

# 2009 Facility and Physician Billing Guide for Procedures that May Utilize an Intracardiac Echocardiography Ultrasound Catheter<sup>1</sup>

This guide has been developed to assist you in obtaining physician payment and hospital reimbursement for cardiology procedures that may utilize the AcuNAV<sup>®</sup> Diagnostic Ultrasound Catheter or the SOUNDSTAR<sup>™</sup> 3D Ultrasound Catheter. These procedures may be a covered service if they meet all of the requirements established by Medicare and private payers. It is essential that each claim be coded properly and supported with adequate documentation in the medical record.

## PHYSICIAN SERVICES

A few of the Current Procedure Terminology (CPT<sup>®</sup>) Codes for describing EP diagnostic and ablation procedures, and septal defect repair are listed below.

### Intracardiac Electrophysiological Procedures

CPT <sup>®</sup> Code <sup>2,3</sup>	Description	Total Relative Value Units (RVUs)	2009 National Average Medicare Reimbursement <sup>4</sup>
93650	Intracardiac catheter ablation of atrioventricular node function, atrioventricular conduction for creation of complete heart block	16.69	\$ 601.95*
93651	Intracardiac catheter ablation of arrhythmogenic focus; for treatment of supraventricular tachycardia by ablation...or other atrial foci, singly or in combination	25.39	\$ 915.73*
93652	Intracardiac catheter ablation of arrhythmogenic focus; for treatment of ventricular tachycardia by ablation	27.63	\$ 996.52*
+93662-26	Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation	4.27	\$ 154.00

### Septal Defect Procedures

CPT <sup>®</sup> Code <sup>2,3</sup>	Description	Total Relative Value Units (RVUs)	2009 National Average Medicare Reimbursement <sup>4</sup>
93580	Percutaneous transcatheter closure of atrial septal defect	25.47	\$ 1,018.18
93581	Percutaneous closure of congenital ventricular septal defect	33.68	\$ 1,334.46

## FACILITY SERVICES

### Inpatient Procedures

The following ICD-9 procedure codes generally describe intracardiac electrophysiology procedures:

ICD-9 <sup>5</sup> Code	Description
37.26	Cardiac electrophysiologic stimulation and recording studies
37.27	Cardiac mapping
37.28	Intracardiac echocardiography
37.34	Excision or destruction of other lesion or tissue of heart, other approach

For FY 2008 the Inpatient Prospective Payment System (IPPS) was revised. The IPPS payment reforms restructured the inpatient Medicare severity diagnosis-related groups (MS-DRGs) to account more fully for the severity of each patient's condition. In addition, the rule included important provisions to ensure that Medicare no longer pays for the additional costs of certain preventable conditions (including certain infections) acquired in the hospital. MS-DRGs are now assigned based on the presence of Major Complications or Co-morbidities (MCC), Complication or Co-morbidities (CC), or no MCCs or CCs along with the procedures that are performed.

The FY 2009 MS-DRG Grouper will generally assign each Medicare patient discharge to MS-DRG 251 when ICD-9 Codes 37.26, 37.27 and/or 37.34 are used to describe the principal procedure that the patient received during their hospital stay. Patient discharges that have a MCC will generally assign to MS-DRG 250.

MS-DRG <sup>6</sup>	Description	2009 National Average Medicare Reimbursement <sup>7</sup>
250	Percutaneous cardiovascular procedures without coronary artery stent or acute myocardial infarction (e.g., PTCA and electrophysiology) with MCC	\$ 16,610
251	Percutaneous cardiovascular procedures without coronary artery stent or acute myocardial infarction (e.g., PTCA and electrophysiology) without MCC	\$ 8,905

When an Ultrasound Catheter is used during valvuloplasty procedures, the FY 2009 DRG Grouper will generally assign each Medicare patient discharge to the following:

<b>MS-DRG<sup>6</sup> Description</b>	<b>2009 National Average Medicare Reimbursement<sup>7</sup></b>
216 Cardiac valve and other major cardiothoracic procedures with cardiac catheterization with MCC	\$ 56,049
217 Cardiac valve and other major cardiothoracic procedures with cardiac catheterization with CC	\$ 38,812
218 Cardiac valve and other major cardiothoracic procedures with cardiac catheterization without CC/MCC	\$ 30,101
219 Cardiac valve and other major cardiothoracic procedures without cardiac catheterization with MCC	\$ 44,604
220 Cardiac valve and other major cardiothoracic procedures without cardiac catheterization with CC	\$ 29,317
221 Cardiac valve and other major cardiothoracic procedures without cardiac catheterization without CC/MCC	\$ 24,359
250 Percutaneous cardiovascular procedure without coronary artery stent or acute myocardial infarction with MCC	\$ 16,610
251 Percutaneous cardiovascular procedure without coronary artery stent or acute myocardial infarction without MCC	\$ 8,905
248 Percutaneous cardiovascular procedure with non drug-eluting stent with MCC or 4+ vessels/stents	\$ 15,573
249 Percutaneous cardiovascular procedure with non drug-eluting stent without MCC	\$ 9,103

When an Ultrasound Catheter is used during percutaneous Atrial Septal Defect (ASD), the FY 2009 DRG Grouper will generally assign each Medicare patient discharge to the following:

<b>MS-DRG<sup>6</sup> Description</b>	<b>2009 National Average Medicare Reimbursement<sup>7</sup></b>
250 Percutaneous cardiovascular procedure without coronary artery stent or acute myocardial infarction (e.g., PTCA and electrophysiology) with MCC	\$ 16,610
251 Percutaneous cardiovascular procedures without coronary artery stent or acute myocardial infarction (e.g., PTCA and electrophysiology) without MCC	\$ 8,905

When an Ultrasound Catheter is used during percutaneous Ventricular Septal Defect (VSD) procedures, the FY 2009 DRG Grouper will generally assign each Medicare patient discharge to the following:

<b>MS-DRG<sup>6</sup> Description</b>	<b>2009 National Average Medicare Reimbursement<sup>7</sup></b>
228 Other cardiothoracic procedures with MCC	\$ 43,234
229 Other cardiothoracic procedures with CC	\$ 27,881
230 Other cardiothoracic procedures without CC/MCC	\$ 22,528

### Outpatient Procedures

CPT code 93662<sup>2</sup> has an "N" status indicator assigned to it. This means the service is packaged into the APC rate. Therefore, there is no separate APC<sup>8,9</sup> reimbursement with the use of ultrasound for an outpatient procedure.

### HCPCS CODE

Medicare has reinstated C-codes to track device cost information for future APC rate-setting purposes. **No additional payment will be provided to the facility.** All appropriate C-codes should be added to the hospital's chargemaster to report device costs used in the outpatient setting.

<b>HCPCS Code</b>	<b>Category Long Descriptor</b>	<b>Product Covered</b>
C1759	Catheter, intracardiac echocardiography	All models – AcuNAV <sup>®</sup> and SOUNDSTAR <sup>™</sup> Ultrasound Catheters

**1 Not all codes provided are applicable for the recommended uses of products manufactured or distributed by Biosense Webster. The most appropriate code for the patient's clinical presentation must be selected.**

**2** All Current Procedural Terminology (CPT) five-digit number codes, descriptions, number modifiers, instructions, guidelines, and other material are Copyright 2008 American Medical Association. All Rights Reserved.

**3** Note: The MFS payment amounts indicated are based upon data elements published in display document CMS-1403-FC, dated 10/30/08. CMS may make adjustments to any or all of the data inputs from time to time. All CPT codes are copyright AMA.

**4** Calculated using 2009 conversion factor of \$36.0666. Federal Register Volume 73, Number 224 November 19, 2008.

**5** Hospital ICD-9-CM 2009 Volumes 1, 2, & 3, 9th Revision-Clinical Modification, American Medical Association. Copyright © 2008 Ingenix, Inc.

**6** Note: The DRG payment amounts indicated are estimates only based upon data elements derived from various CMS sources. These sources include the 8/19/08 Federal Register and the payment impact file dated 9/29/08. Calculations assume that all hospitals are receiving the full 3.6% quality reporting update. Actual payment may vary based on various hospital-specific factors not reflected in the source data. Providers indicated by an asterisk (\*) may be paid based on a methodology, which differs from the standard DRG payment calculation reflected in the amount shown (i.e., rural referral centers, hospitals in the state of Maryland). Actual payment may also vary based on adjustments that CMS may make from time to time.

**7** Federal Register: Medicare Program; Revision to the Hospital Inpatient Prospective Payment Systems, 2008; Final Rule, Vol. 73, No. 161 / Tuesday, August 19, 2008.

**8** Federal Register: Medicare Program; Hospital Outpatient Prospective Payment System and Calendar Year 2008; Final Rule, Volume 73, Number 223, November 18, 2008.

**9** Note: The 2009 APC payment amounts indicated are estimates only based upon data elements derived from various CMS sources. These sources include cms-1404-fc, published 10/30/08, and the IPPS hospital payment impact file, published 9/29/08. Actual payment may vary based on various hospital-specific factors not reflected in the source data. Actual payment may also vary based on adjustments that CMS may make from time to time.

\*Procedure no longer modifier 51 exempt. Payment may be decreased by 50% when multiple procedures performed.

+ Add-on code.

## DISCLAIMER

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The information contained in this guide is provided to assist you in understanding the reimbursement process. It is intended to assist providers in accurately obtaining reimbursement for health care services. It is not intended to increase or maximize reimbursement by any payer. We strongly suggest that you consult your payer organization with regard to local reimbursement policies. The information contained in this document is provided for information purposes only and represents no statement, promise or guarantee by Biosense Webster, Inc. concerning levels of reimbursement, payment or charge. Similarly, all CPT® & HCPCS codes are supplied for information purposes only and represent no statement, promise or guarantee by Biosense Webster, Inc. that these codes will be appropriate or that reimbursement will be made.



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