Interventional Radiology, Cardiology and Endovascular CPT Coding Updates for 2017

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Overview

• 2017 Interventional Radiology Updates
  • New codes: Angioplasty and Venoplasty, Dialysis Circuit Intervention, Mechnochemical Ablation, Epidural Injections/Infusions, Cryoablation of nerves, Moderate Conscious Sedation
  • Guideline changes over 2016 and regulatory updates

• 2017 Cardiology Updates
  • New codes: Left Atrial Appendage Ablation, Paravalvular Leak Closure, Coronary Artery OCT
  • Guideline changes over 2016 and regulatory updates

Angioplasty

• 4 new codes for 2017
  • 37246: Initial arterial angioplasty
  • +37247: additional arterial angioplasty
  • 37248: Initial venous angioplasty
  • +37249: additional venous angioplasty
  • Codes 35450, 35452, 35458, 35460, 35471, 35472, 35475, 35476, 75962, 75964, 75966, 75968 and 75978 are deleted in 2017

Angioplasty

• Utilizes a balloon to dilate a narrowed vessel (this includes a cutting, compliant, non-compliant etc types of balloons)
• New codes are used for both percutaneous and open techniques
• New codes bundle the S&I and closure
Angioplasty

- Angioplasty is coded per vessel treated, not per stenosis (except the femoral/popliteal territory). The tibial/peroneal territory only has 3 vessels.
- Angioplasty of a stenosis in a pre-existing stent is an angioplasty, not a stent placement.
- Do not need to be successful to charge for angioplasty (may need modifier for attempted angioplasty)
- Must have a hemodynamically significant stenosis (e.g., > or = to 50% ?) documented to report angioplasty, atherectomy or stent codes, however, stent codes may be reported when stent is sole treatment for aneurysm, AVM, trauma, dissection, etc.

Do not code angioplasty when a stent is placed at the same lesion or in the same vessel
- Do not code multiple angioplasties in a single vessel
- Do not code two angioplasties when treating a short bridging lesion across two adjacent vessels
  - (Do code to the most distal lesion treated)
- Do not code angioplasty when macerating clot; this is part of a thrombectomy procedure
- Angioplasty is bundled with ALL stent placements in all locations.

Angioplasty

- Do code separately for...
  - Catheter placement (NOT for lower extremities, coronaries, or cerebrals)
  - Diagnostic angiography (will require -59 modifier to let CMS know this was a true diagnostic study)
- Do not code separately for angiography related to...
  - Guiding shots
  - Road mapping/Trace subtraction
  - Positioning
  - Sizing
  - Localization
  - Completion

Brachiocephalic Angioplasty

Carotid and Vertebral artery angioplasty without stent placement are non-covered services for Medicare patients (see NCD 20.7). Consider 37246-GZ (to let payer know that you are not billing the patient as you know it is a non-covered service). GZ modifier is used when a non-covered service is performed and there is no ABN. If you have a signed ABN, use GA modifier.
2017 Dialysis Circuit Angioplasty

- **36902** Peripheral segment angioplasty
- **36905** Thrombectomy with peripheral segment angioplasty
- **+36907** Central segment angioplasty

Peripheral segment angioplasty is not reported with “OPEN” surgical revision and/or thrombectomy codes 36831-36833. Central segment angioplasty add-on code 36907 is allowed with these open procedures.

2017 Dialysis Circuit Stent Placement

- **36903** Peripheral segment stent placement
- **36906** Thrombectomy with peripheral segment stent placement
- **+36908** Central segment stent placement

Peripheral segment stent placement is not reported with “OPEN” surgical revision and/or thrombectomy codes 36831-36833. Central segment stent placement is allowed with these open procedures.

Venous Angioplasty (Venoplasty)

- **37248**: Venoplasty, initial (including S&I)
- **37249**: Venoplasty, each additional vessel

- Same rules as Arterial Angioplasty codes 37246 and 37247

Venous Stent

- **37238**: Initial vessel
- **37239**: Each additional vessel

- Use these for any venous stenosis treated including lower extremity venous stent placement. Code per vessel treated. Be careful to only code ONE treatment for bridging lesions, which are common in the venous system or adjacent vessels treated with a single stent.
- Codes 37220-37235 ONLY describe arterial stenoses treatments
- Do not use when the stent is placed in the dialysis circuit via a direct access of the dialysis circuit, as codes 36903, 36906 and 36908 apply
Venous Interventions Case 1:
Patient with right upper extremity swelling.
Diagnostic venogram from the right basillic vein shows a continuous, long segment 80% stenosis extending from right brachiocephalic vein into proximal superior vena cava. This is a single, continuous lesion. The catheter is placed in the SVC; superior vena cavagram is normal. This is followed by venoplasty to 12 mm giving good results.

36010  Catheter placement vena cava
75820-59  Venogram extremity, unilateral, S&I
75827-59  Superior vena cavagram, S&I
37248  Venoplasty

Venous Interventions Case 2:
Same as case 1 with distinct, separate 80% stenoses of the right brachiocephalic vein and the superior vena cava, both treated with balloon venoplasty (12mm and 16mm).

Add...
+37249 additional venoplasty

Venous Interventions Case 3:
Same as Case 2, but the superior vena cava occludes and clots off requiring four hours of catheter directed continuous TPA infusion. Follow-up angiography shows clearing of the thrombus, however there is extravasation of contrast into the mediastinum through a tear in the SVC. A self-deploying 16mm diameter stent is placed followed by post-stent deployment balloon dilation. Pull-back IVUS shows good apposition to the wall of the vessel. Venography confirms patency and good flow.

37212  Infusion for venous thrombolysis, initial day of therapy
37238  Vascular stent placement (delete venoplasty if performed at the same session)
37252  IVUS of the SVC and right upper extremity

Surgically Created Arteriovenous Anastomoses and Shunts
All new codes for 2017
2017 Dialysis Graft Procedures

- 36901: AV shuntogram
- 36902: AV shuntogram w/angioplasty
- 36903: AV shuntogram, w/stent
- 36904: AV shuntogram w/thrombectomy
- 36905: AV shuntogram w/thrombectomy & angioplasty
- 36906: AV shuntogram w/thrombectomy & stent

- 36907: Central angioplasty
- 36908: Central stent
- 36909: Embolization or occlusion of branch vessels

“Complexity adjustment” applies to add-on code 36909 (for hospital reimbursement)
### 2017 Dialysis Graft Procedures

**Upper Extremity:**
- Peripheral segment includes the peri-anastomotic region, arterial anastomosis, basilic, brachial, axillary, cephalic and other veins of the arm
- Central segment includes the subclavian and brachiocephalic veins and the superior vena cava

**Lower Extremity:**
- Peripheral segment includes the peri-anastomotic region, arterial anastomosis, and common femoral veins
- Central segment includes the external and common iliac veins and the inferior vena cava

### 2017 Dialysis Graft Procedures

**Heirarchy of codes are built on a progressive, increasingly difficult, combination of procedures performed in the peripheral segment (36901-6), and add-on codes for central segment interventions (36907-8) and embolization of side branches (36909)**

### 2017 Dialysis Graft Procedures

**36901:** “Shuntogram”, “Fistulogram”, “AV shunt evaluation” all mean the same thing. This diagnostic imaging procedure includes ALL imaging of the necessary arterial inflow, the arterial anastomosis and “peri-anastomotic” region, and all venous outflow to the right atrium. 36901 includes all direct needle accesses and catheter placements into the dialysis circuit, movement of catheters throughout the circuit, and advancement of the catheter across the arterial anastomosis for routine imaging of the arterial inflow, and access closure. If imaging is via a remote or pre-existing access, use 36901-52.

**36215** Selective upper extremity arterial branch selection if catheter is moved centrally in native arterial circulation for intervention (e.g., subclavian artery angioplasty, or down the arm for hand thrombectomy of arterial emboli)
- **NOT** for crossing the arterial anastomosis for routine imaging of inflow. If catheter reaches the aorta, keep 36215, **NOT** 36200. This is in addition to 36901.

**76937** Appropriate for use with dialysis graft and fistula access when for poorly maturing fistula or failure of the AV graft or fistula
- **37246** and **37236** for angioplasty or stent placement in native artery
2017 Dialysis Graft Procedures

• **36902:** Shuntogram with peripheral segment venoplasty/angioplasty when done via the dialysis circuit access. Only 1 code is submitted even if multiple balloon dilations are performed of separate significant stenoses in the same segment. Same code for arterial or venous dilation. Must be 50% or greater diameter stenosis (per DOJ review of dialysis interventions).

2017 Dialysis Graft Procedures

• **36903:** Shuntogram with peripheral segment stent placement (includes angioplasty/venoplasty anywhere in the peripheral segment) when done via the dialysis circuit access. Only 1 code is submitted even if multiple stents and balloon dilations are performed of separate significant stenoses in the same segment. Same code for arterial or venous stent placement. Must be 50% or greater diameter stenosis (per DOJ review of dialysis interventions).

2017 Dialysis Graft Procedures

• **36904** Percutaneous declot of graft (by any method):
  • Fogarty catheter (to pull the arterial plug)
  • Thrombectomy catheters
  • Thrombolytic therapy (including lyse and wait)
  • Thrombolytic brush
  • Balloon maceration
  • Pull-thru and push-thru
  • Includes dialysis circuit imaging (36901)

2017 Dialysis Graft Procedures

• **36905:** Thrombectomy with peripheral segment angioplasty
• **36906:** Thrombectomy with peripheral segment stent placement, includes peripheral angioplasty
• Do NOT use 36901-36906 with open surgical dialysis procedures (e.g., 36831-36833), however central segment angioplasty or stent placement CAN be submitted (36907-36908)
2017 Dialysis Graft Procedures

- ADD-ON CODES (no payment for hospitals)
- +36907: Central segment angioplasty
- +36908: Central segment stent (includes central angioplasty
  - MUST be done via the dialysis circuit access
  - The “central cephalic vein” is still a peripheral segment vein
- +36909: Embolization or occlusion of branch vessels for non-maturing fistula. Includes all venous catheterizations and embolizations, follow-up imaging and closure.

2017 Dialysis Angioplasty and Stent Placement

- If angioplasty and stent are placed in the same zone, only submit the code for the stent placement.
- Do not use 37246, 37247, 37248 or 37249 for angioplasty or venoplasty in the dialysis circuit, as specific codes (36902, 36905 and 36907) apply...UNLESS done via remote access. Shunt specific codes must be via the dialysis circuit access
- Do not use 37236, 37237, 37238 or 37239 for stent placements in the dialysis circuit, as specific codes (36903, 36906 and 36908) apply...UNLESS done via remote access. Shunt specific codes must be via the dialysis circuit access

Dialysis Graft Procedures

- If peripheral segment angioplasty or stent placement is performed via a remote access, consider 36902-52 or 36903-52 respectively.
- Do not code for balloon dilation for prophylactic angioplasty. A documented hemodynamically significant stenosis must be present, documented as a % stenosis, NOT mild, moderate, or severe.
- Do not code for balloon maceration of clot, as this is part of thrombectomy. There must be a stenosis to code angioplasty
- Do not code angioplasty when using an angioplasty balloon to pull the arterial plug.
- Do not code angioplasty when a stent is placed in the same zone as the angioplasty.

Dialysis Intervention Case 4:
Patient with poor flow in his AV fistula. The fistula is punctured. A fistulogram shows two large branches diverting flow and a venous stenosis in the cephalic vein at the insertion into the subclavian vein. A separate mid subclavian venous stenosis is treated with 12mm balloon angioplasty, rupture resulted, which is treated with a stent. Prolonged 6mm balloon venoplasty of the cephalic vein is performed. Coil embolization of two venous branches are performed w/ follow-up imaging.

- 36902 AV fistula study with cephalic venoplasty
- +36908 Subclavian vein stent placement
- +36909 Embolization of two venous branches
**Dialysis Intervention Case 5:**

Patient with history of clotted arm AV graft.
Arterial limb puncture of graft with 2mg lyse and wait, followed by venous puncture, shuntogram and venography of the arm and superior vena cava. This shows thrombus and 95% stenosis of the peripheral venous anastomosis. Venoplasty of the venous anastomosis is performed. A Fogarty balloon is used to pull the plug, and the residual clot is pushed into the superior vena cava/pulmonary artery. Repeat study shows slow flow into the patent arterial anastomosis. To fully evaluate the cause of thrombosis of the graft and slow inflow, the catheter is advanced across the arterial anastomosis into the native brachial artery and advanced centrally into the thoracic aorta. Imaging of the entire upper extremity arterial inflow is performed. 90% proximal subclavian artery stenosis is identified and successfully treated with angioplasty.

**Dialysis Intervention Case 5 Codes:**

- **36905**  AV shuntogram w/thrombectomy and venoplasty
- **36215**  Catheter placement into thoracic aorta
- **37246**  Angioplasty subclavian artery
- **75710-59**  Upper extremity arteriogram

**Complex Case 6:**

Patient with history of “clotted right dialysis shunt.”
Access is made into the arterial and venous limbs of the graft. 2 mg of TPA is given followed by a 30-minute wait. Two sheaths are placed. A shuntogram is performed. A thrombectomy catheter is placed and thrombectomy is performed in both directions. A Fogarty catheter is used to pull the arterial plug. Venoplasties of the venous anastomotic stenosis, arterial limb of the graft, mid brachial and axillary veins are performed with resolution of stenoses (all stenoses are 80-90%) in these vessels. A stent is placed in the superior vena cava for treatment of a separate 99% stenosis.
Complex Case 6 Codes:

- 36905 AV shuntogram with thrombectomy and peripheral segment venoplasty
- +36908 Central segment stent placement

Saphenous Vein Ablation (NEW for 2017)

- 36473 Percutaneous mechanochemical ablation (MOCA) of incompetent extremity vein, first vein treated
  - Includes access, imaging guidance and monitoring
- 36474 Each additional vein treated (with mechanochemical ablation) through a separate access site
  - This is an add-on code to 36473 and can only be used once regardless of how many additional punctures and veins are treated in one extremity. N-status indicator.
  - “ClariVein Procedure”. Local anesthesia

Saphenous Vein Ablation

- 36475 Percutaneous radiofrequency ablation of incompetent extremity vein, first vein treated
  - Includes imaging guidance and monitoring
- 36476 Each additional vein treated (with radiofrequency ablation) through a separate access site
  - Includes imaging guidance and monitoring
  - This is an add-on code to 36475 and can only be used once regardless of how many additional punctures and veins are treated in one extremity. N-status indicator.
  - Tumescent anesthesia

Saphenous Vein Ablation

- 36478 Percutaneous laser ablation of incompetent extremity vein, first vein treated
  - Includes all imaging guidance and monitoring
- 36479 Each additional vein treated (with laser ablation) through a separate access site
  - Includes all imaging guidance and monitoring
  - This is an add-on code to 36478 and can only be used once regardless of how many additional punctures and veins are treated in one extremity. N status
  - Tumescent anesthesia
Epidural Steroid Injections:
Single Injection

- **DELETED CODES FOR 2017**
- **62310, 62318**  Cervical or Thoracic; dx or therapeutic
- **62311, 62319**  Lumbar or Sacral; dx or therapeutic

Single Injection with Needle or Catheter

- **62320**  Cervical/Thoracic; dx or tx agent, w/o imaging
- **62321**  Cervical/Thoracic; dx or tx agent, with imaging
- **62322**  Lumbar/Sacral; dx or tx agent, w/o imaging
- **62323**  Lumbar/Sacral; dx or tx agent, with imaging
  - Do not submit +77003 with these codes
  - Do use if catheter is placed, but used <1 day

Steroid Infusion through Catheter
Injection with Indwelling Catheter Continuous or Intermittent Bolus

- **62324** Cervical/Thoracic; dx or tx agent, w/o imaging
- **62325** Cervical/Thoracic; dx or tx agent, with imaging
- **62326** Lumbar/Sacral; dx or tx agent, w/o imaging
- **62327** Lumbar/Sacral; dx or tx agent, with imaging
  - Do not submit +77003 with these codes
  - ONLY use when a catheter is placed and is left in place for more than 1 calendar day

Percutaneous Cryoablation of Nerves 2017

- **0440T** Cryoablation of upper extremity distal/peripheral nerve
- **0441T** Cryoablation of lower extremity distal/peripheral nerve
- **0442T** Cryoablation of nerve plexus or truncal nerve (e.g., brachial plexus, pudendal nerve)
  - Done to relieve neuralgia associated with diseases, such as cancer, diabetic neuropathy, post-surgical and post traumatic injuries, and phantom limb pain. Bundles imaging guidance.

Moderate Conscious Sedation 2017

- **99151**: under age 5, initial 15 minutes by MD performing intervention
- **99152**: age 5 or older, initial 15 minutes by MD performing intervention
- **99153**: age 5 or older, add’l 15 minutes by MD performing intervention
  - **99153** is only billed by hospital, or by MD in NON-FACILITY SETTING
  - **99153 MUE** is 9 for hospital billing (2.5 hours total)
  - Based on MD Face to Face time (minutes), patient age (<5 or 5 and older), and presence of “Trained Independent Observer”
- **99155**: under age 5, initial 15 minutes by other MD
- **99156**: age 5 or older, initial 15 minutes by other MD
- **99157**: age 5 or older, add’l 15 minutes by other MD

The physician should document the face-to-face time spent with the patient from the time the drug(s) for moderate sedation are administered until the time the procedure is completed and physician has left the room (end of face to face time)

Less than 10 minutes - no code
- 10-22 minutes initial code (based on age)
  - 23-37 minutes - 1 initial, one additional
  - 38-52 minutes - 1 initial, two additional
  - 53-67 minutes - 1 initial, three additional
  - 68-82 minutes - 1 initial, four additional, etc

Should document drugs and dosages administered.

WE ARE STILL LEARNING ABOUT THESE CODES!
**Interventional Cardiology: Catheter Based Evaluation of Coronaries**

- Optical Coherence Tomography (For use in coronary arteries only). “DragonFly” device.
  - **92978** Initial vessel (once per heart)
  - **+92979** Each additional vessel (up to 4 additional major coronary arteries, branches are included)
- Use unlisted code 93799 when IVUS, OCT, FFR, or iFR is performed w/o a coronary angiogram or coronary artery intervention
- Codes **0291T** and **0292T** are **DELETED** in 2017

**Heart Assist Devices: Balloon Pumps**

**PERCUTANEOUS APPROACH**
- **33967** Intra-aortic balloon pump placement
- **33968** Intra-aortic balloon pump removal
- “OPEN” **FEMORAL APPROACH**
- **33970** Intra-aortic balloon pump placement
- **33971** Intra-aortic balloon pump removal
- No repositioning code. Usually done at bedside after CXR
- **Implantable Aortic Counterpulsation Ventricular Assist System**
- **0451T-0463T** open procedure, new for 2017

**Interventional Cardiology: Catheter Based Evaluation of Coronaries**

- iFR: Instantaneous Free Wave Ratio or Instant Flow Reserve
  - **+93571-52** Initial vessel (once per heart; iFR)
  - **+93572-52** Each additional vessel (up to 4)
- All catheter based evaluation add-on codes require diagnostic heart catheterization or coronary arterial intervention codes as a base code
- Use unlisted code 93799 when IVUS, OCT, or FFR, is performed w/o a coronary angiogram or coronary artery intervention
**Percutaneous Aortic Valve Replacement**

- **33361** TAVR, percutaneous femoral approach
- **33362** TAVR, open femoral approach
- **33363** TAVR, open axillary approach
- **33364** TAVR, open iliac approach
- **33365** TAVR, open aortic approach (e.g., median sternotomy)
- **33366** TAVR, open trans-apical approach

*Do NOT* use 34812 or 34834 for open femoral or brachial access. Open surgical access is bundled with TAVR. **DO** w/perc. LVAD.

- Sapien valve and CoreValve are FDA approved

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**Percutaneous Valve Repairs**

- **33418** Transseptal mitral valve repair (MitraClip)
  - +**33419** additional clip(s)
    - Bundles heart catheterization related to procedure
    - Bundles coronary angiography, unless for CAD
    - Bundles *transseptal* approach, *transapical* approach is billable
    - Bundles US and echo guidance (unless TEE, as 93355 is billable)
  
- **0345T** Mitral Contour System (cinching device in coronary sinus)

- Percutaneous closure of para-prosthetic valve leak with device: same rules except transseptal is allowed with Aortic Paravalvular Leak treatment
  - Mitral: **93590**  Aortic: **93591**  Each additional device(s): +**93592**
Percutaneous Paravalvular Leak Closure

- Replacement Valves are round, however are slightly elliptical in real life. This can lead to a paravalvular leak. This may result in hemolysis and heart failure. Percutaneous closure of para-prosthetic valve leak with a device is a complex treatment, usually requiring “body floss” technique to safely place the plug.
- Mitral leak closure bundles transseptal approach, but not transapical
- Aortic leak closure allows both transseptal and transapical approaches to be billed with CPT 93462.
- Heart catheterization, coronary angiography and chamber imaging are all bundled when related to the closure procedure, but not if for other reasons

- Mitral: 93590  Aortic: 93591  Each additional device(s): +93592

Percutaneous Left Atrial Appendage Closure

- Left atrial appendage closure with implant, includes fluoroscopy, transseptal puncture, catheter placement, left atrial angiography, left atrial appendage angiography, including S&I: 33340 in 2017
  - Do NOT code for transseptal approach (93462)
  - Do code for left/right heart cath/ventriculography, etc, but ONLY if done for indications unrelated to the LAA closure (unlikely)
  - Inpatient only C-status indicator procedure
  - Watchman Device (FDA approved 3/13/2015)
  - Lariat Device is in FDA trials as of May 2016 (AMAZE Trial) This is a suture mediated treatment without implant.
Cardiac Contractility Modulation System

- Enhances strength of heart contraction to help patients with moderate to severe chronic CHF. “Optimizer IV” by Impulse Dynamics. Two leads in the intraventricular septum and one in the right atrium

- Insertion Codes
  - Insertion of generator and leads (total system) – 0408T
  - Insertion of generator only – 0409T
  - Insertion of atrial lead only – 0410T
    - Reported per lead inserted
  - Insertion of ventricular lead only – 0411T
    - Reported per lead inserted

- Removal
  - Generator removal only – 0412T
  - Lead removal – 0413T
    - Reported per lead removed
    - Reported in addition to placement of a lead (0410T and/or 0411T) if a lead is replaced
  - Removal and replacement of pulse generator – 0414T

- If generator and leads are all replaced, report 0408T for placement of the generator and leads, and report 0413T for each lead removed
  - The removal of the generator is not reported separately

Cardiac Contractility Modulation System

- Repositioning of lead – 0415T
  - Do not report in addition to insertion of a new lead unless it is a different lead
  - Do not report in addition to cardiac catheterization codes

- Relocation of skin pocket – 0416T

- Programming device evaluation (in person) – 0417T

- Interrogation device evaluation (in person) – 0418T
  - Do not report at time of insertion or replacement of generator and/or leads
  - Do not report at time of repositioning a lead
Key NCDs for Cardiology/IR

- 20.4: Implantable Automatic Defibrillators (DOJ audits)
- 20.8: Pacemakers
- 20.7: Carotid Stents (and other vessel angioplasty/stent)
- 20.32: Transcatheter Aortic Valve Replacement (TAVR)
- 20.33: Transcatheter Mitral Valve Repair
- 20.34: Left Atrial Appendage Closure (implemented 10/16)
- 240.6: Transvenous (Catheter) Pulmonary Embolectomy

NCDR Registry requirements

- 20.4: Defibrillators (Primary Prevention required)
- 20.7: Carotid Stents (and other vessels: PCI, PVI registry)
- 20.32: Transcatheter Aortic Valve Replacement (TAVR)
- 20.33: Transcatheter Mitral Valve Repair (MitraClip)
- 20.34: Left Atrial Appendage Closure (Watchman Device)
- NCDR Registries may be audited by DOJ

Defibrillator NCD 20.4 Requirements

- NCD 20.4 (No changes since 2005)
- Two types of AICD coverage:
  - Primary prevention: patient has not yet had a Vfib induced cardiac arrest or documented sustained Vtach, but is at high risk (Requires Registry for -Q0 modifier)
  - Secondary prevention: patient has already experienced sustained Vtach or Vfib induced cardiac arrest or has inducible sustained (30 seconds) VT

Defibrillator

- NCD 20.4 (long-standing NCD)
- Focus of DOJ reviews (simple data mining)
  - Reviewing all cases with ICDs placed with:
    - MI within 40 days
    - Stent, CABG, or PTCA (revascularization) within 90 days
- DOJ Resolution Model available over internet
- Requested cases back to after 10/1/03
  - Recouping for overpayments for AICDs not meeting CMS NCD 20.4 guidelines (as of 2/23/16, $273,000,000 from 510 hospitals)
Transcatheter Aortic Valve Replacement (TAVR)

• NCD 20.32 (Implementation 1/7/2013)
• CMS covers when the following are met
  • Furnished according to an FDA approved indication
  • Two cardiac surgeons independently examined the patient, face to face, for suitability for open AVR
  • The patient is under care of a “Heart Team”


Not Documented: Didn’t Happen

Must meet Medical Necessity

Transcatheter Aortic Valve Replacement (TAVR)

• The heart team’s interventional cardiologist and cardiac surgeon must jointly participate in the intra-operative technical aspects of TAVR
• Both hospital and heart team must participate in a prospective, national audited registry

CERT findings for TAVR

Approximately one third of the payments for TAVR/TAVI services were improper payments. The vast majority of the improper payments were due to insufficient documentation. There were NO claims with medical necessity errors in the special study.

Insufficient Documentation Causes Most Improper Payments
Insufficient documentation means that something was missing from the medical records:
  • Pre-operative evaluation(s);
  • Operative note;
  • A physician’s signature; and/or
  • A signature log or attestation for an illegible signature.
CERT findings for TAVR
Case 1: Two cardiac surgeons must have independently examined the patient face-to-face and evaluated the patient's suitability for open Aortic Valve Replacement (AVR) surgery; both surgeons must have documented the rationale for their clinical judgment. However, there was no documentation of preoperative face-to-face evaluations with the cardiovascular surgeon or the interventional cardiologist. This claim was scored as an insufficient documentation error and the MAC recouped the payment from the provider.
Case 2: There was only one preoperative face-to-face evaluation submitted and it was unauthenticated. This claim was scored as an insufficient documentation error and the MAC recouped the payment.

1) % stenosis for angioplasty. 2) “Routine Surveillance” doesn’t meet medically necessary for CMS

The rules also state that angioplasties are reimbursed by Medicare only if, in addition to the clinical findings required to support a fistulagram, there is evidence that the patient’s blood vessel has a restriction greater than 50% of the vessel's diameter.

As part of today’s settlement, MBPC and Dr. Q admitted that they regularly performed, and billed Medicare for, vascular surgery procedures done only for surveillance purposes, in violation of the Medicare billing rules. MBPC agreed to pay $1,000,000 and Dr. Q agreed to pay $150,000 to resolve their respective liabilities for this conduct.

NCD 20.7 Guidelines

- **Symptomatic** carotid artery disease:
  - High risk for CEA
  - ≥ 70% stenosis not in a clinical trial
  - FDA-approved stent
  - FDA-approved embolic protection device (EPD)
    - If EPD can’t be placed, procedure will be non-covered for Medicare patients (use 37216)
  - Stenosis must be confirmed angiographically at time of procedure.
  - History must be in chart prior to performing the procedure (including documentation of high risk and symptoms)
**Medicare Non-covered for CAS**

- Reasons for Medicare non-coverage:
  - Patient is not high risk.
    - May 2011 FDA approves Acculink Carotid Stent System for standard risk (not high risk), but this does not meet NCD 20.7 guidelines, so it is still Medicare non-covered.
  - EPD cannot be placed.
  - < 70% stenosis in symptomatic patient by angiography
  - 100% occlusion of ipsilateral carotid artery
  - Patient is asymptomatic regardless of % stenosis

**Measurement of Stenosis**

- Required to be confirmed with carotid artery angiography using NASCET criteria
  - If stenosis measured by pre-procedure duplex Doppler or CTA/MRA, percent of stenosis must confirmed by angiography prior to stent placement
  - Angiographic measurements to determine % stenosis should use online quantitative determination or be performed with electronic calipers and magnification correction of images (not eyeball technique)

**Pacemaker**

Implantation of pacemaker requires medical necessity of irreversible symptomatic bradycardia (for single or dual chamber)

- **NCD 20.8** final implementation date of Nov. 2015
- Doesn’t pertain to resynchronization therapy (SC modifier)
- Requires KX modifier for payment (This modifier is the attestation that the requirements in the NCD for placement of this pacemaker are met, documented and available for review in the medical record)