

2006 BIOSENSE WEBSTER, INC. PAYMENT AND REIMBURSEMENT GUIDELINES FOR DIAGNOSTIC AND ABLATION ELECTROPHYSIOLOGY CATHETERS

This guide has been developed to assist you in obtaining physician payment and hospital reimbursement for use of diagnostic and ablation electrophysiology catheters.

Diagnostic and ablation electrophysiology 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.

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.

PHYSICIAN SERVICES

Current Procedure Terminology (CPT) Codes are accepted by most payers. The following codes for electrophysiology studies have been established by the AMA and are included in the 2006 CPT Manual. A few of the possible CPT® codes for describing these services are listed below:

Intracardiac Electrophysiological Procedures

CPT® Code	Description ¹	Total Relative Value Units (RVUs)	2006 Estimated Physician Payment ¹
93600-26	Bundle of His recording	3.11	\$ 118
93602-26	Intra-atrial recording	3.11	\$ 118
93603-26	Right ventricular recording	3.11	\$ 118
+93609-26	Intra-ventricular 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)	7.30	\$ 277
93610-26	Intra-atrial pacing	4.42	\$ 168
93612-26	Intraventricular pacing	4.43	\$ 168
+93613-26	Intracardiac electrophysiologic three dimensional mapping	10.25	\$ 388
93618-26	Induction of arrhythmia by electrical pacing	6.22	\$ 236
93619-26	Comprehensive electrophysiologic evaluation without induction or attempted induction of arrhythmia	11.01	\$ 417
93620-26	...with induction or attempted induction of arrhythmia	17.22	\$ 653
+93621-26	...with left atrial recording, with or without pacing	3.07	\$ 116
+93622-26	...with left ventricular pacing and recording	4.53	\$ 172
+93623-26	Programmed stimulation and pacing after intravenous drug infusion	4.16	\$ 158
93624	Electrophysiologic follow-up study with pacing and recording to test effectiveness of therapy, including induction or attempted induction of arrhythmia	7.33	\$ 278

93650-26	Intracardiac catheter ablation of atrioventricular node function, atrioventricular conduction for creation of complete heart block ...	15.66	\$ 593
93651-26	Intracardiac catheter ablation of arrhythmogenic focus; for treatment of supraventricular tachycardia by ablation ... or other atrial foci, singly or in combination	23.70	\$ 898

PHYSICIAN PAYMENT EXAMPLE

A patient, in sinus rhythm, was admitted and brought to the EP lab with an indication of atrial flutter. Electrocardiogram monitoring was established and vascular access achieved through the right femoral vein and the right subclavian vein. Multipolar catheters were advanced to the coronary sinus, the high right atrium, the His bundle recording position, and the right ventricular apex. Programmed stimulation was performed in the atrium and the ventricle in the baseline state after isoproterenol infusion. Typical counter-clockwise atrial flutter was induced with atrial overdrive pacing and the eustachian ridge-tricuspid annulus isthmus was confirmed to be the critical portion of the circuit by entrainment and detailed mapping. Atrial flutter was terminated spontaneously and ablation of atrial foci was performed during coronary sinus pacing. One linear lesion was made with a drag technique and bi-directional block was confirmed. Detailed three-dimensional mapping in the isthmus was performed to confirm complete conduction block.

CPT® Code	Procedure Description	2006 Estimated Physician Payment ¹	Multiple Procedure Discount	2006 Total Estimated Payment ¹
93651-26	Intracardiac ablation of atrial foci	\$898	100%	\$898
93620-26	Electrophysiological study with induction of arrhythmia	\$653	50%	\$326
93623-26	Programmed stimulation after drug infusion	\$158	50%	\$79
+93613-26	3-D mapping of tachycardia site(s)	\$388	100%	\$388
93624-26	EP follow-up study	\$278	50%	\$139
36012	Selective catheter placement, venous system; first order branch (e.g. renal vein, jugular vein)	\$187	50%	\$93
36012-59	Selective catheter placement, venous system; first order branch (e.g. renal vein, jugular vein)	\$187	50%	\$93
75827	Venography, cava, superior with serial-ography, radiological supervision and interpretation	\$563	100%	\$563
			TOTAL PAYMENT	\$2,579

+ Add-on codes. List separately in addition to primary procedure code.
¹ Please refer to the CPT-4 Manual for a complete description of these codes.

National average Medicare reimbursement.

This information is provided as an example of CPT codes used to describe intracardiac electrophysiological procedures for a typical patient. It is possible that you will choose to use different CPT codes than the above to describe the services rendered for a specific patient.

HOSPITAL INPATIENT SERVICES

The following ICD-9 Procedure Codes generally describe intracardiac electrophysiological procedures:

ICD-9 Code	Description
37.26	Cardiac electrophysiologic stimulation and recording studies
37.27	Cardiac mapping
37.34	Catheter ablation of lesion or tissues of heart

The FY 2006 DRG Grouper will generally assign each Medicare patient discharge to DRG 518 when one of the above ICD-9 codes is used to describe the principal procedure that the patient received during their hospital stay.

Patient discharges that have a Major Cardiovascular Condition (MCV) as the primary and secondary diagnosis will generally assign to DRG 555.

National Average Medicare Inpatient Hospital Reimbursement

DRG	Description	Relative Weight ^a	FY 2006 Estimated Hospital Reimbursement ^a
518	Percutaneous cardiovascular procedures without AMI or coronary artery stent implant (e.g., PTCA and electrophysiology)	1.7509	\$8,705
555	Percutaneous cardiovascular procedures with major cardiovascular condition	2.4315	\$12,527

Major Cardiovascular Conditions (MCVs)ⁱⁱ

MCV Code	MCV Code Titles – P = Principal, S = Secondary Diagnosis
398.91	Rheumatic Heart Failure (Congestive).
402.01	Hypertensive Heart Disease, Malignant, With Congestive Heart Failure.
402.11	Hypertensive Heart Disease, Benign, With Congestive Heart Failure.
402.91	Hypertensive Heart Disease, With Congestive Heart Failure, Unspecified Benign or Malignant.
404.01	Malignant Hypertensive Heart and Renal Disease, With Congestive Heart Failure.
404.03	Malignant Hypertensive Heart and Renal Disease, With Congestive Heart Failure and Renal Failure.
404.11	Benign Hypertensive Heart and Renal Disease, With Congestive Heart Failure.
404.13	Benign Hypertensive Heart and Renal Disease, With Congestive Heart Failure and Renal Failure.
404.91	Hypertensive Heart and Renal Disease, Unspecified Benign or Malignant, With Congestive Heart Failure.
404.93	Hypertensive Heart & Renal Disease, Unspecified Benign or Malignant, W/ Congestive Heart Failure & Renal Failure.
410.01	Acute Myocardial Infarction, Anterolateral Wall, Initial Episode of Care.
410.11	Acute Myocardial Infarction, Anterior Wall, Initial Episode of Care.
410.21	Acute Myocardial Infarction, Inferolateral Wall, Initial Episode of Care.
410.31	Acute Myocardial Infarction, Inferoposterior Wall, Initial Episode of Care.
410.41	Acute Myocardial Infarction, Inferior Wall, Initial Episode of Care.
410.51	Acute Myocardial Infarction, Lateral Wall, Initial Episode of Care.
410.61	True Posterior Wall Infarction, Initial Episode of Care.
410.71	Subendocardial Infarction, Initial Episode of Care.
410.81	Acute Myocardial Infarction, Other Specified Site, Initial Episode of Care.
410.91	Acute Myocardial Infarction, Unspecified Site, Initial Episode of Care.
411.0	Postmyocardial Infarction Syndrome.
411.1	Intermediate Coronary Syndrome (Unstable Angina).
411.81	Coronary Occlusion Without Myocardial Infarction.
414.10	Heart (Wall) Aneurysm.
414.11	Aneurysm of Coronary Vessel.
414.12	Dissection of Coronary Artery.
414.19	Aneurysm of Heart.
415.0	Acute Cor Pulmonale.
415.11	Iatrogenic Pulmonary Embolism and Infarction.
415.19	Pulmonary Embolism and Infarction.
420.0	Acute Pericarditis In Diseases Classified Elsewhere.
420.90	Acute Pericarditis Unspecified.
420.91	Acute Idiopathic Pericarditis.
420.99	Acute Pericarditis.
421.0	Acute/Subacute Bacterial Endocarditis.
421.1	Acute/Subacute Infective Endocarditis In Diseases Classified Elsewhere.
421.9	Acute Endocarditis, Unspecified.
422.92	Septic Myocarditis.
423.0	Hemopericardium.
424.90	Endocarditis, Valve Unspecified, Unspecified Cause.
426.0	Atrioventricular Block Complete.
426.53	Bilateral Bundle Branch Block.
426.54	Trifascicular Block.
427.1	Paroxysmal Ventricular Tachycardia.
427.41	Ventricular Fibrillation.

427.5	Cardiac Arrest.
428.0	Congestive Heart Failure.
428.1	Left Heart Failure.
428.20	Unspecified Systolic Heart Failure.
428.21	Acute Systolic Heart Failure
428.22	Chronic Systolic Heart Failure.
428.23	Acute on Chronic Systolic Heart Failure.
428.30	Unspecified Diastolic Heart Failure
428.31	Acute Diastolic Heart Failure.
428.32	Chronic Diastolic Heart Failure.
428.33	Acute on Chronic Diastolic Heart Failure.
428.40	Unspecified Combined Systolic and Diastolic Heart Failure.
428.41	Acute Combined Systolic and Diastolic Heart Failure.
428.42	Chronic Combined Systolic and Diastolic Heart Failure.
428.43	Acute on Chronic Combined Systolic and Diastolic Heart Failure.
428.9	Heart Failure, Unspecified.
429.5	Chordae Tendineae Rupture.
429.6	Papillary Muscle Rupture.
429.71	Acquired Cardiac Septal Defect.
429.79	Other Certain Sequelae of Myocardial Infarction, Not Elsewhere Classified.
429.81	Papillary Muscle Disorder.
430.	Subarachnoid Hemorrhage.
431.	Intracerebral Hemorrhage.
432.0	Nontraumatic Extradural Hemorrhage.
432.1	Subdural Hemorrhage.
432.9	Unspecified Intracranial Hemorrhage.
433.01	Occlusion and Stenosis of Basilar Artery With Cerebral Infarction.
433.11	Occlusion and Stenosis of Carotid Artery With Cerebral Infarction.
433.21	Occlusion and Stenosis of Vertebral Artery With Cerebral Infarction.
433.31	Occlusion and Stenosis of Multiple and Bilateral Precerebral Arteries With Cerebral Infarction.
433.81	Occlusion and Stenosis of Precerebral Artery With Cerebral Infarction.
433.91	Occlusion and Stenosis of Unspecified Precerebral Artery With Cerebral Infarction.
434.00	Cerebral Thrombosis Without Cerebral Infarction.
434.01	Cerebral Thrombosis With Cerebral Infarction.
434.10	Cerebral Embolism Without Cerebral Infarction.
434.11	Cerebral Embolism With Cerebral Infarction.
434.90	Unspecified Cerebral Artery Occlusion Without Cerebral Infarction.
434.91	Unspecified Cerebral Artery Occlusion With Cerebral Infarction.
436.	Acute, But Ill-Defined, Cerebrovascular Disease.
441.00	Dissection of Aorta, Unspecified Site
441.01	Dissection of Aorta, Thoracic.
441.02	Dissection of Aorta, Abdominal.
441.03	Dissection of Aorta, Thoracoabdominal.
441.1	Thoracic Aneurysm, Ruptured.
441.3	Abdominal Aneurysm, Ruptured
441.5	Aortic Aneurysm of Unspecified Site, Ruptured.
441.6	Thoracoabdominal Aneurysm, Ruptured.
443.22	Dissection of Iliac Artery.
443.29	Dissection of Other Artery.
444.0	Embolism or Thrombosis of Abdominal Aorta.

444.1	Embolism or Thrombosis of Thoracic Aorta.
445.81	Atheroembolism of Kidney.
453.2	Embolism and Thrombosis of Vena Cava.
785.50	Shock, Unspecified.
785.51	Cardiogenic Shock.
861.02	Laceration of Heart Without Penetration of Heart Chambers or Open Wound Into Thorax.
861.03	Laceration of Heart With Penetration of Heart Chambers, Without Open Wound Into Thorax.
861.10	Unspecified Injury of Heart With Open Wound Into Thorax.
861.11	Contusion of Heart With Open Wound Into Thorax.
861.12	Laceration of Heart Without Penetration of Heart Chambers With Open Wound Into Thorax.
861.13	Laceration of Heart With Penetration of Heart Chambers, and Open Wound Into Thorax.
862.9	Multiple/Unspecified Intrathoracic Organ Injury With Open Wound Into Cavity.
996.61	Infection and Inflammatory Reaction Due To Cardiac Device/Implant/Graft.
996.62	Infection and Inflammatory Reaction Due To Other Vascular Device/Implant/ Graft.
996.72	Complication Due To Other Cardiac Device/Implant/ Graft.
996.83	Complications of Transplanted Heart.

HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS)

Medicare's Hospital Outpatient Prospective Payment System (OPPS) became effective August 1, 2000. The OPPS System replaced the payment system that was based on a blend of hospital costs and facility fee schedules. With a few exceptions, all outpatient hospital services are assigned to Ambulatory Payment Classifications or APCs. The APCs are based on services/procedures that are clinically similar and require comparable resources. Freestanding Diagnostic Imaging Laboratories, Ambulatory Surgery Centers (ASCs) and Independent Diagnostic Testing Facilities (IDTFs) are not affected by this rule.

Key Points of the OPPS:

- The basis of payment is an encounter. Multiple APC payments can be made if more than one service is provided on a given date.
- HCPCS procedure codes (CPT and alpha-numeric codes) on the claim determine the APC assignment(s). Unlike the DRG inpatient prospective payment system, ICD-9 diagnosis codes are not used to assign cases to APCs.
- Effective January 1, 2003 separate pass-through payments for most eligible drugs and devices came to an end. Payments for these products generally have been bundled into the procedure codes with which they are commonly associated. For a small number of new drugs and devices, separate pass-through payments will continue in 2006.

Status Indicators

The listing of codes that are paid under the OPPTS includes Status Indicators, which designate whether or not a discount (payment reduction) applies to the APC payment rate. An "S" Status Indicator means that the APC is not discounted for multiple procedures, whereas a "T" Status Indicator means the APC is discounted for multiple procedures. Discounting of payments will occur for multiple surgical procedures ("T" status) and for procedures that are terminated before completion. 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 "N" Status Indicator means the costs have been bundled into the APC payment amount for another procedure. No separate payments are made for codes with "N" status indicators. Please refer to the Federal Register for a complete list of Status Indicator codes.

PASS-THROUGH PAYMENTS

Effective January 1, 2004 CMS reactivated the use of the C-codes that were previously discontinued. However, unlike before, the C-codes are only used for tracking devices used in hospital outpatient procedures and do not provide any additional reimbursement dollars to the user.

Effective January 1, 2005, CMS has made device coding mandatory for select device-dependent APCs. Hospitals are required to report device usage for outpatient procedures through the inclusion of the C-codes on claims for dates of service beginning January 1, 2005.

HCPCS Codes for Biosense Webster Products

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

Please note that there is no C-code for the REFSTAR™ Patch or COOLFLOW™ Tubing as they are considered by CMS to be accessory items.

APC, Status Indicator and National Average Payment Amount for Electrophysiology Procedures

Ambulatory Payment Classification	Category Description	Status Indicator	2006 Average Payment Amount ⁱⁱⁱ
0085	Level II Comprehensive electrophysiology procedures (CPT Codes 93619-93622)	T	\$2,036
0086	Ablate heart dysrhythm focus (CPT Codes 93650-93652)	T	\$2,502
0087	Cardiac electrophysiologic recording/mapping (CPT Codes 93600-93618)	T	\$1,964

Example of Hospital Outpatient Payments

(Average hospital payment without any geographic adjustment)

Comprehensive EP Procedure and Ablation of Atrioventricular Node with NAVISTAR® Catheter

Procedure	HCPCS/ CPT Code	APC	Status Indicator	APC Payment Rate ⁱⁱⁱ	Discount Factor	2006 Hospital Payment
Intracardiac catheter ablation of arrhythmogenic focus; for treatment of supraventricular tachycardia by ablation	93651	0086	T	\$2,502	100%	\$2,502
Level II Comprehensive electrophysiology procedure	93619	0085	T	\$2,036	50%	\$1,018
Cardiac electrophysiologic recording/mapping	+93613	0087	T	\$1,964	50%	\$982
					Total Payment	\$4,502



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i 70 Federal Register 70374-70449 (2005)
 ii 70 Federal Register 47477-47478 (2005)
 iii 70 Federal Register 68731-68736 (2005)

National average Medicare reimbursement.

Caution: Federal law restricts these devices to sale by or on the order of a physician. Please refer to the complete product information accompanying each device.

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