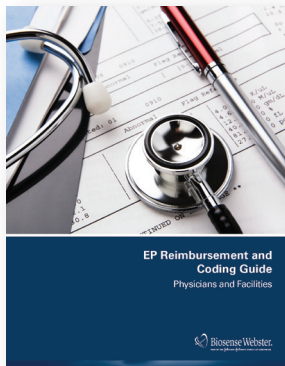




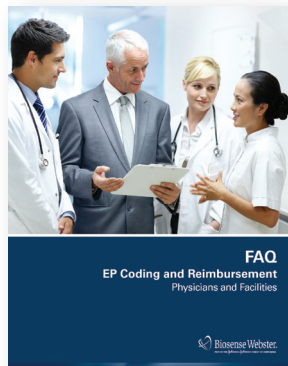
# 2018 EP Reimbursement and Coding Guide

Physicians and Facilities

# Resources to assist you with the Reimbursement Process!



**Reimbursement and Coding Guide**



**Coding and Reimbursement Frequently Asked Questions**



**Electrophysiology Coding Checklist**



**EP Procedure Documentation Best Practices**



**Online HCPCS C-Code Finder**



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# Electrophysiology Diagnostic, Ablation, and Intracardiac Echocardiography Guided Transcatheter Procedures

This guide has been developed to assist you in obtaining physician payment and hospital reimbursement for:

- Electrophysiology (EP) diagnostic and ablation procedures
- The acquisition of radiological images
- EP and Cardiology procedures that may utilize intracardiac echocardiography (ICE)

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 appropriate documentation in the medical record.

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## 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.

Important information: Prior to use, refer to the instructions for use supplied with this device for indications, contraindications, side effects, warnings and precautions.

This product can only be used by healthcare professionals



## PHYSICIAN SERVICES

CPT® codes and Medicare Physician Fee Schedule values for Electrophysiology Diagnostic, Ablation, and Intracardiac Echocardiography Guided Transcatheter Procedures are indicated below. Please note that there were significant revisions to ablation codes in CPT® 2013. Codes were added for paroxysmal atrial fibrillation ablation procedures: 93656 for pulmonary vein isolation, and 93657 for additional linear or focal atrial ablation for atrial fibrillation. Additional ablation package codes are 93653 for atrial flutter and other supraventricular tachycardias; 93654 for ventricular tachycardia; and add-on code 93655 for additional atrial or ventricular mechanism. When reporting ablation therapy codes (93653-93657), the single site electrophysiology studies (93600-93603, 93610, 93612, 93618) and the comprehensive electrophysiology study codes (93619, 93620) are included and may not be reported separately. Other procedures are also bundled into some ablation codes, but should be reported separately with others: review the descriptors and parenthetical notes carefully. Moderate sedation is no longer bundled into CPT® codes as of 2017, and so may be reported separately. There were no revisions to instructional notes or code descriptors for 2018.

### Intracardiac Electrophysiological Procedures

CPT® Code <sup>2</sup>	Description	2018 Work RVUs	2018 Total RVUs	2018 National Average Medicare Reimbursement <sup>3</sup>
+ 93462	Left heart catheterization by transeptal puncture through intact septum or by transapical puncture	3.73	6.11	\$ 220
⊖ 93600-26	Bundle of His recording	2.12	3.46	\$ 125
⊖ 93602-26	Intra-atrial recording	2.12	3.36	\$ 121
⊖ 93603-26	Right ventricular recording	2.12	3.36	\$ 121
+ 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	4.99	8.09	\$ 291
⊖ 93610-26	Intra-atrial pacing	3.02	4.76	\$ 171
⊖ 93612-26	Intraventricular pacing	3.02	4.72	\$ 170
+ 93613	Intracardiac electrophysiologic three-dimensional mapping	5.23	9.38	\$ 338
⊖ 93615-26	Esophageal recording of atrial electrogram with or without ventricular electrogram(s);	0.74	1.10	\$ 40
⊖ 93616-26	...with pacing	1.24	1.77	\$ 64
⊖ 93618-26	Induction of arrhythmia by electrical pacing	4.00	6.44	\$ 232
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 electrode catheters, without induction or attempted induction of arrhythmia	7.06	11.37	\$ 409
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	11.32	18.26	\$ 657
+ 93621-26	...with left atrial pacing and recording from coronary sinus or left atrium	2.10	3.41	\$ 123
+ 93622-26	...with left ventricular pacing and recording	3.10	5.01	\$ 180
+ 93623-26	Programmed stimulation and pacing after intravenous drug infusion	2.85	4.62	\$ 166

<sup>†</sup>THERMOCOOL® Navigation Catheters are approved for drug refractory recurrent symptomatic paroxysmal atrial fibrillation, when used with CARTO® Systems (excluding NAVISTAR® RMT THERMOCOOL® Catheter).

<b>CPT® Code<sup>2</sup></b>	<b>Description</b>	<b>2018 Work RVUs</b>	<b>2018 Total RVUs</b>	<b>2018 National Average Medicare Reimbursement<sup>3</sup></b>
93624-26	Electrophysiologic follow-up study with pacing and recording to test effectiveness of therapy, including induction or attempted induction of arrhythmia	4.55	7.25	\$ 261
93650	Intracardiac catheter ablation of atrioventricular node function, atrioventricular conduction for creation of complete heart block, with or without temporary pacemaker placement	10.24	17.20	\$ 619
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 (when necessary), His bundle recording (when necessary) 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	14.75	24.33	\$ 876
93654	... 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	19.75	32.59	\$ 1,173
+ 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	7.50	12.40	\$ 446
93656	Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia including left or right atrial pacing/recording when necessary, right ventricular pacing/recording when necessary, and His bundle recording when necessary with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation	19.77	32.68	\$ 1,176
+ 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	7.50	12.39	\$ 446
93660	Evaluation of cardiovascular function with tilt table	1.89	2.67	\$ 96
+ 93662-26	Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation	2.80	4.08	\$ 147

#### Septal Defect and Other Transcatheter Procedures

93580	Percutaneous transcatheter closure of congenital interatrial communication (ie Fontan fenestration, atrial septal defect) with implant	17.97	28.42	\$ 1,023
93581	Percutaneous transcatheter closure of a congenital ventricular septal defect with implant	24.39	38.72	\$ 1,394
93582	Percutaneous transcatheter closure of patent ductus arteriosus	12.31	19.36	\$ 697
93583	Percutaneous transcatheter septal reduction therapy (eg, alcohol septal ablation) including temporary pacemaker insertion when performed	13.75	21.61	\$ 778
33340	Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation	14.00	23.09	\$ 831

<sup>†</sup>THERMOCOOL® Navigation Catheters are approved for drug refractory recurrent symptomatic paroxysmal atrial fibrillation, when used with CARTO® Systems (excluding NAVISTAR® RMT THERMOCOOL® Catheter).

## Image Acquisition Procedures

CPT® Code <sup>2</sup>	Description	2018 Work RVUs	2018 Total RVUs	2018 National Average Medicare Reimbursement <sup>3</sup>
93312-26	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report	2.30	3.11	\$ 112
93315-26	Transesophageal echocardiography for congenital cardiac anomalies; image including probe placement, image acquisition, interpretation and report	2.69	3.67	\$ 132
+ 93320-26	Doppler echocardiography; pulsed wave and/or continuous wave with spectral display; complete	0.38	0.52	\$ 19
+ 93321-26	. . . follow-up or limited study	0.15	0.21	\$ 8
+ 93325-26	Doppler echocardiography color flow velocity mapping	0.07	0.09	\$ 3
93355	Echocardiography, transesophageal (TEE) for guidance of a transcatheter intracardiac or great vessel(s) structural intervention(s) (peri- and intra-procedural), real-time image acquisition and documentation, guidance with quantitative measurements, probe manipulation, interpretation, and report, including diagnostic TEE and, when performed, administration of ultrasound contrast, Doppler, color flow, and 3D	4.66	6.49	\$ 234

### Moderate Sedation

99151	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 younger than 5 years of age	0.50	0.70	\$ 25
99152	initial 15 minutes of intraservice time, patient age 5 years or older	0.25	0.36	\$ 13
+ 99153	each additional 15 minutes intraservice time (List separately in addition to code for primary service)	0.00	0.00	\$ 0
99155	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 younger than 5 years of age	1.90	2.74	\$ 99
99156	initial 15 minutes of intraservice time, patient age 5 years or older	2.74	2.15	\$ 77
+ 99157	each additional 15 minutes intraservice time (List separately in addition to code for primary service)	1.25	1.64	\$ 59

**Note:** Code 93355 is intended for reporting with "structural" interventions. It is to be reported by a different physician other than the one performing the intervention, and coverage in conjunction with ablation procedures would be according to payor discretion.

## OUTPATIENT FACILITY SERVICES

Ambulatory Payment Classification (APC) is the Medicare reimbursement methodology under the Hospital Outpatient Prospective Payment System (HOPPS). Procedures which require similar resources are assigned to an APC category for a lump sum payment. Services are reported with CPT® codes. Multiple outpatient APCs may potentially be paid to a facility on a single case, although some CPT® codes may be packaged, ancillary, or combined into a comprehensive APC.

Note: All APC numbers were revised effective 2016.

<b>Ambulatory Payment Classification (APC)</b>	<b>Description</b>	<b>Status Indicator</b>	<b>2018 National Average Medicare Reimbursement<sup>6</sup></b>
5211	Level 1 Electrophysiologic Procedures	J1	\$ 909
5212	Level 2 Electrophysiologic Procedures	J1	\$ 5,314
5213	Level 3 Electrophysiologic Procedures	J1	\$ 18,515
5723	Level 3 Diagnostic Tests and Related Services	S	\$ 444
5194	Level 4 Endovascular Procedures	J1	\$ 16,019
5524	Level 4 Imaging without Contrast	S	\$ 487

- Beginning in 2014, 93462 was assigned a status of 'N', packaged procedure; no separate APC reimbursement will be made for transseptal puncture. Although 93462 may continue to be reported in addition to SVT (93653) or VT (93654) ablation codes for tracking, it is bundled into the atrial fibrillation code (93656) by CPT definition.
- 93603, 93615, 93616, and 92618 are assigned to APC 5211. These CPT® codes all have a status indicator of J1, so only the primary J1 procedure will be reimbursed and the others bundled.
- 93609 and 93613 (mapping), 93621, 93622, 93623, 93655, 93657 (add-on codes), 93320, 93321, and 93325 (Doppler echocardiography), and 93662 (intracardiac echocardiography) are not assigned to an APC, but are ancillary to the primary procedures. Status indicator is "N" on these procedures; no separate APC payment is made.
- 93600, 93602, 93610, 93612, 93619, 93620, 93624, and 93650 are assigned to APC 5212 when performed as a stand-alone procedure, which also have a status indicator of J1.
- 93653, 93654, and 93656 are assigned to APC 5213, as these CPT® codes include both a diagnostic study and ablation in a single code. These also have a status of J1, and will typically be the primary code in a case.
- 93660 (Tilt table evaluation) is assigned to APC 5723, with a status indicator of S.
- Transcatheter closures of septal defects or patent ductus arteriosus (93580, 93581, and 93582) are assigned to APC 5194, which has status J1.
- Septal reduction therapy (93583) and left atrial appendage exclusion (33340) are identified as status "C"; Inpatient Only, and are not approved to be performed in an outpatient setting.
- 93312 (TEE) and 93315 (TEE for congenital cardiac anomalies), are reassigned to APC 5524, which has a status indicator of "S"; indicating separate reimbursement, not subject to multiple procedure discount. However, they are bundled when reported with a procedure of status J1, which is most of the electrophysiology procedures. Code 93355 (TEE guidance for intracardiac or great vessel(s) structural intervention(s)) has a status of N, packaged procedure; no separate APC reimbursement will be made.

<sup>†</sup>THERMOCOOL® Navigation Catheters are approved for drug refractory recurrent symptomatic paroxysmal atrial fibrillation, when used with CARTO® Systems (excluding NAVISTAR® RMTTHERMOCOOL® Catheter).

## INPATIENT FACILITY SERVICES

Medicare reimburses inpatient hospital services under the Inpatient Prospective Payment System (IPPS), which bases payment on diagnosis-related groups (DRGs), now MS-DRGs (Medicare Severity Diagnosis Related Group). The FY 2018 MS-DRG Grouper will generally assign each Medicare patient discharge to MS-DRG 274 when ICD-10-PCS electrophysiology diagnostic and ablation procedure codes 4A0234Z, 02K83ZZ and/or 02583ZZ 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 273. MS-DRGs for other transcatheter procedures which may involve intracardiac echocardiography are also listed below.

<i>MS-DRG</i>	<i>Description</i>	<i>2018 National Average Medicare Reimbursement<sup>5</sup></i>
<b>EP / Ablation and/or ASD Closure</b>		
273	<i>Percutaneous Intracardiac Procedures with MCC</i>	\$ 21,570
274	<i>Percutaneous Intracardiac Procedures without MCC</i>	\$ 16,684
<b>VSD Closure</b>		
228	<i>Other Cardiothoracic Procedures with MCC</i>	\$ 39,740
229	<i>Other Cardiothoracic Procedures with CC</i>	\$ 27,613
<b>Other Surgical Occlusion (PDA Closure)</b>		
270	<i>Other Major Cardiovascular Procedures with MCC</i>	\$ 29,774
271	<i>Other Major Cardiovascular Procedures with CC</i>	\$ 20,389
272	<i>Other Major Cardiovascular Procedures without CC/MCC</i>	\$ 14,788



## PROCEDURE CODES

The following ICD-10-PCS procedure codes generally describe intracardiac electrophysiology procedures, as well as other transcatheter procedures which may involve intracardiac ultrasound.

Ablation procedures are coded to Destruction of applicable body part or portion thereof. However, there is also a body part "Conduction Mechanism" in this section which may capture a wide range of sites as the most specific body part available, since the actual target of the ablation is typically the arrhythmogenic focus.

<b>ICD-10-PCS Tx Code</b>	<b>Description</b>
<b>Intracardiac Electrophysiological Procedures</b>	
4A0234Z	Measurement and monitoring, cardiac, percutaneous, electrical activity
4A023PZ	Measurement and monitoring, cardiac, percutaneous, action currents
02K80ZZ	Map conduction mechanism, open
02K83ZZ	Map conduction mechanism, percutaneous
02K84ZZ	Map conduction mechanism, percutaneous endoscopic
B244ZZ3	Imaging, ultrasonography, right heart, no contrast, intravascular
B245ZZ3	Imaging, ultrasonography, left heart, no contrast, intravascular
B246ZZ3	Imaging, ultrasonography, right and left heart, no contrast, intravascular
B24DZZ3	Imaging, ultrasonography, pediatric heart, no contrast, intravascular
02JA3ZZ	Inspection, heart, percutaneous
02563ZZ	Destruction, percutaneous, right atrium
02573ZZ	Destruction, percutaneous, left atrium
025K3ZZ	Destruction, percutaneous, right ventricle
025L3ZZ	Destruction, percutaneous, left ventricle
02583ZZ	Destruction, percutaneous, conduction mechanism
02553ZZ	Destruction, percutaneous, atrial septum
025M3ZZ	Destruction, percutaneous, ventricular septum
025S3ZZ	Destruction, percutaneous, left pulmonary vein
025T3ZZ	Destruction, percutaneous, right pulmonary vein

**Transthoracic and Transesophageal Echocardiography**

B244ZZZ	Imaging, ultrasonography, right heart, no contrast
B245ZZZ	Imaging, ultrasonography, left heart, no contrast
B246ZZZ	Imaging, ultrasonography, right and left heart, no contrast
B24DZZZ	Imaging, ultrasonography, pediatric heart, no contrast
B244ZZ4	Imaging, ultrasonography, right heart, no contrast, transesophageal
B245ZZ4	Imaging, ultrasonography, left heart, no contrast, transesophageal
B246ZZ4	Imaging, ultrasonography, right and left heart, no contrast, transesophageal
B24DZZ4	Imaging, ultrasonography, pediatric heart, no contrast, transesophageal

**Other Transcatheter Procedures Involving Intracardiac Ultrasound**

02U53JZ	Supplement, atrial septum, percutaneous, with synthetic substitute
02UM3JZ	Supplement, ventricular septum, percutaneous, with synthetic substitute
02Q53ZZ	Repair, atrial septum, percutaneous
02W53JZ	Revision, atrial septum, percutaneous, synthetic substitute
02WM3JZ	Revision, ventricular septum, percutaneous, synthetic substitute
02573ZK	Destruction, left atrium, percutaneous, left atrial appendage
02L73ZK	Occlusion, left atrium, percutaneous, left atrial appendage, no device
02L73CK	Occlusion, left atrium, percutaneous, left atrial appendage, with extraluminal device
02L73DK	Occlusion, left atrium, percutaneous, left atrial appendage, with intraluminal device
02LR3DT	Occlusion, percutaneous, pulmonary artery, ductus arteriosus, with intraluminal device
02LR3ZT	Occlusion, percutaneous, pulmonary artery, ductus arteriosus, with no device

When an Ultrasound Catheter is used during percutaneous procedures, the MS-DRG category will be determined by the principal procedure – such as ablation procedures (ICD-10-PCS code 02583ZZ) or percutaneous atrial septal defect (ASD) closure (ICD-10-PCS code 02U53JZ). The FY2018 MS-DRG Grouper will generally assign each Medicare patient discharge to MS-DRG 274 when one of these ICD-10-PCS procedure codes are used to describe the principal procedure that the patient received during their hospital stay. Patient discharges that have an MCC will generally be assigned to MS-DRG 273.

When an Ultrasound Catheter is used in conjunction with the principal procedure of percutaneous ventricular septal defect (VSD) closure (02UM3JZ), or an atrial septal defect repair (02Q53ZZ), the FY2018 MS-DRG Grouper will generally assign each Medicare patient discharge to one of the MS-DRGs in the range 228 – 230. When the principal procedure is occlusion of patent ductus arteriosus (02LR3DT, 02LR3ZT), the discharge will be assigned to an MS-DRG in the range 270-272.

## DIAGNOSIS CODES

For any patient service or procedure, a diagnosis code(s) will also be reported to indicate the condition for which the patient requires medical care.

Physician and hospital outpatient claims report, as the first-listed diagnosis, the chief complaint. The **chief complaint** can be defined as the 'presenting problem' for which the patient presents to the hospital or other site for care.

For inpatient services, hospitals identify a principal diagnosis. The **principal diagnosis** is defined in the Uniform Hospital Discharge Data Set (UHDDS)<sup>®</sup> as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

The following ICD-10-CM diagnosis codes are generally relevant to intracardiac electrophysiology procedures, septal defect repairs, and other transcatheter interventions. More detailed and precise information in the record is often necessary to accurately assign codes in ICD-10-CM/ICD-10-PCS. The ICD-10 updates for the Fiscal Year (FY) 2018 reflect continued refinement of the new system, with hundreds of new and revised codes. CMS and other reviewers may use coding specificity as the reason for an audit or a denial of a reviewed claim.

**ICD-10-CM  
Dx Code**      **Description**

### Cardiac Dysrhythmias

I47.0	Re-entry ventricular arrhythmia
I47.1	Supraventricular tachycardia [SVT, AVNRT, junctional, nodal]
I47.2	Ventricular tachycardia
I47.9	Paroxysmal tachycardia, unspecified
I48.0	Paroxysmal atrial fibrillation
I48.1	Persistent atrial fibrillation
I48.2	Chronic atrial fibrillation
I48.3	Typical atrial flutter
I48.4	Atypical atrial flutter
I48.91	Unspecified atrial fibrillation
I48.92	Unspecified atrial flutter
I49.01	Ventricular fibrillation
I49.02	Ventricular flutter
I49.1	Atrial premature depolarization
I49.2	Junctional premature depolarization
I49.3	Ventricular premature depolarization
I49.40	Unspecified premature depolarization
I49.49	Other premature depolarization [Ectopic beats, Extrasystoles, Premature contractions]
I49.5	Sick sinus syndrome [Tachycardia-bradycardia syndrome]
I49.8	Other specified cardiac arrhythmias
I49.9	Cardiac arrhythmia, unspecified
R00.0	Tachycardia, unspecified

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<b>ICD-10-CM Dx Code</b>	<b>Description</b>
R00.1	<i>Bradycardia, unspecified</i>
R00.2	<i>Palpitations</i>
R00.8	<i>Other abnormalities of heart beat</i>
R00.9	<i>Unspecified abnormalities of heart beat</i>

### Conduction Disorders

I44.0	<i>Atrioventricular block, first degree</i>
I44.1	<i>Atrioventricular block, second degree [AV, type I and II; Möbitz block, type I and II; Wenckebach's block]</i>
I44.2	<i>Atrioventricular block, complete [third degree block]</i>
I44.30	<i>Unspecified atrioventricular block</i>
I44.39	<i>Other atrioventricular block</i>
I44.4	<i>Left anterior fascicular block</i>
I44.5	<i>Left posterior fascicular block</i>
I44.60	<i>Unspecified fascicular block [Left bundle-branch hemiblock NOS]</i>
I44.69	<i>Other fascicular block</i>
I44.7	<i>Left bundle-branch block, unspecified</i>
I45.0	<i>Right fascicular block</i>
I45.10	<i>Unspecified right bundle-branch block</i>
I45.19	<i>Other right bundle-branch block</i>
I45.2	<i>Bifascicular block</i>
I45.3	<i>Trifascicular block</i>
I45.4	<i>Nonspecific intraventricular block [Bundle-branch block NOS]</i>
I45.5	<i>Other specified heart block [Sinoatrial block, Sinoauricular block]</i>
I45.6	<i>Pre-excitation syndrome [Accelerated AV conduction; Lown-Ganong-Levine syndrome; Wolff-Parkinson-White syndrome]</i>
I45.81	<i>Long QT syndrome</i>
I45.89	<i>Other specified conduction disorders [AV, interference, or isorhythmic dissociation]</i>
I45.9	<i>Conduction disorder, unspecified [Heart block NOS, Stokes-Adams syndrome]</i>
Q24.6	<i>Congenital heart block</i>

### Cardiac Arrest

I46.2	<i>Cardiac arrest due to underlying cardiac condition</i>
I46.8	<i>Cardiac arrest due to other underlying condition</i>
I46.9	<i>Cardiac arrest, cause unspecified</i>
Z86.74	<i>Personal history of sudden cardiac arrest</i>



**Septal Defects, Congenital Anomalies, and Cardiomyopathy**

I42.0	<i>Dilated cardiomyopathy</i>
I42.1	<i>Obstructive hypertrophic cardiomyopathy</i>
I42.2	<i>Other hypertrophic cardiomyopathy</i>
I51.0	<i>Cardiac septal defect, acquired</i>
I23.1	<i>Atrial septal defect as current complication following acute myocardial infarction</i>
I23.2	<i>Ventricular septal defect as current complication following acute myocardial infarction</i>
Q21.0	<i>Ventricular septal defect</i>
Q21.1	<i>Atrial septal defect</i>
Q21.2	<i>Atrioventricular septal defect</i>
Q21.4	<i>Aortopulmonary septal defect</i>
Q21.8	<i>Other congenital malformations of cardiac septa</i>
Q21.9	<i>Congenital malformation of cardiac septum, unspecified</i>
Q25.0	<i>Patent ductus arteriosus</i>

## HCPCS CODES FOR BIOSENSE WEBSTER, INC. PRODUCTS

Medicare uses 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 return a hospital claim if the appropriate tracking code is not identified on the claim when a device-dependent procedure is performed.

### HCPCS CODES FOR BIOSENSE WEBSTER, INC. PRODUCTS

<b>HCPCS Code</b>	<b>Category Long Descriptor</b>	<b>BWI Product Covered</b>
C1730	<i>Catheter, electrophysiology, diagnostic, other than 3D mapping (19 or fewer electrodes)</i>	WEBSTER® Quadrapolar, Hexapolar, Octapolar, Decapolar, Orthogonal and WEBSTER COMPLI® Fixed Diagnostic Catheters WEBSTER® Quadrapolar, Hexapolar, Octapolar, Decapolar, Orthogonal and WEBSTER® CS Bi-Directional and Unidirectional Deflectable Diagnostic Catheters EZ STEER® CS Catheters WEBSTER® HIS Catheters LASSO® Decapolar Catheters LASSO® 2515 Variable Decapolar Catheters
C1731	<i>Catheter, electrophysiology, diagnostic, other than 3D mapping (20 or more electrodes)</i>	HALO® and ISMUS® Twenty Electrode Catheters CRISTACATH® Catheters PENTARAY® High Density Mapping Catheters WEBSTER® Duo-Decapolar Twenty Electrode Catheters 20-Pole Special Catheters LASSO® Twenty Electrode Catheters LASSO® 2515 Variable Twenty Electrode Catheters
C1732	<i>Catheter, electrophysiology, diagnostic/ablation, 3D or vector mapping</i>	THERMOCOOL SMARTTOUCH® SF Catheters THERMOCOOL SMARTTOUCH® Catheters LASSO® NAV Catheters LASSO® 2515 NAV Variable Decapolar Catheters LASSO® 2515 NAV Variable Twenty Electrode Catheters LASSO® NAV eco Catheters LASSO® 2515 NAV Variable eco Catheters NAVISTAR® 4mm Catheters PENTARAY® NAV and PENTARAY® NAV eco Catheters LASSO® NAV Duo Loop Catheters NAVISTAR® DS Catheters NAVISTAR® THERMOCOOL® Catheters NAVISTAR® RMT THERMOCOOL® Catheters NAVISTAR® RMT 4mm Steerable Catheters THERMOCOOL® SF NAV Catheters EZ STEER® THERMOCOOL® NAV Catheters EZ STEER® NAV 8mm Catheters EZ STEER® NAV 4mm Catheters ESOPHASTAR® Esophageal Mapping Catheters DECANAV® Catheters RHYTHMFINDER™ Catheters
C1733	<i>Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, other than cool-tip</i>	CELSIUS® 4mm Non Temperature Sensing Catheters CELSIUS® 8mm Catheters CELSIUS® 4mm Catheters EZ STEER® 4mm Bi-Directional Catheters EZ STEER® 8mm Bi-Directional Catheters CELSIUS® RMT 4mm Steerable Catheters CELSIUS FLTR® Catheters
C2630	<i>Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, cool-tip</i>	CELSIUS® THERMOCOOL® Catheters CELSIUS® THERMOCOOL® RMT Catheters EZ STEER® THERMOCOOL® Catheters THERMOCOOL® SF Catheters

<b>HCPCS Code</b>	<b>Category Long Descriptor</b>	<b>BWI Product Covered</b>
C1759	<i>Catheter, intracardiac echocardiography</i>	ACUNAV™ Ultrasound Catheters SOUNDSTAR® 3D Ultrasound Catheters SOUNDSTAR® eco Catheters
C1893	<i>Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, other than peel-away</i>	PREFACE® Braided Guiding Sheaths
C1766	<i>Introducer/sheath, guiding, intracardiac electrophysiological, steerable, other than peel-away</i>	MOBICATH® Bi-Directional Sheaths CARTO VIZIGO™ Bi-Directional Sheaths

**Please note that there is no C-code for the REFSTAR® Catheter with QWIKPATCH® External Reference Patch, COOLFLOW® Pump Tubing, PERRY® Exchange Dilator, or HeartSpan® Transseptal Needle, MOBICATH® Transseptal Needle as they are considered by CMS to be accessory items. Not all devices will have an associated C-code; if none is defined, then the facility will assign its own internal charge code associated with an appropriate revenue code.**

2017 Healthcare Common Procedure Coding System (HCPCS), Centers for Medicare and Medicaid Services.

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Caution: US law restricts this device to sale by or on the order of a physician.

Important information: Prior to use, refer to the instructions for use supplied with this device for indications, contraindications, side effects, warnings and precautions.

## NOTES

- 1 Not all codes provided are applicable for the recommended uses of Biosense Webster, Inc.'s products. The most appropriate code for the patient's clinical presentation must be selected.
- 2 CPT® codes, descriptions, and other CPT® material only are copyright 2017 American Medical Association (AMA). All Rights Reserved. No fee schedules, basic units, relative values or related listings are included in CPT®. The AMA does not directly or indirectly practice medicine or dispense medical services. AMA assumes no liability for data contained or not contained herein.
- 3 The Medicare Physician Fee Schedule (MPFS) payment amounts indicated are based upon data elements published by the Centers for Medicare and Medicaid Services (CMS) in the Final Rule [CMS-1676-F] on 11/2/2017, and published in the Federal Register on 11/15/17, with a conversion factor of \$35.9996. CMS may make adjustments to any or all of the data inputs from time to time.
- 4 ICD-10-CM 2018 and ICD-10-PCS. AMA Copyright ©2017 Optum360, LLC. 2018 ICD-10-CM/ICD-10-PCS files are also published online at the CMS website.
- 5 The FY 2018 MS-DRG payment amounts indicated are estimates only based upon data elements derived from various CMS sources. MS-DRG national average payments were calculated with a base rate of \$6,028.08 using the national adjusted operating standardized amounts and the capital standard federal payment rate as issued in the Medicare Inpatient Prospective Payment System Final Rule issued by CMS on 8/2/17 [CMS-1677-F] and published in the Federal Register (Vol. 82, Issue 155) on 8/14/17, and Correction Notice issued on 10/4/17 [CMS-1677-CN]; Tables 1A and 1D, Table 5, and assume that all hospitals are receiving the full 1.35% updates for successful quality reporting and EHR meaningful use. Actual payment may vary based on various hospital-specific factors not reflected in the source data. Some providers may be paid based on a methodology which differs from the standard MS-DRG 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.
- 6 The APC payment amounts indicated are estimates only based upon data elements derived from various CMS sources. These sources include the Medicare Hospital Outpatient Prospective Payment System Final Rule [CMS-1678-FC] issued by CMS on 11/1/2017 and published in the Federal Register on 11/13/17. Actual payment may vary based on various hospital-specific factors not reflected in the source data.
- 7 Status Indicators identify a payment mechanism under the Ambulatory payment classifications. Definitions for status indicators are derived from Table D1 of the Medicare Hospital Outpatient Prospective Payment System Final Rule [CMS-1678-FC] issued by CMS on 11/1/2017 and published in the Federal Register on 11/13/17.

Indicator	Item/Code/Service	OPPS Payment Status
N	Items and Services Packaged into APC Rates	Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.
J1	Hospital Part B services paid through a comprehensive APC	Paid under OPPS; all covered Part B services on the claim are packaged with the primary "J1" service for the claim, except services with OPPS SI = F, G, H, L and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services.
S	Procedure or Service, Not Discounted When Multiple	Paid under OPPS; separate APC payment.
T	Procedure or Service, Multiple Procedure Reduction Applies	Paid under OPPS; separate APC payment.

- 8 The UHDDS definitions are used by acute care short-term hospitals to report inpatient data elements in a standardized manner, and initially only applied to inpatients in acute, short-term, general hospitals. These data elements and their definitions can be found in the July 31, 1985, Federal Register (Vol. 50, No. 147), pp. 31038-40. Since that time the application of the UHDDS definitions has been expanded to include all non-outpatient settings (acute care, short term, long term care and psychiatric hospitals; home health agencies; rehab facilities; nursing homes, etc).

### CPT® Symbols:

○ Procedure is identified as modifier 51 exempt. These procedures are typically performed with another procedure, but may be a stand-alone procedure and not always performed in conjunction with other specified procedures. Multiple procedure payment reduction does not apply to these codes. Note that other invasive electrophysiology procedure codes may be subject to a multiple procedure payment reduction (eg, payment may be decreased by 50% when multiple procedures are performed during the same day or session), dependent upon payer policy.

+ Add-on code. (List separately in addition to code for primary procedure) Add-on codes are always performed in addition to the primary service or procedure and must never be reported as a stand-alone code. All add-on codes are exempt from multiple procedure payment reduction.

- New procedure numbers added to the CPT® codebook are identified with the symbol • placed before the code number.

## 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.





Biosense Webster, Inc.  
33 Technology Drive  
Irvine, CA 92618  
USA

Tel: 909-839-8500  
Tel: 800-729-9010  
Fax: 909-468-2905

[www.biosensewebster.com](http://www.biosensewebster.com)

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