

2009 Facility and Physician Billing Guide for Electrophysiology Diagnostic and Ablation Procedures¹

This guide has been developed to assist you in obtaining physician payment and hospital reimbursement for electrophysiology (EP) diagnostic and ablation procedures and for the acquisition of radiological images that may be used for the procedures. 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®) Codes for describing EP diagnostic and ablation procedures, and image acquisition services are listed below. Please note CPT 93651 is generally used for ablation of paroxysmal atrial fibrillation, atrial flutter and other supraventricular tachycardias.

Intracardiac Electrophysiological Procedures

CPT® Code ^{2,3}	Description	Total Relative Value Units (RVUs)	2009 National Average Medicare Reimbursement ⁴
93600-26	Bundle of His recording	3.31	\$ 119.38
93602-26	Intra-atrial recording	3.30	\$ 119.02
93603-26	Right ventricular recording	3.31	\$ 119.38
+93609-26	Intraventricular and/or intra-atrial mapping of tachycardia site(s) with catheter manipulation to record from multiple sites to identify origin of tachycardia (list separately in addition to code for primary procedure)	7.80	\$ 281.32
93610-26	Intra-atrial pacing	4.69	\$ 169.15
93612-26	Intraventricular pacing	4.67	\$ 168.43
+93613-26	Intracardiac electrophysiologic three-dimensional mapping	9.88	\$ 395.29
93616-26	...with pacing	1.93	\$ 69.61
93618-26	Induction of arrhythmia by electrical pacing	6.70	\$ 241.65
93619-26	Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording, including insertion and repositioning of multiple electrodes	11.57	\$ 417.29*
93620-26	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording	18.18	\$ 655.69*
+93621-26	...with left atrial pacing and recording from coronary sinus or left atrium	3.29	\$ 188.66
+93622-26	...with left ventricular pacing and recording	4.81	\$ 173.48
+93623-26	Programmed stimulation and pacing after intravenous drug infusion	4.46	\$ 160.86
93624	Electrophysiologic follow-up study with pacing and recording to test effectiveness of therapy, including induction or attempted induction of arrhythmia	7.60	\$ 274.11*
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

Image Acquisition Procedures

CPT® Code^{2,3}	Description	Total Relative Value Units (RVUs)	2009 National Average Medicare Reimbursement⁴
71275-26	Computed tomographic angiography, chest, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing	2.73	\$ 98.46
71550-26	Magnetic resonance (e.g. proton) imaging, chest (e.g. for evaluation of hilar and mediastinal lymphadenopathy), without contrast material(s)	2.05	\$ 73.94
71551-26	Magnetic resonance (e.g. proton) imaging, chest (e.g. for evaluation of hilar and mediastinal lymphadenopathy), with contrast material(s)	2.43	\$ 87.64
75557	Cardiac magnetic resonance imaging for morphology and function without contrast material	3.45	\$ 124.43
75558	Cardiac magnetic resonance imaging for morphology and function without contrast material; with flow/velocity quantification	3.58	\$ 129.12**
75559	Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging	4.40	\$ 158.69
75560	Cardiac magnetic resonance imaging for morphology and function without contrast material; with flow/velocity quantification and stress	4.11	\$ 148.23**
75561	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences	3.81	\$ 137.41
75562	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with flow/velocity quantification	3.93	\$ 141.74**
75563	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging	4.55	\$ 164.10
75564	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with flow/velocity quantification and stress	4.60	\$ 165.91**

FACILITY SERVICES

Inpatient Procedures

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

ICD-9⁵ 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-DRG⁶	Description	2009 National Average Medicare Reimbursement⁷
250	Percutaneous cardiovascular procedure without coronary artery stent implant or acute myocardial infarction (e.g., PTCA and electrophysiology), with MCC	\$ 16,610.34
251	Percutaneous cardiovascular procedure without coronary artery stent or acute myocardial infarction (e.g., PTCA and electrophysiology), without MCC	\$ 8,905.28

Outpatient Procedures

Ambulatory Payment Classification (APC)⁸	Description	Status Indicator	2009 National Average Medicare Reimbursement⁹
0085	Level II comprehensive electrophysiology procedures (CPT Codes 93619, 93620 and 93624-93650 when performed as a stand-alone procedure)	T	\$ 3,259.99
0086	Ablate heart dysrhythm focus (CPT Codes 93651-93652 when performed as a stand-alone procedure)	T	\$ 6,615.35
8000	Cardiac electrophysiologic evaluation and ablation composite (CPT Codes 93619 or 93620 performed in conjunction with 93650, 93651 or 93652)	T	\$ 9,418.24

A "T" Status Indicator means the APC is discounted for multiple procedures. For claims that include more than one code with a "T" status, full payment will be made for the highest paying procedure. All other procedures performed during the same operative session having a "T" status indicator will be paid at 50% of the amount allowed by Medicare. An APC with an "S" status indicator means that it is not discounted for multiple procedures. A "Q" Status Indicator means the service is a packaged service subject to separate payment under OPPS payment criteria.

HCPCS Codes for Biosense Webster Products

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. CMS will reject a hospital claim if the appropriate pass through code is not identified on the claim.

HCPCS Code	Category Long Descriptor	BWI Product Covered
C1730	Catheter, electrophysiology, diagnostic, other than 3D mapping (19 or fewer electrodes)	All models – WEBSTER® Quadrapolar, Hexapolar, Octapolar, Decapolar and Orthogonal Fixed Curve & Small Dome Deflectable Diagnostic Catheters including specials, LASSO®, EZ STEER® DS, WEBSTER COMPLI® and AVAIL® Catheters
C1731	Catheter, electrophysiology, diagnostic, other than 3D mapping (20 or more electrodes)	All models – SANTORO®, HALO® XP, CRISTACATH®, ISMUS™ CATH, LASSO® 20-Pole and PENTARAY™ Catheters; 20-Pole specials
C1732	Catheter, electrophysiology, diagnostic/ablation, 3D or vector mapping	All models – ESOPHASTAR™ Esophageal Mapping Catheter; NAVISTAR® 4 mm Tip, NAVISTAR® DS 8 mm Tip, NAVISTAR® RMT 4 mm Tip, NAVISTAR® THERMOCOOL®, NAVISTAR® RMT THERMOCOOL®, EZ STEER® THERMOCOOL® NAV and QWIKSTAR® 4 mm Tip Ablation Catheters
C1733	Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, other than cool-tip	All models – WEBSTER® Non-Temperature Large Dome, CELSIUS® 4 mm Tip, CELSIUS® DS 8 mm Tip, CELSIUS® RMT 4 mm Tip, EZ STEER® Bi-Directional 4 mm Tip, and EZ STEER® Bi-Directional DS 8 mm Tip Ablation Catheters
C1759	Catheter, intracardiac echocardiography	All models – ACUNAV® Ultrasound Catheter
C2630	Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, cool-tip	All models – CELSIUS® THERMOCOOL® Ablation Catheter, EZ STEER® THERMOCOOL® Non-NAV Catheter
C1893	Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, other than peel-away	All models – PREFACE® Braided Guiding Sheath

Please note that there is no C-code for the REFSTAR® Catheter with QWIKPATCH® External Reference Patch, COOLFLOW® Pump Tubing or PERRY® Exchange Dilator, or HEARTSPAN™ Transseptal Needle, as they are considered by CMS to be accessory items.

- 1 Not all codes provided are applicable for the recommended uses of Biosense Webster products. 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. <http://www.cms.hhs.gov/transmittals/downloads/R258OTN.pdf>
- 5** Hospital ICD-9-CM 2009 Volumes 1, 2, & 3, 9th Revision-Clinical Modification, American Medical Association. Copyright © 2008 Ingenix, Inc.
- 6** Note: The MS-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** 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.
- 9** Federal Register: Medicare Program; Hospital Outpatient Prospective Payment System and Calendar Year 2008; Final Rule, Federal Register Vol. 73, No. 223 / Tuesday, November 18, 2008.

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

** Although there are RVUs established for the code, it is not covered by Medicare.

+ Add-on code.

Disclaimer

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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