

# Transcatheter Closure of Atrial Septal Defects

## Coverage, Coding and Reimbursement Overview — Physician / Hospital

2011 Edition<sup>†</sup> — All Reimbursement Amounts are Listed at National Medicare Rates



### PHYSICIAN OVERVIEW

Physician rates effective January 1, 2011 through December 31, 2011.

#### COVERAGE

Medicare	Carrier LCD (Local Coverage Determination)
Medicaid	State Policies
Commercial Insurance	Plan Design, Medical Policies, Patient Eligibility

Procedure	CODING		REIMBURSEMENT <sup>A</sup>	
	CPT <sup>®</sup> Codes		Professional or Facility	Technical or Non-Facility
Percutaneous transcatheter closure of congenital interatrial communication (i.e., Fontan fenestration, atrial septal defect) with implant	93580		\$1,056	—
<b>Potential Ancillary Services</b>				
Transthoracic echocardiography for congenital cardiac anomalies; complete	93303		\$66	\$144
Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study	93304		\$38	\$96
Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report	93315		\$146	Carrier Determined
Transesophageal echocardiography for congenital cardiac anomalies; placement of transesophageal probe only	93316		\$45	—
Transesophageal echocardiography for congenital cardiac anomalies; image acquisition, interpretation and report only	93317		\$95	Carrier Determined
Intracardiac echocardiography during therapeutic / diagnostic intervention, including imaging supervision and interpretation (list separately in addition to code for primary procedure)	+93662		\$149	Carrier Determined

### HOSPITAL (FACILITY) OVERVIEW

Hospital Inpatient rates effective October 1, 2010 through September 30, 2011.  
Hospital Outpatient rates effective January 1, 2011 through December 31, 2011.

#### COVERAGE

Medicare	Fiscal Intermediary (Local Coverage Determination)
Medicaid	State Policies
Commercial Insurance	Plan Design, Medical Policies, Patient Eligibility

Device Code	CODING		REIMBURSEMENT			
	ICD-9 Procedure Codes	HCPCS / CPT <sup>®</sup> Codes	Inpatient (IPPS)		Outpatient (OPPS)	
			MS-DRG <sup>B</sup>	Rate	APC	SI <sup>C</sup> Rate
					Required for Medicare Outpatient claims	
Septal defect implant system, intracardiac		C1817			—	N —
<b>Procedure</b>						
Repair of atrial septal defect with prosthesis, closed technique	35.52		250	\$16,102		
Percutaneous transcatheter closure of congenital interatrial communication (i.e., Fontan fenestration, atrial septal defect) with implant		93580	251	\$10,047	0434	T \$10,815
<b>Imaging<sup>D</sup></b>						
Transthoracic echocardiography for congenital cardiac anomalies; complete		93303	250	\$16,102	0270	S \$562
Transthoracic echocardiography with contrast for congenital cardiac anomalies; complete		C8921	251	\$10,047	0128	S \$499
Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study		93304			0269	S \$402
Transthoracic echocardiography with contrast for congenital cardiac anomalies; follow-up or limited study		C8922			0128	S \$499
Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report		93315			0270	S \$562
Transesophageal echocardiography (TEE) with contrast for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report		C8926			0128	S \$499
Transesophageal echocardiography for congenital cardiac anomalies; placement of transesophageal probe only		93316			0270	S \$562
Transesophageal echocardiography for congenital cardiac anomalies; image acquisition, interpretation and report only		93317			—	N —
Intracardiac echocardiography during therapeutic / diagnostic intervention, including imaging supervision and interpretation (list separately in addition to code for primary procedure)		+93662			—	N —

<sup>A</sup> Conversion factor used for this Overview is \$33.9764, as published in CMS Change Request 7330.

<sup>B</sup> Commercial insurance carriers may not adopt the MS-DRG system implemented by Medicare October 1, 2007.

<sup>C</sup> Status Indicators: C—Inpatient Procedures; N—Items & Services Packaged into APC Rates; Q1—STVX-Packaged Codes; Q2—T-Packaged Codes; S—Significant Procedure, Not Discounted When Multiple; T—Significant Procedure, Multiple Reduction Applies

<sup>D</sup> For imaging services (excluding screening and diagnostic mammograms), the DRA of 2005 caps the physician technical component rate at the payment level established for the OPSS fee schedule.

## TERMINOLOGY AND ACRONYMS

**ABN: Advance Beneficiary Notice.** A legal, written notice to a Medicare beneficiary from a physician or hospital informing the patient that the health service or item that the physician has prescribed is not or may not be a covered service under Medicare, and that the patient will be responsible for payment if denied.

**Anesthesia Guidelines:** The rules for coding and charging are complex. Variable circumstances can include duration, method of anesthesia / sedation, the physician or specialist administering services, and the site of service. Local Medicare Policies, and the AMA CPT® coding book, professional edition, should be consulted for questions regarding the proper coding and billing for anesthesia services.

**APC: Ambulatory Payment Classification.** These are numeric classifications used by Medicare to reimburse services performed in a hospital outpatient setting. An APC will contain multiple HCPCS Codes that are similar both clinically and in terms of resources used by the hospital. The APC rate is set prospectively by CMS based on historic claims data.

**APC Status Indicator:** Alpha characters are used to designate the APC payment calculation method. For multiple APCs on a single claim with Status Indicator "T" the first APC will be paid at 100% and all others at 50%. For all APCs with Status Indicator "S" each APC will be paid at 100%, no discounting.

**ASC: Ambulatory Surgery Center.** When used by Medicare, this designation describes a legal licensing status establishing a site of service distinct from a physician's office or hospital-based facility.

**Bundled:** Certain supplies / procedures provided by a physician as described by CPT® Codes / HCPCS Codes may be included ("Bundled") with another service for reimbursement purposes.

**Carrier:** A Medicare contractor responsible for physician and ASC medical policies, adjudication of claims and other administrative functions.

**CC: Complications and Comorbidities.** Patient conditions utilized as two of several factors in MS-DRG Groupers.

**CCI: Correct Coding Initiative.** A listing of CPT® Codes that are designated as comprehensive or component codes. If comprehensive and component codes are submitted on the same bill, only the comprehensive code will be paid unless a modifier is submitted. Medicare uses these as NCCI (National Correct Coding Initiative) edits.

**CPT® Code: Current Procedural Terminology Code.** These 5-digit numeric codes are the property of the American Medical Association and are used to describe physician services. Additionally, Medicare licenses these codes from the AMA and uses them to describe physician, hospital outpatient, ASC services, and other outpatient services.

**DRG: Diagnosis Related Group.** A numeric classification system used by Medicare and some commercial payers to reimburse for hospital inpatient services. The DRG is assigned by software that considers the ICD-9 procedure and diagnosis codes submitted on a claim.

**DME: Durable Medical Equipment.** Certified supplies, prosthetics, equipment, etc., provided to patients in other than a hospital inpatient setting.

**DMERC: Durable Medical Equipment Regional Contractor.** Medicare contractor that adjudicates claims for DME providers.

**Facility / Non-Facility:** For some physician procedures, the reimbursement is determined by the site of service. If the fee is designated as "Facility," the procedure is performed in a site of service other than a physician office. If the fee is designated as "Non-Facility," the procedure is performed in a physician office.

**FI: Fiscal Intermediary.** A Medicare contractor responsible for hospital inpatient and outpatient medical policies, adjudication of claims and other administrative functions.

**HCPCS: Healthcare Common Procedure Coding System.** The name of a coding system established by Medicare to describe services and supplies. The base (Level I) codes are CPT® Codes.

**ICD-9: International Classification of Diseases.** Numeric codes used by essentially all payers to describe diagnosis and procedures. The combination of procedure and diagnosis codes determines DRG assignment for inpatient reimbursement.

**ICD-9 procedure** 4-digit codes (e.g., 39.90 Insertion of non-drug-eluting peripheral vessel artery stent(s)) Abbrev: Px.

**ICD-9 diagnosis** 3, 4 or 5-digit codes (e.g., 586 Renal failure, unspecified) Abbrev: Dx.

**Inpatient:** The status used to describe a patient who has been admitted to the hospital. Usually involves multi-day stay.

**IPPS: Inpatient Prospective Payment System.** Medicare (CMS) per case (see "DRG" and "MS-DRG") methodology for hospital inpatient services.

**LCD / LMRP: Local Coverage Determination / Local Medical Review Policy.** The written policies produced by Medicare contractors applicable to geographic areas. A CMS national policy (see NCD) supersedes a LCD.

**MCC: Major Complications and Comorbidities.** Patient conditions utilized as two of several factors in MS-DRG Groupers. MCC are typically significant acute manifestations or advanced stages of chronic conditions that would result in higher resource utilization in the course of treatment.

**MS-DRG: Medicare Severity Diagnosis Related Group.** A numeric classification system effective October 1, 2007 used by Medicare to reimburse for hospital inpatient services. The MS-DRG is assigned by the combination of ICD-9 procedure codes, diagnosis codes and the presence or absence of MCC / CCs as derived from the medical record documentation. The MS-DRG system was designed to more accurately pay hospitals based on patient severity of illness.

**Modifier:** A 2-digit alphanumeric code that is appended to a CPT® Code for further specificity.

**NCD: National Coverage Determination.** The written policies from Medicare that have a national jurisdiction (supersedes any LCD).

**Observation:** Hospital outpatient services to monitor and assess a patient for determination of hospital admission or discharge.

**OPPS: Outpatient Prospective Payment System.** Medicare (CMS) per group (see "APC") methodology for hospital outpatient services.

**Outpatient:** A patient admitted to a hospital to receive treatment but not admitted as an inpatient (see "Observation").

**Packaged:** Certain supplies / procedures provided by a facility as described by CPT® Codes / HCPCS Codes may be included ("Packaged") with another service for reimbursement purposes.

**Prospective:** A predetermined reimbursement rate, regardless of the cost of that service.

**Pro / Tech: Professional / Technical.** For some diagnostic tests, the physician reimbursement is established in two components. The "Professional" component is for the physician supervision, interpretation and other personal service. The "Technical" component is for the equipment, supplies, staff and other costs related to the test.

**S&I: Supervision and Interpretation.** This term is sometimes used to differentiate the imaging service (professional reading / interpretation) from other components of the procedure, such as introduction and placement of catheters.

**Unadjusted Rate:** The prospective reimbursement rate before it is adjusted for local factors such as the wage index, graduate medical education, outlier cases, disproportionate share and other factors. This is sometimes called the "national average" rate. All Medicare reimbursement will have local adjustment factors.

## PHYSICIAN AND HOSPITAL 2011 EDITION

**Suggested Resources:** Coding and reimbursement is complex, specific to case documentation and variable by geographic location. Always consult current physician, hospital and ASC resources.

1. Medicare national (NCD) and local policies (LCD / LMRP): <http://www.cms.hhs.gov/mcd/search.asp>
2. *CPT® guide 2007*, American College of Cardiology: <http://www.acc.org/education/products/CPT2007.htm>
3. *Current Procedural Terminology CPT®, 2011*, American Medical Association: <http://www.ama-assn.org>
4. *ICD-9-CM 2011*
5. *CSI Navigator For: Comprehensive Cardiology 2011 ed.*; Coding Strategies, Inc.: <http://www.codingstrategies.com>
6. Coding Terminology and Acronyms and additional resource: <http://goremedical.com/coding/>

† **Disclaimer:** The payment amounts listed in this guide are national averages. Actual payment will vary based on several factors including the site of the service, geographic location, patient population mix, and hospital teaching status. References to particular applications and procedures listed in this Coding Overview do not represent the appropriateness or market availability of any Gore Medical Product. The information contained in this Overview is provided for general information purposes only and should NOT be relied on for submission purposes. Consult your professional resources and the patient's insurer for situation-specific information.

Physicians and hospitals are responsible for selecting and reporting the code(s) that most accurately describe the procedure(s) performed, the products used and the patient's condition. The basis for accurate coding is clear and complete documentation in the medical record, precisely describing the procedures performed and products used.

Providers should follow coding guidelines from the patient's insurer, and should also review the complete coding authorities (e.g., CPT®, HCPCS, ICD-9-CM) used by the insurer.

The identification of a code in this Coding Overview should not be construed to guarantee coverage for a product or procedure, or payment in any particular amount.



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