or cannulation for sampling, monitoring or transfusion

- Peri-Procedural device reprogramming
  - 93286 (pacemaker) 93287 (defibrillator)
  - Billable with EP procedures but not device procedures
  - Bill one time for pre-procedure reprogramming – Example 93287
  - Bill a second time for post-procedure reprogramming – Example 93287-76

Correct Coding Initiative Edits

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EP Studies & Ablations

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Moderate Sedation

- Included in procedural payment until 2017
- Sedation, and its associated payment, is now carved out.
  - Expected 2017 payment for dual chamber pacemaker (33208)
    • 2016 payment = $553.53 +
    • 2017 MACRA & Budget Neutrality adj. (0.24%) = $1.32
    • Expected 2017 payment = $554.85
  - Actual 2017 payment = $543.35

- Total reduction for moderate sedation = $11.50

Applies to: implantable loop recorder surgeries, pacemaker surgeries, defibrillator surgeries, EP studies, ablations, cardioversions (internal and external), and transesophageal echo.

Moderate Sedation Coding

- Moderate sedation is billable in 15-minute increments
  • 1st 15 minute code billable after 10 minutes
  • Additional 15-minute code billable after 23 minutes

- 2 sets of codes
  • Sedation by operator:
    • 99152 – 1st 15 minutes (0.25 wRVU)
    • 99153 – each addtl. 15 minutes (no wRVU)
  • Sedation by other qualified professional:
    • 99156 – 1st 15 minutes (1.65 wRVU)
    • 99157 – each addtl. 15 minutes (1.25 wRVU)

- Some procedures are reported with multiple codes that each had moderate sedation carved out of them - unintended payment reduction:
  • Defibrillator implant (33249) & DFT (93641)
  • Electrode removal, electrode repair, or skin pocket relocation at the time of a device procedure (implant, gen change)  
  
  Document medical necessity

For patients <5 yrs. Old substitute 99151 for 99152 and 99155 for 99156
**Moderate Sedation Documentation**

- The operative report needs to support the codes reported
  - 99152 - 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 intraservice time, patient age 5 years or older
    - Establish “administration of moderate sedation”
    - Establish duration of intraservice time
      - Starts when sedating agent(s) are administered
      - Ends with the procedure – when face-to-face time concludes
    - Document the presence of a dedicated, trained observer
  - 99156 - Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient age 5 years or older
    - Same as above, but no need for a dedicated, trained observer

**Services Included in the Global Surgical Package**

1. **Preoperative Visits:**
   - The initial evaluation for a minor surgical procedure.
   - Critical care related to the performance of the procedure.
2. **Intraoperative Services:** services that are normally a usual and necessary part of the surgical procedure.
3. **Complications Following Surgery:** include all additional medical or surgical services required of the surgeon during the postoperative period of the surgery due to complications that do not require additional trips to the operating room.
4. **Postoperative Visits:** follow-up visits during the postoperative period of the surgery that are related to recovery from the surgery.
5. **Post surgical pain management by the surgeon.**
6. **Miscellaneous Services:** includes items such as dressing changes; local incision care; removal of operative pack; removal of cutaneous sutures, staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters; routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.
Services Not Included in the Global Surgical Package

1. Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications from the surgery.

2. Postoperative complications that require a return trip to the operating room. An operating room for this purpose is defined in Medicare regulations as:
   - A place of service specifically equipped and staffed for the sole purpose of performing surgical procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient’s room, a minor treatment room, a recovery room, or an intensive care unit unless the patient’s condition was so critical there would be insufficient time for transportation to an operating room.

3. Diagnostic tests and procedures

4. Critical care services (procedure codes 99291 and 99292) unrelated to the surgery when a seriously injured or burned patient is critically ill and requires constant attendance by the provider. Use modifier 24 or 25 as appropriate.

5. Evaluation and management (E/M) services unrelated to a surgical procedure.

Common ICD-10 Codes
New vs. Established Patient Status

Interpret the phrase "new patient" to mean a patient who has not received any professional services, i.e., evaluation and management service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous three years.

What is the definition of "new patient" for billing ... - CMS: FAQs

• Cardiology consists of three specialties:
  1. General cardiology
  2. Interventional cardiology
  3. Electrophysiology
• When a general cardiologist refers to an EP, the EP can bill new patient.
  • High level new patient visit: 99205 - $209.23*
  • High level est patient visits: 99215 - $146.43*
  • New patient premium = $62.80 (43%)

*2017 Medicare Physician Fee schedule – National Average payment

Jim Collins, CPC, CCC
Certified Professional Coder, Certified Cardiology Coder
Jim@CardiologyCoder.Com (518) 320-4376

• Billing Services
• Chart auditing
• Training
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