Medtronic

Reimbursement guide

Cardiac catheter ablation and electrophysiology procedures

Hospital & physician coding, coverage, and payment

January 2023

Hospital & physician reimbursement guide

Cardiac catheter ablation and electrophysiology procedures

This guide has been developed to help you understand coverage, coding, and Medicare payment for cardiac catheter ablation and electrophysiology procedures.

Please contact Medtronic Reimbursement Customer Support for further information:

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Overview

Cardiac catheter ablation procedures

The scope of this document is coding, coverage, and Medicare payment for cardiac catheter ablation and electrophysiology procedures including:

- Transseptal puncture
- Intracardiac echocardiography (ICE)
- Mapping
- Comprehensive diagnostic electrophysiologic studies (EPS) and components
- Moderate (conscious) sedation

2023 updates

ICD-10-CM diagnosis coding changes for ventricular tachycardia (VT)

Change

The ICD-10-CM diagnosis code for VT I47.2 is no longer valid and has been replaced by new, more specific ICD-10-CM diagnosis codes[1].

2022 ICD-10-CM code for VT	New ICD-10-CM codes for VT
I47.2	**I47.20** – ventricular tachycardia, unspecified
	I47.21 – Torsades de pointes
	I47.29 – Other ventricular tachycardia

Impact

Providers should discontinue use of ICD-10-CM code I47.2 and begin using the new codes for VT, effective October 1, 2022.

2023 updates

Procedure coding for cardiac catheter ablation procedures

There are **no changes to the primary procedure codes** for cardiac catheter ablation procedures in 2023

The descriptions of the primary procedure codes for SVT, VT and PVI cardiac catheter ablations continue to include mapping, intracardiac echocardiogram (ICE), and left atrial (LA) pacing.

	Procedure	2021 Procedure Coding[2]	Procedure Coding as of 2022[2]
SVT	Primary ablation	93653	**93653**
	3D mapping	+93613	
	LA Pacing	+93621-26	
VT	Primary ablation	93654 3D mapping was bundled with VT prior to 2022	**93654**
	3D mapping		
	LA pacing	+93621-26	
PVI	Primary ablation	93656	**93656**
	3D mapping	+93613-26	
	ICE	+93662-26	

2023 updates

Medicare physician fee schedule rate changes

Change

The Centers for Medicare and Medicare Services (CMS) has finalized the 2023 physician fee schedule which is effective January 1, 2023.

Impact

These changes impact physician work relative value units (RVU's) and payment rates for cardiac catheter ablation procedures.

Procedure	Current Procedure Coding[2]	2022 work RVU[3]	2022 National Unadjusted* Physician Rate[3]	2023 work RVU[4]	2023 National Unadjusted* Physician Rate[5]
SVT	93653 includes 3D mapping, LA pacing	14.75	$848	15.00	$837†
VT	93654 includes 3D mapping, LA pacing	19.75	$1,134	18.10	$1,009
PVI	93656 includes 3D mapping, ICE	19.77	$1,137	17.00	$949

2023 updates

Medicare hospital outpatient rate changes

Change

The Centers for Medicare and Medicare Services (CMS) has finalized updated payment rule for outpatient payment rates effective January 1, 2023.

Impact

Nationally, outpatient payments for cardiac catheter ablations are increasing +7.1%[6].

CPT® code[2]	Brief description	C-APC	FY2022 National Unadjusted* Rate[7]	FY2023 National Unadjusted* Rate[6]	% Change
93650	AV node ablation	5212	$6,208	$6,733	8.5%
93653	SVT ablation and complete EPS	5213	$21,916	$23,481	7.1%
93654	VT ablation and complete EPS				
93656	PVI ablation for AF with TS puncture and complete EPS				

2023 updates

Medicare hospital inpatient rate changes

Change

The Centers for Medicare and Medicare Services (CMS) has finalized updated payment rule for inpatient payment rates, effective October 1, 2022.

Impact

Nationally, inpatient payments for cardiac catheter ablations are increasing +6.2%[8].

MS-DRG	Description	FY2022 National Unadjusted* Rate[9]	FY2023 National Unadjusted* Rate[8]	% Change
273	Percutaneous and other intracardiac procedures w/ MCC	$25,234	$27,527	9.1%
274	Percutaneous and other intracardiac procedures w/o MCC	$21,673	$23,044	6.3%

Coverage

Medicare and Medicare Advantage

Traditional Medicare coverage

For traditional Medicare patients, Medicare has not issued a national coverage determination nor have any contractors issued a local coverage determination for cardiac catheter ablation therapies. In the absence of formal coverage policy, the Social Security Act allows coverage and payment of only those services that are considered to be medically reasonable and necessary[10]. The medical necessity for services provided must be documented in the medical record.

Medicare Advantage coverage

Medicare Advantage plans are required to cover at least what is covered by Traditional Medicare. Therefore, Medicare coverage policies apply to both traditional Medicare and Medicare Advantage plans[11]. Medicare Advantage plan administrators may have policies and additional requirements such as prior testing and prior authorization.

Medtronic recommends that you review the specific payer coverage policies applicable to your patient to verify all the criteria for coverage are met and/or to request a prior authorization. Requesting authorization after an implant procedure may result in unpaid claims, leaving both the hospital and the physician without compensation.

Coverage

Non-Medicare payers and documentation best practices

Non-Medicare payer coverage

Non-Medicare payers typically determine coverage for procedures based on applicable medical policies and prior authorization when required. Not all published policies apply to all patients covered by a particular payer.

Medtronic recommends that you review the specific payer coverage policies applicable to your patient to verify that all the criteria for coverage are met and to request a prior authorization. Requesting authorization after an implant procedure may result in unpaid claims, leaving both the hospital and the physician without compensation.

Best practices for documentation

Documentation in the patient's medical record must support the medical necessity of all procedures being performed. Some factors to consider to include-in that documentation might be:

- Relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.
- Failure or intolerance of other therapies or preference for the procedure being performed.

Coding

The coding information below does not replace seeking coding advice from the payer and/or your own coding staff. The ultimate responsibility for correct coding lies with the provider of services. All diagnosis and procedure codes musts be supported by clear documentation within the medical record.

Click on the links below to access codes associated with cardiac catheter ablation procedures.

- Cardiac catheter ablation procedure CPT® codes
- Additional cardiac catheter ablation CPT® codes
- Moderate (conscious) sedation CPT® codes
- HCPCS codes
- ICD-10-PCS (procedure codes)
- ICD-10-CM (diagnosis codes)
- MS-DRGs

Coding

Cardiac catheter ablation procedure CPT® codes

CPT® codes

The following CPT® codes describe procedures associated with cardiac catheter ablation and other electrophysiology procedures. Services rendered will dictate the appropriate coding. These codes may be used by physicians for all services and may be used by facilities when services are rendered in the outpatient hospital setting. It is the physician's discretion as to what codes to report based on what procedures were performed.

CPT® code[2]	Description
Cardiac catheter ablation primary procedures	
93650	Intracardiac catheter ablation of atrioventricular note function, atrioventricular conduction for creation of complete heart block, with or without temporary pacemaker placement
93653	Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and His bundle recording, when performed; 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

Coding

Cardiac catheter ablation procedure CPT® codes

CPT® code[2]	Description
Cardiac catheter ablation primary procedures	
93654	Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and His bundle recording, when performed; with treatment of ventricular tachycardia or focus of ventricular ectopy including left ventricular pacing and recording, when performed
93656	Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation, including intracardiac electrophysiologic 3-dimensional mapping, intracardiac echocardiography including imaging supervision and interpretation, induction or attempted induction of an arrhythmia including left or right atrial pacing/recording, right ventricular pacing/recording, and His bundle recording when performed

Additional cardiac catheter ablation and electrophysiology CPT® codes

The following add-on codes may be used in addition to an appropriate primary procedure code when cardiac catheter ablation is performed after the treatment of the primary ablated mechanism during the same session.

The following add-on codes are not assigned to an APC because they are ancillary to the primary cardiac catheter ablation procedure. These codes are all classified by Medicare with a status indicator of “N” meaning that these services are not separately payable to hospitals. It is, however, important to report all codes for procedures performed for accuracy and cost accounting purposes.

Coding

Additional cardiac catheter ablation CPT® codes

CPT® code[2]	Description	Status indicator
Additional cardiac catheter ablation procedures		
+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 (Use 93655 in conjunction with 93653, 93654, 93656)	N
+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 (Use 93657 in conjunction with 93656)	N

Coding

Additional cardiac catheter ablation CPT® codes

Transseptal puncture CPT® codes

The following add-on code is reported when transseptal puncture is performed, however, it is included in the primary procedure code description for pulmonary vein isolation and therefore not separately reported for cardiac catheter ablation

CPT® code[2]	Description	Status indicator
Transseptal puncture		
+93462-26	Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (Use 93462 in conjunction with 33477, 93452, 93453, 93458, 93459, 93460, 93461, 93582, 93653, 93654) (Do not report 93462 in conjunction with 93656)	N

Coding

Additional cardiac catheter ablation CPT® codes

Intracardiac echocardiography (ICE) CPT® codes

Report the following when intracardiac echocardiography is performed

CPT® code[2]	Description	Status indicator
Intracardiac echocardiography		
	Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation	
+93662-26	(Use 93662 in conjunction with 92987, 93453, 93460-93462, 93532, 93580, 93581, 93582, 93583, 93620, 93621, 93622, 93653, 93654 as appropriate) (Do not report 93662 in conjunction with 92961, 0569T, 0570T, 0613T)	N

Coding

Additional cardiac catheter ablation CPT® codes

2-D Mapping CPT® codes

Traditional (not 3-D) mapping is considered a distinct procedure and is separately reported when performed.

CPT® code[2]	Description	Status indicator
Mapping		
+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 (Use 93609 in conjunction with 93620, 93653, 93656) (Do not report 93609 in conjunction with 93613, 93654)	N

Additional cardiac catheter ablation CPT® codes

Comprehensive diagnostic electrophysiological studies (EPS) CPT® codes

Report one of the following codes when a physician performs a diagnostic electrophysiologic study (EPS) on a different date of service prior to a cardiac catheter ablation procedure. When a comprehensive EPS is performed on the same date of service as the cardiac catheter ablation procedure, it is generally included in the description for the primary ablation procedure code and is not separately reportable.

CPT® code[2]	Description
Comprehensive diagnostic electrophysiological studies	
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 (Do not report 93619 in conjunction with 93600, 93602, 93603, 93610, 93612, 93618, 93620, 93621, 93622, 93653, 93654, 93655, 93656,)
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 (Do not report 93620 in conjunction with 93600, 93602, 93603, 93610, 93612, 93618, 93619, 93653, 93654, 93656, 93657)

Coding

Additional cardiac catheter ablation CPT® codes

Electrophysiology study (EPS) Components CPT® codes

When a comprehensive EPS is not performed on the same date of service as the cardiac catheter ablation procedure, report additional components separately as appropriate according to parenthetical instructions and documentation in the medical record.

CPT® code[2]	Description	Status indicator
Electrophysiology study components		
93621-26	Comprehensive electrophysiologic evaluation; with left atrial pacing and recording from coronary sinus or left atrium (Use 93621 in conjunction with 93620, 93653, 93654) (Do not report 93621 in conjunction with 93656)	N
93622-26	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left ventricular pacing and recording (Use 93622 in conjunction with 93620, 93653, 93656) (Do not report 93622 in conjunction with 93654)	N
93623-26	Programmed stimulation and pacing after intravenous drug infusion (Use 93623 in conjunction with 93610, 93612, 93619, 93620, 93653, 93654, 93656)	N

Coding

Additional cardiac catheter ablation CPT® codes

A checkmark (✓) indicates which add-on codes may be reported by a primary ablation code, when performed and documented.

CPT® code[2]	Brief description	93653 SVT ablation	93654 VT ablation	93656 PVI for AF
+93609	Standard (2D mapping)	✓	Cannot use	✓
+93622	LV pacing/recording	✓	Cannot use	✓
+93623	Stimulation and pacing after IV drug infusion	✓	✓	✓
+93462	Left heart catheterization by transseptal puncture	✓	✓	Cannot use
+93655	Additional ablation of discrete mechanism of arrhythmia which is distinct from the primary ablation	✓	✓	✓
+93657	Additional linear or focal ablation of LA or RA for treatment of remaining AF after PVI	Cannot use	Cannot use	✓
+93662	Intracardiac echocardiography (ICE)	✓	✓	Cannot use

Moderate (conscious) sedation CPT®[2] codes

Since 2017, moderate sedation is separately reportable from the cardiac catheter ablation procedure. Moderate sedation codes are time-based services. The codes are organized according to two factors: (1) whether it's the same or a different physician or qualified healthcare provider performing the sedation and also performing the therapeutic service, and (2) the age of the patient for whom the services are being provided.

Coding

Moderate (conscious) sedation CPT® codes

Same physician or qualified healthcare professional

Use the following codes when it is the same physician or other qualified healthcare professional performing the cardiac catheter ablation service and the sedation. Report either 99151 or 99152 depending on the age of the patient, and report additional unit(s) of add-on code +99153 as required depending on the intraservice time of moderate sedation.

CPT® code[2]	Description
Moderate conscious 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
99152	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 age 5 years or older
+99153	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; each additional 15 minutes intraservice time (Use 99153 in conjunction with 99151, 99152) (Do not report 99153 in conjunction with 99155, 99156)

Coding

Moderate (conscious) sedation CPT® codes

Different physician or qualified healthcare professional

Use the following services of codes when it is a different physician or other qualified healthcare professional performing the cardiac catheter ablation service and the sedation. Report either 99155 or 99156 depending on the age of the patient, and report additional unit(s) of add-on code +99157 as required depending on the intraservice time of moderate sedation.

CPT® code[2]	Description
Moderate conscious sedation	
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
99156	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 aged 5 years or older
+99157	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; each additional 15 minutes intraservice time (Use 99157 in conjunction with 99155, 99156) (Do not report 99157 in conjunction with 99151, 99152)

Coding

HCPCS codes

Hospital outpatient cardiac catheter ablation C-code listing

Medicare provides device C-codes for hospital use in billing Medicare for medical devices in the outpatient setting[12]. For a complete list of Medtronic cardiac catheter ablation products and their associated C-Codes, access our searchable, downloadable (Excel, CSV) C-Code Finder found here.

Coding

ICD-10-PCS codes

The coding information below does not replace seeking coding advice from the payer and/or your own coding staff. The ultimate responsibility for correct coding lies with the provider of services. All diagnosis and procedure codes musts be supported by clear documentation within the medical record.

ICD-10-PCS procedure codes for percutaneous cardiac catheter ablation procedures

Hospitals assign ICD-10-PCS codes for procedures performed during an inpatient admission. The following ICD-10-PCS code describes all percutaneous cardiac catheter ablation procedures.

ICD-10 procedure code[13]	Description
Percutaneous cardiac catheter ablation procedures	
02583ZZ	Destruction of conduction mechanism, percutaneous approach

Coding

ICD-10-PCS codes

ICD-10 procedure code[13]	Description
Transesophageal echocardiography (TEE)	
B246ZZ4	Ultrasonography of right and left heart, transesophageal
Intracardiac echocardiography (ICE)	
B246ZZ3	Ultrasonography of right and left heart, intravascular
Electrophysiologic study (EPS)	
4A0234Z	Measurement of cardiac electrical activity, percutaneous approach
Mapping	
02K83ZZ	Map conduction mechanism, percutaneous approach

Coding

ICD-10-CM codes

The coding information below does not replace seeking coding advice from the payer and/or your own coding staff. The ultimate responsibility for correct coding lies with the provider of services. All diagnosis and procedure codes musts be supported by clear documentation within the medical record.

ICD-10-CM diagnosis codes that may support cardiac catheter ablation procedures

The following is a list of diagnosis codes that may be associated with VT, SVT, and PVI ablation procedures. The list is for illustrative purposes only. Refer to the Instructions for Use supplied with a product for indications, contraindications, side effects, warnings, and precautions.

ICD-10-CM diagnosis code[1]	Description
Cardiac catheter ablation procedures	
I47.0	Re-entry ventricular arrhythmia
I47.1	Supraventricular tachycardia (Includes AVNRT)
I47.20	Ventricular tachycardia, unspecified
I47.21	Torsades de pointes
I47.29	Other ventricular tachycardia
I47.9	Paroxysmal tachycardia, unspecified

Coding

ICD-10-CM codes

ICD-10-CM diagnosis code[1]	Description
Cardiac catheter ablation procedures	
I48.0	Paroxysmal atrial fibrillation
I48.11	Longstanding persistent atrial fibrillation
I48.19	Other persistent atrial fibrillation
I48.20	Chronic atrial fibrillation, unspecified
I48.21	Permanent atrial fibrillation
I48.3	Typical atrial flutter (type I)
I48.4	Atypical atrial flutter (type II)
I49.01	Ventricular fibrillation
I49.02	Ventricular flutter
I49.1	Atrial premature depolarization (premature atrial beats and contractions)
I49.2	Junctional premature depolarization
I49.3	Ventricular premature depolarization (premature ventricular contractions)

Coding

ICD-10-CM codes

ICD-10-CM diagnosis code[1]	Description
Cardiac catheter ablation procedures	
I49.40	Unspecified premature depolarization (unspecified premature beats)
I49.49	Other premature depolarization (includes ectopic beats)
I49.5	Sick sinus syndrome (tachycardia-bradycardia syndrome)
I49.8	Other specified cardiac arrhythmias
I49.9	Cardiac arrhythmia, unspecified
I48.91	Unspecified atrial fibrillation
I48.92	Unspecified atrial flutter

Coding

MS-DRG assignments

The coding information below does not replace seeking coding advice from the payer and/or your own coding staff. The ultimate responsibility for correct coding lies with the provider of services. All diagnosis and procedure codes musts be supported by clear documentation within the medical record.

MS-DRG assignments (MS-DRG: Medicare Severity Diagnosis Related Groups)

Medicare reimbursement for inpatient hospital services is based on a classification system known as Medicare Severity Diagnosis Related Groups (MS-DRGs). MS-DRG assignment is determined by patient diagnoses and procedures. Only one MS-DRG is assigned per hospital admission, and one payment is made for all procedures and supplies related to that inpatient stay. MS-DRG assignment may be affected when one or more secondary diagnoses that are included in the major complication or comorbidity (MCC) or complication or comorbidity (CC) lists are present. MCC and CC lists are updated annually and maintained by CMS.

MS-DRG[14]	Brief description
Percutaneous intracardiac procedures	
273	Percutaneous and other intracardiac procedures w/ MCC
274	Percutaneous and other intracardiac procedures w/o MCC

Payment

Physician

Physician coding and payment

Effective January 1, 2023-December 31, 2023

Physicians use CPT® codes to represent procedures and services performed in all places of service. Under Medicare's methodology for physician payment, each CPT® code is assigned a value, known as a relative value units (RVU). RVU's are part of how Medicare determines a payment amount.

CPT® code[2]	Description	FY2023 Medicare national unadjusted* physician rate[5]	FY2023 physician work RVU[4]	FY2023 total RVU[4]
Cardiac catheter ablation procedures				
93650	AV node ablation	$583	10.24	17.20
93653	SVT ablation and complete EPS	$837	15.00	24.70
93654	VT ablation and complete EPS	$1,009	18.10	29.77
93656	PVI ablation for AF with TS puncture and complete EPS	$949	17.00	28.01

*Unadjusted rates do not include sequestration or any other local payment adjustments.

Payment

Physician

CPT® code[2]	Description	FY2023 Medicare national unadjusted* physician rate[5]	FY2023 physician work RVU[4]	FY2023 total RVU[4]
Additional cardiac catheter ablation procedures				
93655	Additional catheter ablation of discrete mechanism	$307	5.50	9.06
93657	Additional catheter ablation for remaining AF	$307	5.50	9.06
Transseptal puncture				
93462-26	Left heart cath by transseptal puncture	$207	3.73	6.11
Intracardiac echocardiography (ICE)				
93662-26	Intracardiac echocardiography (ICE)	$73	1.44	2.16

*Unadjusted rates do not include sequestration or any other local payment adjustments.

Payment

Physician

CPT® code[2]	Description	FY2023 Medicare national unadjusted* physician rate[5]	FY2023 physician work RVU[4]	FY2023 total RVU[4]
Mapping				
93609-26	Intracardiac 2D mapping of tachycardia	$272	4.99	8.03
Complete diagnostic electrophysiologic studies (EPS)				
93619-26	Comprehensive EP study without induction of arrhythmia	$383	7.06	11.29
93620-26	Comprehensive EP study with induction of arrhythmia	$616	11.32	18.17
Electrophysiology study (EPS) components				
93622-26	Comprehensive EP study with LV pacing and recording	$169	3.10	4.98
93623-26	Programmed stimulation and pacing following IV drug infusion	$83	0.98	2.44

*Unadjusted rates do not include sequestration or any other local payment adjustments.

Payment

Physician

CPT® code[2]	Description	FY2023 Medicare national unadjusted* physician rate[5]	FY2023 physician work RVU[4]	FY2023 total Facility RVU[4]
Moderate (conscious) sedation – same physician				
99151	Moderate sedation same physician initial 15 min. Patient under 5 years of age	$24	0.50	0.72
99152	Moderate sedation same physician initial 15 min. Patient 5 years of age or older	$13	0.25	0.37
+99153	Moderate sedation same physician each addl. 15 min intraservice time	$11	0.00	0.33
Moderate (conscious) sedation – different physician				
99155	Moderate sedation different physician initial 15 min. Patient under 5 years of age	$83	1.90	2.44
99156	Moderate sedation different physician initial 15 min. Patient 5 years of age or older	$76	1.65	2.24
+99157	Moderate sedation different physician each addl. 15 min intraservice time	$62	1.25	1.83

*Unadjusted rates do not include sequestration or any other local payment adjustments.

Payment

Hospital outpatient coding & payment (APC)

Hospital outpatient coding and payment

Effective January 1, 2023-December 31, 2023

Hospital outpatient reimbursement is subject to various packaging rules, including comprehensive APCs (C-APCs). Under C-APCs, only one payment is made for all procedures and supplies provided during the outpatient episode of care.

CPT® code[2]	Brief description	2023 Medicare national unadjusted* hospital outpatient rate[6]	C-APC	Status indicator	C-APC description
Cardiac catheter ablation procedures					
93650	AV node ablation	$6,733	5212	J1	Level 2 electrophysiologic procedures
93653	SVT ablation and complete EPS	$23,481	5213	J1	Level 3 electrophysiologic procedures
93654	VT ablation and complete EPS				
93656	PVI ablation for AF with TS puncture and complete EPS				

*Unadjusted rates do not include sequestration or any other local payment adjustments.

Payment

Hospital outpatient coding & payment (APC)

The following add-on codes are not assigned to an APC because they are ancillary to the primary cardiac catheter ablation procedure. These codes are all classified by Medicare with a status indicator of "N" meaning that these services are not separately payable to hospitals. It is, however, important to report all codes for procedures performed for accuracy and cost accounting purposes.

CPT® code[2]	Description	Status indicator
Transseptal puncture		
+93462	Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (Use 93462 in conjunction with 33477, 93452, 93453, 93458, 93459, 93460, 93461, 93582, 93653, 93654) (Do not report 93642 in conjunction with 93656)	N
Stimulation and pacing after IV drug infusion		
+93623	Programmed stimulation and pacing after intravenous drug infusion (Use 93623 in conjunction with 93610, 93612, 93619, 93620, 93653, 93654, 93656) (Do not report 93623 more than once per day)	N

Payment

Add-on codes

CPT® code[2]	Description	Status indicator
Mapping		
+93609	Intraventricular and/or intra-atrial mapping of tachycardia site(s) with catheter manipulation to record from multiple sites to identify origin of tachycardia (Use 93609 in conjunction with 93620, 93653, 93656) (Do not report 93609 in conjunction with 93613, 93654)	N
Additional ablation beyond primary ablation procedure		
+93655	Additional ablation of discrete arrhythmia beyond primary ablation procedure, SVT or VT (Use 93655 in conjunction with 93653, 93654, 93656)	N
+93657	Additional ablation for remaining AF after PVI (Use 93657 in conjunction with 93656)	N

Payment

Add-on codes

CPT® code[2]	Description	Status indicator
Electrophysiologic studies		
+93621	Comprehensive EP evaluation; with left atrial pacing and recording from coronary sinus or left atrium (Use 93621 in conjunction with 93620, 93653, 93654) (Do not report 93621 in conjunction with 93656)	N
+93622	Comprehensive EP evaluation; with left ventricular pacing and recording (Use 93622 in conjunction with 93620, 93653, 93656) (Do not report 93622 in conjunction with 93654)	N
Intracardiac echocardiography (ICE)		
+93662	Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (Use 93662 in conjunction with 92987, 93453, 93460-93462, 93532, 93580, 93581, 93582, 93583, 93620, 93621, 93622, 93653, 93654 as appropriate) (Do not report 93662 in conjunction with 92961, 0569T, 0570T, 0613T)	N

Payment

Inpatient

Hospital inpatient coding and payment

Effective October 1, 2022- September 30, 2023

Medicare reimbursement for inpatient hospital services is based on a classification system known as Medicare severity diagnosis related groups (MS-DRGs). MS-DRG assignment is determined by patient diagnoses and procedures. Only one MS-DRG is assigned per hospital admission, and one payment is made for all procedures and supplies related to that inpatient stay. MS-DRG assignment may be affected when one or more secondary diagnoses that are included in the major complication or comorbidity (MCC) or complication or comorbidity (CC) lists, which are maintained by CMS. Each MS-DRG has a relative weight that is then converted to a flat payment amount. The MS-DRGs shown are those typically assigned to the following scenarios.

MS-DRG[14]	Brief description	2023 MS-DRG Medicare national unadjusted* payment rate[8]
Percutaneous intracardiac procedures		
273	Percutaneous and other intracardiac procedures w/ MCC	$27,527
274	Percutaneous and other intracardiac procedures w/o MCC	$23,044

*Unadjusted rates do not include sequestration or any other local payment adjustments.

Frequently asked questions

01

How is an additional ablation of a different arrhythmia reported?

When there is another separately identifiable arrhythmia ablated that is different from the initial arrhythmia ablation that would be reported with 93655[15].

02

How many times may an add-on ablation code(s) be used?

Medicare Medically Unlikely Edits (MUEs) allow for 2 units of both +93655 and +93657.
In the event that an additional ablation(s) is performed beyond these edits, a payer denial may be appealed by submitting documentation supporting the medical necessity of the service.

03

Is all mapping now included in the ablation procedure codes?

No, only 3-D mapping is included in the ablation procedure codes[15].

Frequently asked questions

04

Do the codes change if a different energy is used?

No, the cardiac catheter ablation codes do not specify the energy source used.

05

How would an additional ablation done to treat atrial fibrillation remaining after PVI be reported

This would be reported with the add-on code 93657 which can only be reported with 93656[15].

Resources

For questions on how to bill for CardioInsight Noninvasive 3D Mapping System, please refer to the Coding & Payment Guide: CardioInsight Noninvasive 3D Mapping System document for additional information.
It can be found here.

For additional information

Visit our website: www.Medtronic.com/crhfreimbursement

Email us: rs.healthcareeconomics@medtronic.com

Call our Reimbursement Customer Support team: 1-866-877-4102

References

References

[1] ICD-10-CM The Complete Official Codebook. 2022 AAPC

[2] CPT codes and descriptions only are copyright ©2022 American Medical Association. All rights reserved. No fee schedules are included in CPT. The American Medical Association assumes no liability for data contained or not contained herein.

[3] MPFS 2022 Final Rule CMS-1751-F released November 2, 2021 https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1751-f Updates to conversion factor from legislation passed on December 10,2021 https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-relative-value-files/rvu22a

[4] The Medicare Physician Fee Schedule (MPFS) 2023 Relative Value Unit (RVU) amounts are based on information in Addendum B from the MPFS final rule CMS-1770-F which was released on November 11, 2022 and updates from the legislation signed on December 29, 2022. PFS Federal Regulation Notices. cms.gov https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1770-f

[5] PFS 2023 Final Rule CMS-1770-F released November 2, 2022 and updates from the legislation signed on December 29, 2022. https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1770-f

[6] OPPS/ASC 2023 final rule CMS-1772-FC released November 2, 2022 https://www.cms.gov/medicaremedicare-fee-service-paymenthospitaloutpatientppshospital-outpatient-regulations-and-notices/cms-1772-fc

[7] The OPPS 2022 National payment rates based on information published in the OPPS/ASC final rule CMS-1753-FC and corresponding Addendum B table which was published on November 16, 2021. Hospital Outpatient Regulations and Notices. cms.gov. https://www.cms.gov/medicaremedicare-fee-service-paymenthospitaloutpatientpps/cms-1753-fc. Accessed November 23, 2021.

[8] Rates represent the volume-weighted average rates across relevant MS-DRGs representing these procedures. Source: Acute Inpatient PPS, CMS https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps IPPS 2023 final rule CMS-1771-F and corrected amendment CMS-1771-F2 released August 2, 2022 https://www.cms.gov/medicare/acute-inpatient-pps/fy-2023-ipps-final-rule-home-page

[9] The IPPS FY 2022 National payment rates based on information published in the IPPS final rule CMS-1752-F and corresponding tables and data files which was published on August 13, 2021. IPPS Final Rule Home Page. cms.gov https://www.cms.gov/medicare/acute-inpatient-pps/fy-2022-ipps-final-rule-home-page Updated August 13, 2021. Accessed September 1, 2021.

[10] Social Security Act Section 1862 42 U.S.C. 1395y(a)(1)(A). Available at: https://www.ssa.gov/OP_Home/ssact/title18/1862.htm Accessed January 12, 2023

[11] Centers for Medicare and Medicaid Services. Medicare Managed Care Coverage Manual – Chapter 4 section 10.7.1 and 10.7.3 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c04.pdf Accessed on January 12, 2023

[12] HCPCS 2023 Level II Professional Edition. American Medical Association; 2022.

[13] 2023 ICD-10-PCS. cms.gov. https://www.cms.gov/medicare/icd-10/2023-icd-10-pcs Updated May 26, 2022. Accessed November 21, 2022.

[14] MS-DRG v40.0 Definitions Manual. Cms.gov. https://www.cms.gov/icd10m/version40-fullcode-cms/fullcode_cms/P0001.html Accessed November 21, 2022.

[15] American Medical Association. (2021). CPT professional 2022.

* ICD-10-CMThe following information reflects the Medicare national allowable amount published by CMS and does not include Medicare payment reductions resulting from sequestration adjustments to the amount payable to the provider, as mandated by the Budget Control Act of 2011. The Medtronic Healthcare Economics and Reimbursement teams can provide site-specific information reflective of sequestration upon request.

† Reduction in payment driven by lower final CY23 conversion factor

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