2013 Medicare Physician Coding and Reimbursement Changes
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Note: CPT code descriptions may be abbreviated and not listed in their entirety in all cases in this presentation. For full descriptions, please refer to your CPT code book.
Medtronic CRDM Economic Strategies and Solutions Department

Our Mission

• To educate customers on the economically efficient use of our products and therapies.

Our Goals

• Educate customers on coverage, coding, policy, and reimbursement issues.

• Create support programs that help providers understand how our products can be used in a cost-effective manner.

• Engage in collaboration and dialogue on economic issues that impact quality and patient access in the healthcare system.

www.Medtronic.com/crdmreimbursement
Today’s Agenda

• Executive Summary
• Review of Coding Changes
• Coding Scenarios
  - Cardiac Rhythm Devices/Catheters
• Cardiac Device Monitoring Services
• Other Information
• Appendix
Executive Summary
• For CRDM, new ablation codes package the EP study.

• Practice Expense Relative Value Units (RVUs): The four year transition to use Physician Practice Information Survey (PPIS) data is now complete.

• Multiple Procedure Payment Reduction (MPPR): 25% reduction to the technical component of the second and subsequent selected cardiovascular services

• Two new procedure codes (99495 and 99496) for primary care and care coordination (Transitional Care Management)

• Physician Value-Based Payment Modifier (PVBM): Effective in CY 2017 for all physicians who participate in FFS Medicare.

Sources: See Appendix
# National Medicare Physician Payment Rates for Significant Medtronic Therapies

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ICDs (33249)</td>
<td>$919</td>
<td>$983</td>
<td>$963</td>
<td>$926</td>
<td>$909</td>
<td>-1.1%</td>
</tr>
<tr>
<td>CRT-Ds (33249 + 33225)</td>
<td>$1,384</td>
<td>$1,481</td>
<td>$1,448</td>
<td>$1,392</td>
<td>$1,365</td>
<td>-1.4%</td>
</tr>
<tr>
<td>Pacemakers (33208)</td>
<td>$532</td>
<td>$566</td>
<td>$556</td>
<td>$536</td>
<td>$526</td>
<td>-1.1%</td>
</tr>
</tbody>
</table>

Medicare national payment rates shown above are based on the rates posted on the CMS website for CY 2009 – 2013.

* Physician payments effective June 1 through December 31, 2010 based on the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 and the Affordable Care Act.

^ CY 2012 payments are based on the Temporary Payroll Tax Cut Continuation Act of 2011 and the Middle Class Tax Relief and Job Creation Act of 2012.

~ CY 2013 payments are based on the American Taxpayer Relief Act of 2012 signed into law on January 2, 2013.

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## RVU Change for CRT-D Implant:

33249, +33225, 93641-26

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>33249</td>
<td>15.17</td>
<td>8.23</td>
<td>3.32</td>
<td>26.72</td>
<td>15.17</td>
<td>8.70</td>
<td>3.32</td>
<td>27.19</td>
<td>(1.7%)</td>
</tr>
<tr>
<td>+33225</td>
<td>8.33</td>
<td>3.26</td>
<td>1.82</td>
<td>13.41</td>
<td>8.33</td>
<td>3.54</td>
<td>1.82</td>
<td>13.69</td>
<td>(2.0%)</td>
</tr>
<tr>
<td>93641-26</td>
<td>5.92</td>
<td>2.29</td>
<td>1.29</td>
<td>9.50</td>
<td>5.92</td>
<td>2.52</td>
<td>1.29</td>
<td>9.73</td>
<td>(2.4%)</td>
</tr>
</tbody>
</table>

### Sources
See Appendix

Fac: Facility (Hospital)
Prac: Practice expense
MP: Malpractice expense

* Multiple Procedure Payment Reduction (MPPR); + add on codes are not subject to a MPPR
Review of Coding Changes
New Ablation Codes
Primary and Add-on

• When services occur concurrently 75% or more of the time, AMA considers packaging these services. For 2013:
  CPT added three new primary ablation codes that combine the elements of the EP study with the ablation procedure:
  1. EPS plus SVT (supraventricular) ablation
  2. EPS plus VT (ventricular tachycardia) ablation
  3. EPS plus PVI (Pulmonary Vein Isolation for A-fib)

• To accommodate treatment of additional lesions after the primary code, CPT added 2 new add-on codes:
  1. Ablation of additional discrete mechanism, or SVT or VT remaining after the primary procedure.
  2. Additional ablation (linear or focal) to treat AF remaining after PVI.

• CPT 93650 for AV (atrioventricular node) ablation remains unchanged.
### SVT Ablation: CPT 93653

<table>
<thead>
<tr>
<th>Brief Description</th>
<th>Required for SVT Ablation 93653</th>
</tr>
</thead>
<tbody>
<tr>
<td>Induction or attempted induction of arrhythmia</td>
<td>X</td>
</tr>
<tr>
<td>RA pacing/recording</td>
<td>X</td>
</tr>
<tr>
<td>RV pacing/recording</td>
<td>X</td>
</tr>
<tr>
<td>His bundle recording</td>
<td>X</td>
</tr>
<tr>
<td>SVT ablation</td>
<td>X</td>
</tr>
</tbody>
</table>

Add-on code +93655 may be reported with 93653
## VT Ablation: CPT 93654

<table>
<thead>
<tr>
<th>Brief Description</th>
<th>Required for VT Ablation 93654</th>
</tr>
</thead>
<tbody>
<tr>
<td>Induction or attempted induction of arrhythmia</td>
<td>X</td>
</tr>
<tr>
<td>RA pacing/recording</td>
<td>X</td>
</tr>
<tr>
<td>RV pacing/recording</td>
<td>X</td>
</tr>
<tr>
<td>His bundle recording</td>
<td>X</td>
</tr>
<tr>
<td>VT ablation</td>
<td>X</td>
</tr>
<tr>
<td>3D mapping</td>
<td>X when performed</td>
</tr>
<tr>
<td>LV pacing/recording</td>
<td>X when performed</td>
</tr>
</tbody>
</table>

Add-on code +93655 may be reported with 93654

2013 CPT manual
## PVI Ablation: CPT 93656

<table>
<thead>
<tr>
<th>Brief Description</th>
<th>Required for PVI 93656</th>
</tr>
</thead>
<tbody>
<tr>
<td>Induction or attempted induction of arrhythmia</td>
<td>X</td>
</tr>
<tr>
<td>Transseptal catheterizations</td>
<td>X</td>
</tr>
<tr>
<td>RV pacing/recording</td>
<td>X</td>
</tr>
<tr>
<td>His bundle recording</td>
<td>X</td>
</tr>
<tr>
<td>PVI</td>
<td>X</td>
</tr>
<tr>
<td>Atrial recording/pacing</td>
<td>X when performed</td>
</tr>
</tbody>
</table>

Add-on codes +93655 and +93657 may be reported with 93656

2013 CPT manual
The following parenthetical instruction comes from the 2013 CPT manual.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Do not report in conjunction with..........</th>
</tr>
</thead>
<tbody>
<tr>
<td>93653 SVT</td>
<td>93600-93603, 93610, 93612, 93618-93620, 93642, 93654</td>
</tr>
<tr>
<td>93654 VT</td>
<td>93279-93284, 93286-93289, 93600-93603, 93609, 93610, 93612, 93613, 93618-93620, 93622, 93642, 93653</td>
</tr>
<tr>
<td>93656 AF by PVI</td>
<td>93279-93284, 93286-93289, 93462, 93600, 93602, 93603, 93610, 93612, 93618, 93619, 93620, 93621, 93653, 93654</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Use in conjunction with..........</th>
</tr>
</thead>
<tbody>
<tr>
<td>+93655 Discrete mechanism</td>
<td>93653, 93654, 93656</td>
</tr>
<tr>
<td>+93657 Additional linear</td>
<td>93656</td>
</tr>
</tbody>
</table>
Coding Questions With These New Codes

• Do I need to report modifier 52 (reduced services) if all packaged services are not documented/performed?
• Will the parenthetical information for several of the add-on codes be updated to include the new catheter ablation codes (e.g., +93621 – Use 93621 in conjunction with 93620)?
• Will the NCCI procedure to procedure edits and Chapter XI of the National Correct Coding Policy Manual be changed to reflect the same information that is included the CPT manual?
  – CPT manual page 519: Codes 93622 and 93623 may be reported separately with 93656 for treatment of AF.
  – NCCI procedure to procedure edits: 93656 in Col. 1 and 93623 in Col. 2 (modifier allowed).
  – NCCI Chapter XI (page XI-19): CPT 93623 is an add-on code that may be reported only with CPT codes 93619 and 93620. CPT 93623 is not intended to be reported with the intracardiac catheter ablation procedure codes, and confirmation of the adequacy of ablation is included in the intracardiac catheter ablation procedure.

Sources: NCCI edit information is available at:
http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
2013 CPT manual
Coding Scenarios
AV Node ablation with Pacemaker Implant

• A patient with medically refractory SVT undergoes a diagnostic EPS and planned ablation. During diagnostic EPS, physician determines patient does not have an ablatable focus so an AV node/His ablation is performed instead. A pacemaker is implanted following the ablation.

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>National Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic EPS</td>
<td>93620-26</td>
<td>$634</td>
</tr>
<tr>
<td>AV node ablation</td>
<td>93650-51 @50%</td>
<td>$293²</td>
</tr>
<tr>
<td>3D mapping</td>
<td>+93613</td>
<td>$384</td>
</tr>
<tr>
<td>Insert SC ventricular pacer</td>
<td>33207-51 @50%</td>
<td>$243²</td>
</tr>
<tr>
<td><strong>Total Estimated Payment</strong></td>
<td><strong>$1,554</strong></td>
<td></td>
</tr>
</tbody>
</table>

SC: Single Chamber
Modifier 26: Professional Component
Modifier 51: Multiple Procedures

¹ HRS 2013: Coding Guide for Heart Rhythm Procedures and Services, page 48
² Multiple procedure reductions for AV node ablation and insert SC pacemaker
SVT Catheter Ablation

- A patient with paroxysmal supraventricular tachycardia (PSVT) had a diagnostic EP study with mapping a week ago, identifying AVN (atrioventricular node) reentry as the tachycardia mechanism. Programmed atrial and ventricular stimulation are performed, and the slow pathway area is mapped and ablated.

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>National Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>SVT catheter ablation</td>
<td>93653-52</td>
<td>Unknown²</td>
</tr>
<tr>
<td>Mapping (93609 or 93613)</td>
<td>+93609-26</td>
<td>$273</td>
</tr>
<tr>
<td><strong>Total Estimated Payment</strong></td>
<td></td>
<td><strong>Unknown</strong></td>
</tr>
</tbody>
</table>

Modifier 52: Reduced Services  
Modifier 26: Professional Component

¹ HRS 2013: Coding Guide for Heart Rhythm Procedures and Services, page 49
² Medicare contractor will determine payment as a result of the -52 modifier
Ablation procedure and comprehensive EPS including attempts at arrhythmia induction and mapping are performed on the same day. Programmed stimulation of the atrium and ventricle may be performed following the ablation to confirm a successful procedure. Atrial and ventricular pacing was provided before the ablation. After the primary target site is ablated, a post-ablation EP evaluation including pacing maneuvers are performed and an additional distinct mechanism and location of tachycardia is identified. Catheter ablation is performed at this distinct location.

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>National Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ablate VT</td>
<td>93654</td>
<td>$1,098</td>
</tr>
<tr>
<td>Left atrial pacing/recording</td>
<td>+93621-26*</td>
<td>$115</td>
</tr>
<tr>
<td>Ablate additional VT</td>
<td>+93655</td>
<td>$411</td>
</tr>
<tr>
<td><strong>Total Estimated Payment</strong></td>
<td></td>
<td><strong>$1,624</strong></td>
</tr>
</tbody>
</table>

* +93621: May not be reportable based on primary code (93620) requirement
  Modifier 26: Professional Component

1 HRS 2013: Coding Guide for Heart Rhythm Procedures and Services, page 54
Pulmonary Vein Isolation (PVI) Ablation

- A patient with paroxysmal atrial fibrillation undergoes a comprehensive EPS and PVI. A catheter is placed across the atrial septum for ablation of the pulmonary vein focus. Intracardiac echocardiography is used to assist with transseptal sheath placement. After the successful PVI, attempts at re-induction of atrial fibrillation identify an additional left-sided atrial flutter and further ablation of this new focus is performed.

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>National Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>PVI ablation</td>
<td>93656</td>
<td>$1,098</td>
</tr>
<tr>
<td>Intracardiac echocardiography</td>
<td>+93662-26</td>
<td>$139</td>
</tr>
<tr>
<td>Ablate atrial flutter</td>
<td>+93657</td>
<td>$412</td>
</tr>
<tr>
<td><strong>Total Estimated Payment</strong></td>
<td></td>
<td><strong>$1,649</strong></td>
</tr>
</tbody>
</table>

Modifier 26: Professional Component

¹ HRS 2013: Coding Guide for Heart Rhythm Procedures and Services, page 52
Important note on pages 42 and 52 of the HRS coding guide: Code +93655 may be reported with 93656 when an additional non-atrial fibrillation tachycardia is separately diagnosed after PVI. Page 52: Code 93655 should not be reported for ablation of inducible left-sided or right-sided atrial flutters after PVI. Code 93657 should be reported in this clinical scenario (patient above).
Dual Chamber Pacemaker upgrade to ICD

- A patient with previously placed dual DC pacemaker has VT and requires an ICD. The old pacemaker is removed, the RV lead is capped, and a new DC ICD is implanted, using the existing RA lead and new RV endocardial leads. Defibrillator threshold testing (DFT) is performed.

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>National Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remove pacer generator</td>
<td>33233-51</td>
<td>@50% $119(^2)</td>
</tr>
<tr>
<td>Insert DC ICD</td>
<td>33249</td>
<td>$909</td>
</tr>
<tr>
<td>DFT</td>
<td>93641-26</td>
<td>@50% $162(^2)</td>
</tr>
<tr>
<td><strong>Total Estimated Payment</strong></td>
<td></td>
<td><strong>$1,190</strong></td>
</tr>
</tbody>
</table>

DC: Dual Chamber
Modifier 51: Multiple Procedures
Modifier 26: Professional Component

\(^1\) HRS 2013: Coding Guide for Heart Rhythm Procedures and Services, page 67
\(^2\) Multiple procedure reductions for pacemaker generator removal and DFT testing
Upgrade Single Chamber Pacemaker to CRT-P¹

- A patient had a SC ventricular pacemaker placed 2 years ago to treat symptomatic bradycardia has subsequently developed Class III CHF, refractory to maximal medical therapy and associated with an intraventricular conduction delay measuring 150 msec. Pacer system is upgraded to a system capable of Bi-V pacing to achieve cardiac resynchronization therapy. The old ventricular pacemaker is removed, the RV pacing lead is used for the new system, an atrial pacing lead is placed, and a third lead is placed transvenously in the CS and advanced into the coronary venous system to pace the left ventricle. Contrast injection with CS imaging is performed to assess the coronary venous anatomy and assist with LV lead placement.

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>National Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upgrade SC to DC pacemaker</td>
<td>33214</td>
<td>$485</td>
</tr>
<tr>
<td>Insert LV lead</td>
<td>+33225</td>
<td>$456</td>
</tr>
<tr>
<td><strong>Total Estimated Payment</strong></td>
<td></td>
<td><strong>$941</strong></td>
</tr>
</tbody>
</table>

SC: Single Chamber  
DC: Dual Chamber

¹ HRS 2013: Coding Guide for Heart Rhythm Procedures and Services, page 62
The cardiac device monitoring codes (93279-93295, 93297-93298) had the following change:

<table>
<thead>
<tr>
<th>CPT code</th>
<th>CPT code description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>… with physician analysis, review and report</td>
</tr>
<tr>
<td>2013</td>
<td>… with analysis, review and report by a physician or other qualified health care professional</td>
</tr>
</tbody>
</table>
Cardiac Device Monitoring Services
Pacemaker Cardiac Device Monitoring - 2013

The National Medicare pacemaker follow-up Guidelines released in 1984 are still in effect.

Programming evaluation per encounter
- Single Lead
  - G: $50
  - TC: $18
  - PC: $32
- Dual Lead
  - G: $57
  - TC: $20
  - PC: $37
- Multiple Lead
  - G: $67
  - TC: $23
  - PC: $44

Interrogation
- In Person
  - G: $37
  - TC: $16
  - PC: $21
- Remote
  - PC: $33

Peri-Procedural in person only any # of leads
- 93286
  - G: $27
  - TC: $12
  - PC: $15

Professional Analysis any # of leads Up to 90 days
- 93294
  - PC: $33

Technical Support any # of leads Up to 90 days
- 93296
  - TC: $26

Transtelephonic one code any # of leads Up to 90 days
- 93293
  - G: $53
  - TC: $38
  - PC: $15

Calendar Year 2013 Medicare physician payments are available at:
ICD Cardiac Device Monitoring - 2013

G: Global  
TC: Technical Component  
PC: Professional Component

Programming evaluation per encounter

- Single Lead  
  G: $62  
  TC: $21  
  PC: $41
- Dual Lead  
  G: $80  
  TC: $24  
  PC: $56
- Multiple Lead  
  G: $88  
  TC: $28  
  PC: $60

Interrogation

- In Person  
- Remote  

- One code any # of leads per encounter
  G: $64  
  TC: $20  
  PC: $44

Professional Analysis

- any # of leads  
- Up to 90 days
  PC: $64

Technical Support

- any # of leads  
- Up to 90 days
  TC: $26

Peri-Procedural in person only any # of leads

- 93287
  G: $35  
  TC: $13  
  PC: $22

Calendar Year 2013 Medicare physician payments are available at:  
Implantable Cardiovascular Monitor (ICM)

In Person per encounter

- 93290
  - G: $30
  - TC: $10
  - PC: $20

Remote

- 93297
  - Professional Analysis
  - Up to 30 days
  - PC: $26

- 93299
  - Remote Data Acquisition and Technical Support
  - Up to 30 days
  - Contractor Priced

Calendar Year 2013 Medicare physician payments are available at:
Implantable Loop Recorder (ILR)

93285
Programming evaluation per encounter
G: $41
TC: $16
PC: $25

93291
In Person per encounter
G: $35
TC: $15
PC: $20

93285
Interrogation

93291
Remote
93298
Professional Analysis
Up to 30 days
G: $35
TC: $15
PC: $20

93299
Remote Data Acquisition and Technical Support
Up to 30 days
PC: $26

Contractor Priced

Calendar Year 2013 Medicare physician payments are available at:
CRT-D device follow-up

- A patient with intermittent complete heart block had an ICD with DC pacemaker capacity. The patient had an interrogation device evaluation yesterday (remote) that noted a marked elevation of shocking impedance. The ICD clinic contacted the patient to assess current symptoms and had him come in to the ICD clinic where a programming device evaluation was performed.

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>National MPFS Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provider-based</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Programming evaluation dual lead</td>
<td>93283-26</td>
<td>$55.46</td>
</tr>
<tr>
<td>ICD system</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Private clinic</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Programming evaluation dual lead</td>
<td>93283</td>
<td>$79.61</td>
</tr>
<tr>
<td>ICD system</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DC: Dual Chamber
Modifier 26: Professional Component

1 HRS 2013: Coding Guide for Heart Rhythm Procedures and Services, page 82
Other Information
Effective 1-1-2013 a 25% reduction is applied to the technical component of the second and subsequent cardiovascular diagnostic procedures when furnished by the same physician (or physicians in the same group practice) to the same patient on the same day. Several procedure codes from Table 12 are shown below.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Brief Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>93000</td>
<td>EKG complete</td>
</tr>
<tr>
<td>93005</td>
<td>EKG tracing only</td>
</tr>
<tr>
<td>93279</td>
<td>Programming device evaluation single lead pacemaker system</td>
</tr>
<tr>
<td>93280</td>
<td>Programming device evaluation dual lead pacemaker system</td>
</tr>
<tr>
<td>93281</td>
<td>Programming device evaluation multiple lead pacemaker system</td>
</tr>
<tr>
<td>93282</td>
<td>Programming device evaluation single lead implantable cardioverter-defibrillator (ICD) system</td>
</tr>
<tr>
<td>93283</td>
<td>Programming device evaluation dual lead ICD system</td>
</tr>
<tr>
<td>93284</td>
<td>Programming device evaluation multiple lead ICD system</td>
</tr>
<tr>
<td>93285</td>
<td>Programming device evaluation implantable loop recorder system</td>
</tr>
<tr>
<td>93286</td>
<td>Peri-procedural device evaluation and programming, all pacemaker systems</td>
</tr>
<tr>
<td>93287</td>
<td>Peri-procedural device evaluation and programming, all ICD systems</td>
</tr>
<tr>
<td>93290</td>
<td>Interrogation device evaluation, implantable cardiovascular monitor system</td>
</tr>
</tbody>
</table>

* MPPR: Multiple Procedure Payment Reduction
Source: Pages 68941-68943 Final rule Federal Register dated 11 16 2012
## Transition Care Management (TCM) Codes
New for 2013

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT code 99495</th>
<th>CPT code 99496</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of patient</strong></td>
<td>Established per CPT; New or Established per Medicare</td>
<td>Established per CPT; New or Established per Medicare</td>
</tr>
<tr>
<td><strong>Level of service</strong></td>
<td>Moderate complexity</td>
<td>High complexity</td>
</tr>
<tr>
<td><strong>Transitioning from</strong></td>
<td>Inpatient hospital setting including acute, rehab, long-term acute care,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>partial hospitalization, OBS status in a hospital or SNF/nursing facility</td>
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<tr>
<td></td>
<td>to the patient’s community setting (i.e., home)</td>
<td></td>
</tr>
<tr>
<td><em><em>Face-to-face</em> visit</em>*</td>
<td>Within 14 days of discharge</td>
<td>Within 7 days of discharge</td>
</tr>
<tr>
<td><strong>Interactive contact</strong></td>
<td>Within 2 business days of discharge</td>
<td></td>
</tr>
<tr>
<td><strong>Discharge services</strong></td>
<td>The same individual may report hospital or observation discharge services.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The same individual should not report TCM services provided in the postoperative period.</td>
<td></td>
</tr>
<tr>
<td><strong>Global period</strong></td>
<td>The physician who reports a service with a 10 or 90 day period may not report TCM service.</td>
<td></td>
</tr>
<tr>
<td><strong>Facility (MPFS)</strong></td>
<td>Medicare national $135</td>
<td>Medicare national $164</td>
</tr>
<tr>
<td><strong>Non-Facility</strong></td>
<td>Medicare national $198</td>
<td>Medicare national $231</td>
</tr>
</tbody>
</table>

* Calendar days

Sources: CPT code manual and also see the Appendix
Effective July 1, 2013

- Audit by the OIG in October 2004 identified place of service (POS) billing by physicians as a payment error.

- 79% of 100 sampled physician services selected from a population of services identified as having a high potential for error, were performed in a facility but were billed by the physicians using the “office” as the POS.

- CMS is implementing an IUR (Information Unsolicited Response) for all claims where:
  DOS, Health Insurance Claim number (HIC #), and CPT surgical procedure code (10021-69990) are identical to an IP Part B or ASC (12x and 83x), excluding the admission and discharge dates.

- Physician payments are higher when performed in a non-facility setting to compensate for the additional costs (e.g. Practice Expense) incurred to provide the service at an office location.

Facility versus Non-facility

- Services that may be performed at either a facility (hospital setting) or non-facility (office setting), are assigned Practice Expense RVUs for each setting
  - When the service is performed at a hospital, the hospital is receiving payment for many of the elements of the Practice expense.
  - Example: Minor surgical procedures, office visits, therapeutics

Facility versus Non-Facility RVUs for removal of foreign body, CPT 10120

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</thead>
<tbody>
<tr>
<td>10120</td>
<td>1.22</td>
<td>1.72</td>
<td>0.16</td>
<td>3.10</td>
<td>1.22</td>
<td>3.21</td>
<td>0.16</td>
<td>4.59</td>
</tr>
</tbody>
</table>

Fac: Facility (Hospital); Prac: Practice expense; MP: Malpractice expense; NF: Non-Facility (Physician practice)

Sources: See Appendix
The global surgical period can be classified as major or minor.

- 90 days for major surgical procedures
- (This includes all CRDM implants)
- 10 days for minor surgical procedures
- Some procedures have zero global days
- Each CPT code has a surgical period associated with it.

Other points related to the global surgical period for major surgical procedures:

- Preoperative visits after the decision is made to operate (includes 1 day before procedure), and 90 days post-implant, are bundled.
- Routine follow-up (e.g., post-op visits), including wound checks, are included in global surgical period.

Medicare Global Surgical Period\(^1\) - continued

- Services not included in the Global Surgery Package that may be paid separately:
  
  ✓ Initial consultation or evaluation by the surgeon to determine the need for surgery (major surgical procedures).
  
  ✓ Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complication of the surgery.
  
  ✓ Diagnostic tests and procedures, including diagnostic radiological procedures.
    - Device monitoring procedures are diagnostic procedures.

Medicare Supervision Requirements for the Technical Component of Diagnostic Tests

**DIRECT SUPERVISION**
Applies to the technical component for all **in person** cardiac device interrogations. The physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.

**GENERAL SUPERVISION**
Applies to the technical component for all **remote** interrogation service. The procedure is furnished under the physician’s overall direction and control, but the physician’s presence is not required during the performance of the procedure. Under general supervision, the training of the nonphysician personnel who actually performs the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.

Click on PFS Relative Value Files, then Calendar Year 2013. The most updated file is “RVU13B.”
• 1-24-2013 CMS accepted formal request from HRS and ACCF for reconsideration of dual chamber pacemaker coverage

• Initial comment period (National Coverage Analysis) ended on 2-23-2013

• CMS expects to release their proposed decision memorandum by 7-24-2013.

• Expected NCA completion date is 10-22-2013.

The decision as to how often any patient’s pacemaker should be monitored is the responsibility of the patient’s physician who is best able to take into account the condition and circumstances of the individual patient.

Transtelephonic monitoring (TTM) Guidelines I and II for both single and dual chamber pacemakers are included in this NCD.

Pacemaker clinic service frequency guidelines for routine monitoring are:
- Single chamber: Twice in the first 6 months following implant, then once every 12 months
- Dual chamber: Twice in the first 6 months following implant, then once every 6 months

Increased frequency of monitoring must be supported by documented medical necessity.

Medtronic economic resources include webcasts for hospitals & physicians on key topics

www.medtronic.com/crdmreimbursement

Updates

As a service to our customers, we provide resources to assist with coding, coverage, and reimbursement for our therapies. You will find some of these tools available for download on this site, or you may contact us for more information.

News and Updates

Medicare Physician Coding and Reimbursement Changes for Calendar Year 2013

The CRDM Economic Strategies & Solutions team will present an audio conference and live presentation. Please use the following links for registration:

- Tuesday, March 26, 2013 11:00 am – Noon Central Time
- Wednesday, March 27, 2013 11:00 am – Noon Central Time

Please try to register early, as the above link will not be available after 5:00 pm on Monday, March 25, 2013.

Agenda:

- Executive Summary
- Review of Coding Practices
- Review of CRDM Provider-Based/Private Clinic Scenarios
  - Cardiac Rhythm Devices
  - Device Monitoring

Who should Attend:

- Physicians and Fellows
- Physician Practice/Clinic Administrators
- Physician Practice/Clinic Coders and Billers
- EP Service Line Administrators
- EP Lab Personnel

Learn about ICD-10

- View Hospital slides (PDF, 7.5 MB)
- View Hospital Presentation (1:25:37)
- View Physician slides (PDF, 2.5 MB)
- View Physician Presentation (56:12)

Trouble viewing the video?

- Download Windows Media Player

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Resources

- Medicare C-Code List (color)
- Medicare C-Code List (b/w)

Reimbursement Hotline

(866) 877-4102
To ensure you receive advance notification of webcast events, it is very easy to register at www.Medtronic.com/CRDMreimbursement:

Join our E-mail List
Subscribe to receive news and updates.
### Medtronic Cardiovascular Contact Information

<table>
<thead>
<tr>
<th>Vascular Contact:</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alex Au-Yeung:</td>
<td><a href="mailto:Alex.c.au-yeung@medtronic.com">Alex.c.au-yeung@medtronic.com</a></td>
</tr>
<tr>
<td>Or</td>
<td></td>
</tr>
<tr>
<td>Jennifer Williams:</td>
<td><a href="mailto:Jennifer.m.williams@medtronic.com">Jennifer.m.williams@medtronic.com</a></td>
</tr>
</tbody>
</table>

**Coding Hotline number:** 1 (877) 347-9662

**Submit a question:**
rs.srreimbursement@medtronic.com
Appendix
Data Sources


- CMS November 1, 2011 Fact Sheet: “Payments to primary care physicians increase in 2013” is available at: http://www.cms.gov/apps/media/fact_sheets.asp

- Medicare Physician Final rule information for CY 2013 and CY 2012 can be found at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html
  The above link also includes the Federal Register publications.

- Updated 2013 Medicare Physician payment information is at: http://www.cms.gov/PhysicianFeeSched/

- Physician value-based payment modifier: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/index.html


- TCM link: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-TCMS.pdf