MEET THE PRESENTER

Rhonda Granja

On the topic:
Coding and Billing for Cardiology
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2015 Final Rule

- Conversion Factor thru March 31, 2015 = $35.8228.
- Federal Register, Vol. 79, No. 219
**Evaluation and Management Services**

<table>
<thead>
<tr>
<th>Clinical Circumstance</th>
<th>Adequate Documentation for Code 99211</th>
</tr>
</thead>
</table>
| Blood pressure check                   | 1. Blood pressure and other vital signs recorded.  
|                                        | 2. Clinical reason for checking blood pressure recorded (i.e., follow-up to previous abnormal finding, symptoms suggestive of abnormal blood pressure, etc.).  
|                                        | 3. Current medications listed (with notation of level of compliance).  
|                                        | 4. Indication of doctor's evaluation of the clinical information obtained and his management recommendation.  
|                                        | 5. Identity and credentials of provider(s) as listed in text above. |
| Prescription refill or injection/infusion | 1. Reason for the visit. A physician visit is not necessary to routinely provide stable patients with an ongoing medication supply. Therefore, the documentation for code 99211 or any other E/M code in this circumstance must demonstrate a need for clinical E/M (for instance, symptoms or signs reported that are significant enough to necessitate evaluation).  
|                                        | 2. Current medications listed (with notation of level of compliance).  
|                                        | 3. Indication of doctor's evaluation of the clinical information obtained and his management recommendation.  
|                                        | 4. Identity and credentials of provider(s) as listed in text above. |
| Prothrombin time evaluation for patients on chronic warfarin anticoagulation | 1. Reason for the visit. A physician visit is not routinely necessary to draw blood for prothrombin time or other laboratory tests. Therefore, the documentation for code 99211 or any other E/M code in this circumstance must demonstrate a need for clinical E/M. In this case, services that would serve to demonstrate that E/M was performed include an evaluation of significant new symptoms (such as excessive bruising or hemorrhage).  

**Evaluation and Management Services**

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|                       | Alternatively, for patients who have no new clinical concerns, documentation that contemporaneous laboratory values were obtained, reviewed and used to guide current and/or future therapy documents that a separately payable E/M service has been performed.  
|                       | 2. Current medications listed (with notation of level of compliance).  
|                       | 3. Indication of doctor's evaluation of the information about signs/symptoms and laboratory test result and his management recommendation.  
|                       | 4. Identity and credentials of provider(s) as listed in text above. |
Lost Revenue $

- How many code(s) do you bill for a congenital echocardiogram. Answer is not 93306.
- Correct way: 93303, 93320, 93325

Up In Smoke....

- 99406 Smoking & Tobacco Cessation Counseling 3-10 minutes
- 99407 Smoking & Tobacco Cessation Counseling 10 minutes or greater
Up In Smoke....

- G0436 Smoking & Tobacco Cessation Counseling 3-10 minutes; asymptomatic

- G0437 Smoking & Tobacco Cessation Counseling 10 minutes or greater; asymptomatic

Smoking Cessation Diagnosis

- 305.1 Tobacco use disorder (current smoker)

- V15.82 History of tobacco use (previous smoker)
New Modifiers

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>XE</td>
<td>(Separate encounter) A service that is distinct because it occurred during a separate encounter.</td>
</tr>
<tr>
<td>XS</td>
<td>(Separate structure) A service that is distinct because it was performed on a separate organ/structure.</td>
</tr>
<tr>
<td>XP</td>
<td>(Separate practitioner) A service that is distinct because it was performed by a different practitioner.</td>
</tr>
<tr>
<td>XU</td>
<td>(Unusual non-overlapping service) The use of a service that is distinct because it does not overlap usual components of the main service.</td>
</tr>
</tbody>
</table>

• CMS has defined four new HCPCS modifiers for practices to use for services where you might currently append modifier 59:
• These modifiers do not replace (59). However, CMS may request that 59 not be used when a more descriptive modifier is available.

• Be sure to check with your local MAC’s for additional information/clarification.

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**Care Management Services**

Care Management Services for 2015 include:
- One new code
- Two revised codes
- New Introductory Language

These codes are reported only once per calendar month and may only be reported by the single physician or other qualified health care professional who assumes the care management role.
**Provisions in 2014 PFS Final Rule**

- In 2015, Medicare will begin making separate payment for Chronic Care Management.
- CPT language does refer to certain capabilities
- Proposes use of certified EHRs for care; employment of advance practice registered nurses/physician assistants with written job descriptions.
- Informed consent from the beneficiary.

**Chronic Care Management (CCM)**

- **99490** – Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:
  - Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
  - Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
  - Comprehensive care plan established, implemented, revised, or monitored.
Complex Chronic Care Management Services Revised Codes

- **99487** – Complex chronic care management services, with the following required elements:
  - Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
  - Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
  - Establishment or substantial revision of a comprehensive care plan;
  - Moderate or high complexity medical decision making;
  - 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

- **+99489** – each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

Example

<table>
<thead>
<tr>
<th>Total Duration of Staff Care Management Services</th>
<th>Complex Chronic Care Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 60 minutes</td>
<td>Not reported separately</td>
</tr>
<tr>
<td>60 to 89 minutes</td>
<td>99487</td>
</tr>
<tr>
<td>90-119 minutes</td>
<td>99487 and 99489</td>
</tr>
<tr>
<td>120 minutes</td>
<td>99487 and 99489 x 2 (and 99489 for each additional 30 minutes)</td>
</tr>
</tbody>
</table>
Patient Consent Agreement For Chronic Care Services

Medicare now offers a new benefit for patients with multiple chronic diseases, and by consenting to this Agreement, you designate your provider, (Provider Name) "Provider", to provide chronic care management (CCM) services per the new rule.

Only patients with more than one chronic condition are eligible for this benefit and your provider agrees not to bill Medicare for this service if you don’t have more than one chronic condition. Medicare defines a chronic condition as one that is expected to last at least 12 months, and that increases the risk of death, acute exacerbation of disease, or a decline in function.

Provider Chronic Care Services
As part of this new benefit, your Provider agrees to make available the following services:

1. 24/7 access to a healthcare provider to address your acute chronic care needs
2. Use of certified EFIR software to document your care
3. Provide a written or electronic version of your care plan
4. Perform medication reviews and oversight
5. Assist in the management of transitions of care from one provider to another

In connection with this new benefit, your provider agrees to bill Medicare just one time per each 30-day billing cycle and if you revoke this Agreement, provide you with a written confirmation of the revocation, stating the effective date of the revocation.

Beneficiary Consent Terms
By signing this Agreement, you agree to the following terms required by Medicare:

1. You consent to your Provider providing CCM services to you.
2. You acknowledge that only one practitioner can furnish CCM Services to you during a thirty (30)-day period.
3. You authorize electronic communication of your medical information with other treating providers to facilitate the coordination of your care.
4. You understand that the Medicare Co-Insurance amount applies to CCM Service.
5. You have the right to stop CCM Services at any time by revoking this Agreement effective at the end of the then-current thirty 30-day period of services by notifying our practice in writing.

Beneficiary or Caregiver
Signature: ___________________  Print Name: ___________________
Date: ___________________
Advanced Care Planning

- **99497** – Advanced care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

- **99498** – each additional 30 minutes (List separately in addition to code form primary procedure)

Surgery Section

- Cardiovascular
Pacemaker/Implantable Defibrillator Revisions

CPT® codes
• 33215 – 33220,
• 33223 – 33225,
• 33240 – 33264,
• 33243 – 33249 (#)

Revisions were made to the phrase pacing cardioverter-defibrillator. The new language is implantable defibrillator.

Implantable Defibrillator

Two general categories of implantable defibrillators exist:
1. Transvenous implantable pacing cardioverter-defibrillator
2. Subcutaneous implantable defibrillator

The following new codes for Subcutaneous Implantable Defibrillator use a single subcutaneous electrode to treat ventricular tachyarrhythmias.
Subcutaneous Implantable Defibrillator Codes

• **33270** – Insertion or replacement of permanent subcutaneous implantable defibrillator system, with subcutaneous electrode, including defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters, when performed

• CPT 33270 is a bundled code.


• # Resequenced code
• **33271** – *Insertion* of subcutaneous implantable defibrillator electrode

• **33272** – *Removal* of subcutaneous implantable defibrillator electrode

• **33273** – *Repositioning* of previous implantable defibrillator electrode

• These codes are specific to the subcutaneous device.

• Reference pg. 191, CPT book.
Subcutaneous implantable defibrillators differ from Transvenous implantable pacing cardioverter-defibrillators in that subcutaneous defibrillators do not provide antitachycardia pacing or chronic pacing.

Changes

Defibrillator threshold testing (DFT) during ICD insertion or replacement may be separately reportable. DFT testing during subcutaneous implantable defibrillator system insertion is not separately reportable.
Transcatheter Mitral Valve Repair (TMVR)

- **33418** – Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis

- **+ 33419** – additional prosthesis(es) during same session (List separately in addition to code for primary procedure)

- 90 day global
- Dictation of mitral clip
- Not specific to one manufacture
- Very uncommon to use more than (2) clips
- Reference pg. 196 CPT book
Coding Guidelines

- Codes 33418 and 33419 are used to report TMVR. Code 33419 should only be reported once per session.
- Codes 33418 and 33419 include the work, when performed, of percutaneous access, placing the access sheath, transseptal puncture, advancing the repair device delivery system into position, repositioning the device as needed, and deploying the device(s).
- Angiography, radiological supervision, and interpretation performed to guide TMVR (e.g., guiding device replacement and documenting completion of the intervention) are included in these codes.

Extracorporeal Membrane Oxygenation (ECMO) or Extracorporeal Life Support Services (ECLS)

CPT® Guidelines

**There are two methods**

1. **Veno-arterial**
   - Supports both the heart and lungs.
   - Requires two cannula(e):
     - one in a large vein
     - one in a large artery.

2. **Veno-venous**
   - Support lung only
   - Requires one or two cannula(e) placed in a vein
• Services directly related to the ECMO/ECLS
  – Cannulation
  – Cannula management – reposition, removal, or adding cannula(e)
  – Initiation of the circuit
  – Daily Management of the circuit
  – Decannulation
  – Daily overall management of the patient

The daily overall management of the patient is a factor that will vary greatly depending on the patient’s age, disease process, and condition.

ECMO Codes

• Initiation
• Daily Management
• Cannulation (Further defined by age)
  – Insertion
  – Reposition
  – Removal
Reporting Guidelines

- Reposition of the ECMO/ECLS cannula(e) at the same session as insertion is not separately reportable.
- Replacement of ECMO/ECLS cannula(e) in the same vessel should only be reported using the insertion code.
- If cannula(e) are removed from one vessel and new cannula(e) are placed in a different vessel, report the appropriate cannula(e) removal and insertion codes.

- Fluoroscopic guidance used for cannula(e) repositioning is included in the procedure when performed and should not be separately reported.
- If provided, the same physician may report the appropriate codes for the services they performed:
  - Cannula insertion
  - ECMO/ECLS initiation
  - Overall patient management
• If different physicians provide parts of the service, each physician may report the correct code(s) for the service(s) they provided, except as noted
  – Daily Management may not be reported same day as initiation
  – Repositioning may not be reported the same day as initiation

Initiation

• **33946** – Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, *veno-venous*

• **33947** – initiation, *veno-arterial*
• **33948** – daily management, each day, veno-venous

• **33949** – daily management, each day, veno-arterial

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**Cannula Insertion**

(Birth – 5 years)

• **33951** insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)

• **33953** insertion of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age

• **33955** insertion of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age
Cannula Insertion (6 years +)

- **33952** insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed)
- **33954** insertion of peripheral (arterial and/or venous) cannula(e), open, 6 years and older
- **33956** insertion of central cannula(e) by sternotomy or thoracotomy, 6 years and older

Cannula Repositioning (Birth – 5 years)

- **33957** reposition peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)
- **33959** reposition peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age (includes fluoroscopic guidance, when performed)
- **# 33963** reposition of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age (includes fluoroscopic guidance, when performed)
### Cannula Repositioning
(6 years +)

- **33958** reposition peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed)
- **33962** reposition peripheral (arterial and/or venous) cannula(e), open, 6 years and older (includes fluoroscopic guidance, when performed)
- **# 33964** reposition of central cannula(e) by sternotomy or thoracotomy, 6 years and older (includes fluoroscopic guidance, when performed)

### Cannula Removal
(Birth – 5 years)

- **# 33965** removal of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age
- **# 33969** removal of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age
- **# 33985** removal of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age
Cannula Removal (6 years +)

- #33966 removal of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older
- #33984 removal of peripheral (arterial and/or venous) cannula(e), open, 6 years and older
- #33986 removal of central cannula(e) by sternotomy or thoracotomy, 6 years and older

Add-On Code

- # + 33987 – Arterial exposure with creation of graft conduit (e.g., chimney graft) to facilitate arterial perfusion for ECMO/ECLS (List separately in addition to code for primary procedure)

(Use 33987 in conjunction with 33953, 33954, 33955, 33956)
Deleted ECMO Codes

33960 – Prolonged extracorporeal circulation for cardiopulmonary insufficiency; initial day

33961 - each subsequent day

36822 – Insertion of cannula(s) for prolonged extracorporeal circulation for cardiopulmonary insufficiency (ECMO) (separate procedure)

Left Heart Vent Codes

• #33988 – Insertion of left heart vent by thoracic incision (e.g., sternotomy, thoracotomy) for ECMO/ECLS

• #33989 – Removal of left heart vent by thoracic incision (e.g., sternotomy, thoracotomy) for ECMO/ECLS
Fenestrated Endovascular Repair of the Visceral and Infrarenal Aorta

- **34839** – Physician Planning of a patient-specific fenestrated visceral aortic endograft requiring a minimum of 90 minutes of physician time.
- Work does not have to be continuous!!

Code 34839 is used to report the physician planning and sizing for a patient-specific fenestrated visceral aortic endograft. The planning includes review of high resolution cross-sectional images (e.g., CT, CTA, MRI) and utilization of 3D software for iterative modeling of the aorta and device in multiplanar views and center line of flow analysis. Code 34839 may only be reported when the physician spends a minimum of 90 total minutes performing patient-specific fenestrated endograft planning. Physician planning time does not need to be continuous and should be clearly documented in the patient record. Code 34839 is reported on the date that planning work is complete and may not include time spent on the day before or the day of the fenestrated endovascular repair procedure (34841, 34842, 34843, 34844, 34845, 34846, 34847, 34848) nor be reported on the day before or the day of the fenestrated endovascular repair procedure.
Cervicocerebral Arteries
Addition to the Introductory Language

Code 36228 is an add-on code to report unilateral selective arterial catheter placement and diagnostic imaging of the initial and each additional intracranial branch of the internal carotid or vertebral arteries. Code 36228 is reported in conjunction with 36223, 36224, 36225, or 36226. This includes any additional second or third order catheter selective placement in the same primary branch of the internal carotid, vertebral, or basilar artery and includes all the work of accessing the additional vessel, placement of catheter(s), contrast injection(s), fluoroscopy, radiological supervision and interpretation. It is not reported more than twice per side, regardless of the number of additional branches selectively catheterized.

Do not report 36218 or 75774 as part of diagnostic angiography of the extracranial and intracranial cervicocerebral vessels. It may be appropriate to report 36218 and 75774 for diagnostic angiography of upper extremities and other vascular beds of the neck and/or shoulder girdle performed in the same session as vertebral angiography (e.g., workup of a neck tumor that requires catheterization and angiography of the vertebral artery as well as other brachiocephalic arteries).
Revisions to the Transcatheter Placement of Intravascular Stent Codes

• **37215** – Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection

• **37216** – without distal embolic protection

• **37217** – Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery by retrograde treatment, open ipsilateral cervical carotid artery exposure, including angioplasty, when performed, and radiological supervision and interpretation

• (For open or percutaneous transcatheter placement of intravascular cervical carotid artery stent[s], see 3715, 37215)

• (For open or percutaneous antegrade transcatheter placement of innominate and/or intrathoracic carotid artery stent[s], use 37218)

• (For open or percutaneous transcatheter placement of extracranial vertebral artery stent[s], see 0075T, 0076T)
New Transcatheter Placement of Intravascular Stent

- **37218** – Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery, open or percutaneous antegrade approach, including angioplasty, when performed, and radiological supervision and interpretation.

- (37218 includes all ipsilateral extracranial intrathoracic selective innominate and carotid catheterization, all diagnostic imaging for ipsilateral extracranial intrathoracic innominate and/or carotid artery stenting, and all related radiologic supervision and interpretation. Report 37218 when the ipsilateral extracranial intrathoracic carotid arteriogram (including imaging and selective catheterization) confirms the need for stenting. If stenting is not indicated, report the appropriate codes for selective catheterization and imaging.)

- (Do not report 37218 in conjunction with 36222, 36223, 36224 for the treated carotid artery)

- (For open or percutaneous transcatheter placement of intravascular cervical carotid artery stent[s], see 37215, 37216)

- (For open or percutaneous transcatheter placement of extracranial vertebral artery stent[s], see 0075T, 0076T)

- (For transcatheter placement of intracranial stent[s], use 61635)
• **37236** – Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery
  • + **37237** - each additional artery (List separately in addition to code for primary procedure)
  • (For stent placement(s) in iliac, femoral, popliteal, or tibial/peroneal artery(s) for occlusive disease, see 37221, 37223, 37226, 37227, 37230, 37231, 37234, 37235)
  • (For open or percutaneous antegrade transcatheter placement of intrathoracic carotid/innominate artery stent[s], use 37218)
  • (For open or percutaneous transcatheter placement of extracranial vertebral artery stent[s], see Category III codes 0075T, 0076T)

**Introductory Language Addition**

• Codes 37236-37239 are used to report endovascular revascularization for vessels other than lower extremity artery(s) for occlusive disease (i.e., 37221, 37223, 37226, 37227, 37230, 37231, 37234, 37235), cervical carotid (i.e., 37215, 37216), intracranial (i.e., 61635), intracoronary (i.e., 92928, 92929, 92933, 92934, 92937, 92938, 92941, 92943, 92944), innominate and/or intrathoracic carotid artery through an antegrade approach (i.e., 37218), extracranial vertebral (i.e., 0075T, 0076T) performed percutaneously and/or through an open surgical exposure, or open retrograde intrathoracic common carotid or innominate (i.e., 37217).
Vascular Embolization and Occlusion

- The embolization codes includes all associated radiological supervision and interpretation, intraprocedural guidance and road-mapping, and imaging necessary to document completion of the procedure. They do not include diagnostic angiography and all necessary catheter placement(s). Code(s) for catheter placement(s) may be separately reported using selective catheter placement code(s), if used consistent with guidelines. Code(s) for diagnostic angiography may also be separately reported, when performed according to guidelines for diagnostic angiography during endovascular procedures, using the appropriate diagnostic angiography codes. Report these services with an appropriate modifier (e.g., modifier 59). Please see the guidelines on the reporting of diagnostic angiography preceding 75600 in the Vascular Procedures, Aorta and Arteries section.

Medicine Section

- Cardiovascular
Implantable and Wearable Cardiac Device Evaluations

Changes to the Introductory Language for Implantable and Wearable Cardiac Device Evaluations

1. Replaced implantable cardioverter-defibrillator with implantable defibrillator
2. Accommodate the two new codes for subcutaneous defibrillator into coding guidelines

Example

2014 – *Implantable cardioverter-defibrillator*: Programmed parameters, lead(s), battery, capture and sensing function, presence or absence of therapy for ventricular tachyarrhythmias and underlying heart rhythm

2015 – *Implantable defibrillator*: Programmed parameters, lead(s), battery, capture and sensing function, presence or absence of therapy for ventricular tachyarrhythmias and underlying heart rhythm
New and Revised Codes

- **93279** – Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead pacemaker system
- **93280** – dual lead pacemaker system
- **93281** – multiple lead pacemaker system
- **93282** – single lead transvenous implantable defibrillator system
- **93283** – dual lead transvenous implantable defibrillator system
- **93284** – multiple lead transvenous implantable defibrillator system
- **#93260** – implantable subcutaneous lead defibrillator system
- **93285** – implantable loop recorder system

- **93288** – Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead pacemaker system
- **93289** – single, dual, or multiple lead transvenous implantable defibrillator system, including analysis of heart rhythm derived data elements
- **93261** – implantable subcutaneous lead defibrillator system
- **93290** – implantable cardiovascular monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors
**Revised Codes**

- **93294** – Interrogation device evaluations(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional
- **93295** – single, dual, or multiple lead implantable defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional
- **93296** – single, dual, or multiple lead pacemaker system or implantable defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results

**Echocardiography**

- **93355** – Echocardiography, transesophageal (TEE) for guidance of a transcatheter intracardiac or great vessel(s) structural intervention(s) (e.g., TAVR, transcatheter pulmonary valve replacement, mitral valve repair, paravalvular regurgitation repair, left atrial appendage occlusion/closure, ventricular septal defect closure) peri-and intraprocedural), 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
  - (To report placement of transesophageal probe by separate physician, use 93313)
  - (Do not report 93355 in conjunction with 76376, 76377, 93312, 93313, 93314, 93315, 93316, 93317, 93318, 93320, 93321, 93325)
Introductory Language Addition

- Code 93355 is used to report transesophageal echocardiography (TEE) services during transcatheter intracardiac therapies. Code 93355 is reported once per intervention and only by an individual who is not performing the interventional procedure. 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. Code 93355 describes TEE during advanced transcatheter structural heart procedures (e.g., transcatheter aortic valve replacement [TAVR], left atrial appendage closure [LAA], or percutaneous mitral valve repair). See 93313 for separate reporting of the probe insertion by a physician other than the physician performing the TEE.

Intracardiac Electrophysiological Procedures/Studies

- **93642** – Electrophysiologic evaluation of single or dual chamber transvenous pacing cardioverter-defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)
- **93644** – Electrophysiologic evaluation of subcutaneous implantable defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)
Cerebrovascular Arterial Studies

• **93895** – Quantitative carotid intima media thickness and carotid atheroma evaluation, bilateral
  • Using ultrasound

Category III Mitral Valve Code

• **0345T** – Transcatheter mitral valve repair percutaneous approach via the coronary sinus
  (For transcatheter mitral valve repair percutaneous approach including transseptal puncture when performed, see 33418, 33419)
  (Do not report 0345T in conjunction with 93451, 93452, 93453, 93456, 93457, 93458, 93459, 93460, 93461 for diagnostic left and right heart catheterization procedures intrinsic to the valve repair procedure)
  (Do not report 0345T in conjunction with 93453, 93454, 93563, 93564 for coronary angiography intrinsic to the valve repair procedure)
Resource


QUESTIONS

- Thank you for your attendance!

- Get your questions answered on PMI’s Discussion Forum: http://www.pmimd.com/pmiForums/rules.asp

- Contact information: rgranja@pmimd.com
Questions?

Post yours on PMI’s Discussion Forum:
– Click **Accept** to continue

Discussion Forum Walk Through

1) Go to [www.pmiMD.com](http://www.pmiMD.com).

2) Hover the cursor over “Practice Tools” which is the fourth button from the left on the top of the page. This will give you a dropdown menu.

3) Click on the second option listed: “Discussion Forum.”
-This will bring you to the Discussion Forum Disclaimer page. You will click, “Accept.”

The Discussion Forum is a free service to our guests. Material posted herein can be accessed by any visitor to our website. As such you are advised that PMI does not control the postings on our website and therefore cannot be held accountable for the accuracy of postings. The Discussion Forum is meant to share the thoughts, suggestions and comments of our visitors and not the owner of this website.

Advice given by professionals on our website should only be considered as general advice applicable to general matters and not applicable to any specific use of facts or for any particular course of action. The content of postings is the sole opinion of the person providing it. PMI does not edit the postings. The content of the postings does not reflect the views of PMI.

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-After clicking on the “Accept” button, you will be guided to the actual discussion forum.
LOGIN OPTION 1
In order to Login to the Discussion Forum, please follow the following steps:

- In the Forum Home block located to the left, click on the “Login” option (this button will have a picture of a key next to the option).

- This will bring you to the “Forum Login” page.

- Enter your username and password

- You will be given the option of whether you will like to be kept logged in. This option is purely up to you.

- You will also be asked if you would like to be added to the active users list. You will want to click yes.