PHILIPS

Image Guided Therapy

Structural Heart Disease Imaging

2022 Medicare coding and reimbursement

Legal disclaimer

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Structural Heart Disease Imaging (ICE & TEE)

Medicare 2022 National Reimbursement Guide

Medicare 2022 payment rates shown as outlined in the Medicare Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs, 2022 Final Rule Correction Notice, OPPS Addendum B 01142022; Medicare Physician Fee Schedule for Calendar Year 2022 (CMS-1751-F, Addendum B 12/16/21 update), 2022 conversion factor 34.6062. Medicare Payment rates are based on national averages as identified in the Medicare Final Rules. Payment rates do not take into account geographical differences, sequestration reduction or payment increases or decreases based on performance measures.

ICD-10-CM diagnosis

For a list of possible ICD-10 diagnosis codes, please refer to the ICD-10-CM 2022: The Complete Official Codebook for coding options.

Hospital Inpatient: ICD-10 Procedure codes

Procedures will vary. For a list of ICD-10 procedure codes, refer to the ICD-10-PCS 2022: The Complete Official Codebook for coding options.

Hospital Inpatient: Diagnosis Related Groupings (DRG)

MS-DRG payment is driven by the patient's primary procedure (eg, ablation) and/or diagnosis(es) as documented in the patient's medical record. Use of ICE and TEE does not affect MS-DRG assignment, as they are not the principal reason for admission. The DRGs listed below are most common for structural heart procedures.

MS-DRG	Description	FY2022 Medicare National Average Payment
LAAC / Valve procedures / PFO / Intracardiac ablation		
273	Percutaneous and Other Intracardiac Procedures with MCC	$25,234
274	Percutaneous and Other Intracardiac Procedures without MCC	$21,673
Ventricular septal defect closure		
228	Other Cardiothoracic Procedures with MCC	$35,149
229	Other Cardiothoracic Procedures without MCC	$22,692
Tricuspid valve / Transcatheter aortic valve replacement (TAVR)		
266	Endovascular Cardiac Valve Replacement & Supplement Procedures with MCC	$46,476
267	Endovascular Cardiac Valve Replacement & Supplement Procedures without MCC	$36,915

Hospital Outpatient & Physician: Medicare 2022 Coding and Payment

Intracardiac Echo (ICE)

		Hospital Outpatient		Physician		
				RVUs	Facility	Non Facility
CPT code	Description	APC	Payment	Work	Payment	Payment
Intracardiac Echocardiography (ICE)						
+93662	Intracardiac echocardiography during therapeutic/ diagnostic intervention, inc imaging supervision and interpretation (List separately in addition to code for primary procedure)	N	Pkgd	2.67	$92	NA

Tips for Billing ICE

CPT code +93662 (ICE) is a designated add-on code per CPT® definition and may only be reported in conjunction with a primary procedure. This guide lists structural heart procedures considered primary for CPT +93662 (ICE). Consult your current CPT guide for all appropriate primary codes reportable with ICE. In instances where ICE is the only procedure performed (no primary procedure involved), unlisted code 93799 should be used.

Report CPT code +93662 once per patient encounter. This includes preliminary evaluation, use during an intervention and follow up studies.

Do not use Coronary IVUS, OCT or Doppler codes to describe ICE procedures. ICE procedures are utilized for evaluation of cardiac chamber, structure and morphology. IVUS, OCT & Doppler codes.

Structural Heart - Primary Procedures for ICE

		Hospital Outpatient		Physician		
				RVUs	Facility	Non Facility
CPT code	Description	APC	Payment	Work	Payment	Payment
Left Atrial Appendage Closure (LAAC)						
33340	Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, inc fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography and radiological sprvsn and interp	Inpatient only		14.00	$800	NA
Septal defect / PFO						
93580	Perc transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect with implant	5194/J1	$16,402	17.97	$988	NA
93581	Percutaneous transcatheter closure of a congenital ventricular septal defect with implant	5194/J1	$16,402	24.39	$1,345	NA
93582	Percutaneous transcatheter closure of patent ductus arteriosus	5194/J1	$16,402	12.31	$673	NA

CPT code	Description	Hospital Outpatient		Physician		
				RVUs	Facility	Non Facility
		APC	Payment	Work	Payment	Payment
Transcatheter atrial septostomy (TAS)						
33741	Transcatheter atrial septostomy (TAS) for congenital cardiac anomalies to create effective atrial flow, including all imaging guidance by the proceduralist, when performed, any method (eg, Rashkind, Sang-Park, balloon, cutting balloon, blade)	Inpatient only		14.00	$765	NA
Transcatheter intracardiac shunt (TIS)						
33745	Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catheterization for congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); initial intracardiac shunt	Inpatient only		20.00	$1,093	NA
Aortic valve						
92986	Percutaneous balloon valvuloplasty; aortic valve	5192/J1	$5,062	22.60	$1,344	NA
93591	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve	5192/J1	$16,402	17.97	$752	NA
Mitral valve						
33418	Transcatheter mitral valve repair, percutaneous approach, inc transseptal puncture when performed; initial prosthesis	Inpatient only		32.25	$1,828	NA
92987	Percutaneous balloon valvuloplasty; mitral valve	5193/J1	$10,258	22.38	$1,390	NA
93590	Perc transcatheter closure of paravalvular leak; initial occlusion device, mitral valve	5193/J1	$10,258	21.70	$1,084	NA
0345T	Transcatheter mitral valve repair percutaneous approach via the coronary sinus	Inpatient only		Carrier Determined		NA
0483T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; percutaneous approach, including transseptal puncture, when performed	Inpatient only		Carrier Determined		NA
0484T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; transthoracic exposure (eg, thoracotomy, transapical)	Inpatient only		Carrier Determined		NA
0543T	Transapical mitral valve repair, including transthoracic echocardiography, when performed, with placement of artificial chordae tendineae	Inpatient only		Carrier Determined		NA
0544T	Transcatheter mitral valve annulus reconstruction, with implantation of adjustable annulus reconstruction device, percutaneous approach including transseptal puncture	Inpatient only		Carrier Determined		NA

		Hospital Outpatient		Physician		
				RVUs	Facility	Non Facility
CPT code	Description	APC	Payment	Work	Payment	Payment
Tricuspid valve						
0545T	Transcatheter tricuspid valve annulus reconstruction with implantation of adjustable annulus reconstruction device, percutaneous approach	Inpatient only		Carrier Determined		NA
Pulmonary valve						
33477	Transcatheter pulmonary valve implantation, perc approach, inc pre-stenting of the valve delivery site, when performed	Inpatient only		Carrier Determined		NA
92990	Percutaneous balloon valvuloplasty; pulmonary valve	5193/J1	10,258	18.27	$1,107	NA
Transcatheter aortic valve replacement (TAVR)						
33361	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach	Inpatient only		22.47	$1,229	NA
33362	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach	Inpatient only		24.54	$1,339	NA
33363	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach	Inpatient only		25.47	$1,388	NA
33364	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach	Inpatient only		25.97	$1,387	NA
33365	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach	Inpatient only		26.59	$1,449	NA
33366	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical exposure (eg, left thoracotomy)	Inpatient only		29.35	$1,596	NA
Pulmonary artery - angioplasty						
92997	Percutaneous transluminal pulmonary artery balloon angioplasty; single vessel	5193/J1	$10,258	11.98	$646	NA

		Hospital Outpatient		Physician		
				RVUs	Facility	Non Facility
CPT code	Description	APC	Payment	Work	Payment	Payment
EP ablation						
93620	Comprehensive electrophysiologic evaluation inc 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	5212/J1	$6,208	11.32	$634	NA
93653	Comprehensive electrophysiologic eval 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, inc intracardiac electrophysiologic 3D mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and His bundle recording, with treatment of SVT 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	5213/J1	$21,916	14.75	$848	NA
93654	; with treatment of ventricular tachycardia or focus of ventricular ectopy inc left ventricular pacing & recording, when performed	5213/J1	$21,916	19.75	$1,134	NA
93656	*(Effective 1/1/22, CPT code 93656 includes 93662 (ICE) - do not bill separately for ICE)* Comprehensive electrophysiologic evaluation inc transseptal catheterizations, insertion and repositioning of multiple electrode catheters with intracardiac catheter ablation of atrial fib by pulmonary vein isolation, inc intracardiac electrophysiologic 3-D mapping, intracardiac echocardiography inc imaging supervision and interp, induction or attempted induction of an arrhythmia including left or right atrial pacing/recording, right ventricular pacing/recording, and His bundle recording, when performed	5213/J1	$21,916	19.77	$1,137	NA
Cardiac catheterization						
93451	Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed	5191/J1	$2,962	2.47	$132	$934
93452	Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging suprvsn and interp	5191/J1	$2,962	4.50	$240	$968
93453	Combined right & left heart catheterization inc intraprocedural injection for left ventriculography, imaging supervision and interpretation, when performed	5191/J1	$2,962	5.99	$319	$1,226

		Hospital Outpatient		Physician		
				RVUs	Facility	Non Facility
CPT code	Description	APC	Payment	Work	Payment	Payment
93454	Catheter placement in coronary artery(s) for coronary angiography, inc intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation	5191/J1	$2,962	4.54	$243	$970
93455	; with catheter placement(s) in bypass graft(s) ... Including intraprocedural injection(s) for bypass graft angiography	5191/J1	$2,962	5.29	$282	$1,078
93456	; with right heart catheterization	5191/J1	$2,962	5.90	$314	$1,205
93457	; with catheter placement(s) in bypass graft(s) ... including intraprocedural injection(s) for bypass graft angiography and right heart catheterization	5191/J1	$2,962	6.64	$354	$1,314
93458	; with left heart catheterization inc intraprocedural injection(s) for left ventriculography	5191/J1	$2,962	5.60	$298	$1,112
93459	; w left heart cath inc intraprocedural injection(s) for lt ventriculography..., catheter placement(s) in bypass graft(s) .. with bypass graft angiography	5191/J1	$2,962	6.35	$338	$1,195
93460	; with right and left heart cath inc intraprocedural injection(s) forleft ventriculography	5191/J1	$2,962	7.10	$379	$1,328
93461	; with right and left heart cath inc intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s)	5191/J1	$2,962	7.85	$419	$1,464
93593	Right heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone; normal native connections	5191/J1	$2,962	3.99	$191	NA
93594	; abnormal native connections	5191/J1	$2,962	6.10	$302	NA
93595	; normal or abnormal native connections	5191/J1	$2,962	5.50	$272	NA
93596	Right and left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone(s); normal native connections	5191/J1	$2,962	6.84	$329	NA
93597	Right and left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone(s); abnormal native connections	5191/J1	$2,962	8.88	$440	NA

HCPCS code

MS-DRG	Description	Device Name	APC/Payment
C1759	Catheter, intracardiac echocardiography	VeriSight Pro (2D/3D)	Pkgd

Transesophageal Echocardiography (TEE)

CPT code	Description	Hospital Outpatient		Physician		
				RVUs	Facility	Non Facility
		APC	Payment	Work	Payment	Payment
Transesophageal Echocardiography (TEE) CPT codes 93312-93318 include conscious sedation and should not be billed separately. CPT codes 76376 and 76377 and 93319 (3D echocardiography) should be billed in conjunction with the base code for the imaging procedure.						
93312	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); inc probe placement, image acquisition, interp and report	5524/S	$493	2.30	$109	$247
93313	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); placement of transesophageal probe only	5524/S	$493	0.26	$11	NA
93314	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); image acquisition, interp and report only	Packaged		1.85	$91	$237
93315	Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report	5524/S	$493	2.69	$128	NA
93316	Transesophageal echocardiography for congenital cardiac anomalies; placement of transesophageal probe only	5524/S	$493	0.60	$26	NA
93317	Transesophageal echocardiography for congenital cardiac anomalies; image acquisition, interpretation and report only	Packaged		1.84	$90	NA
93318	TEE for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interp leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis	5524/S	$493	2.15	$104	NA
+93319	3D echocardiographic imaging and postprocessing during transesophageal echocardiography, or during transthoracic echocardiography for congenital cardiac anomalies, for the assessment of cardiac structure(s) (eg, cardiac chambers and valves, left atrial appendage, interatrial septum, interventricular septum) and function, when performed (List separately in addition to code for echocardiographic imaging)	Packaged		0.50	$25	$62
+93320	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete	Packaged		0.38	$18	$18

		Hospital Outpatient		Physician		
				RVUs	Facility	Non Facility
CPT code	Description	APC	Payment	Work	Payment	Payment
+93321	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); follow-up or limited study (List separately in addition to codes for echocardiographic imaging)	Packaged		0.15	$7	$26
+93325	Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)	Packaged		0.07	$3	$25
Intraoperative TEE CPT code 93355 bundles Doppler, color flow, 3D reconstruction & all echo imaging related to the evaluation, performance and completion of a percutaneous structural heart intervention. This TEE procedure must be performed by a physician NOT performing the structural heart intervention						
93355	TEE for guidance of a transcatheter intracardiac or great vessel(s) structural intervention(s) (eg,TAVR, transcatheter pulmonary valve replacement, mitral valve repair, paravalvular regurgitation repair, LAAOC, ventricular septal defect closure) (peri-and intra-procedural), real-time image acquisition, documentation, guidance with quantitative msrmts, probe manipulation, interp and report, inc dx TEE and administration of ultrasound contrast, Doppler, color flow, and 3D	Packaged		4.66	$229	NA
3D Rendering CPT codes 76376 and 76377 and 93319 (3D echocardiography) should be billed in conjunction with the base code for the imaging procedure. The base codes for CPT 76376 and 76377 are 93312, 93314, 93315, 93317 and the base codes for CPT 93319 are 93312, 93314, 93315, 93317.						
76376	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation	Packaged		0.20	$10	$24
76377	; requiring image postprocessing on independent workstation	Packaged		0.79	$39	$74

Moderate Sedation

CPT code	Description	Hospital Outpatient		Physician		
				RVUs	Facility	Non Facility
		APC	Payment	Work	Payment	Payment
Moderate Sedation						
Moderate sedation is separately reported with codes 99151-99157. Review documentation requirements prior to billing. CPT codes 93312-93318 include conscious sedation and should not be billed separately.						
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	Packaged		0.50	$25.26	$71.29
99152	; initial 15 minutes of intraservice time, patient age 5 years or older	Packaged		0.25	$12.80	$52.26
+99153	; each additional 15 minutes intraservice time (List separately in addition to code for primary service)	Packaged		0.00	$0.00	$11.07
99155	Moderate sedation services provided by a physician or other QHCP other than the physician or other QHCP performing the diagnostic or therapeutic service that the sedation supports; initial 15 mins of intraservice time, pt < than 5 years of age	Packaged		1.90	$84.09	NA
99156	, patient age 5 years or older	Packaged		1.65	$77.17	NA
+99157	; each additional 15 minutes intraservice time	Packaged		1.25	$62.98	NA

Structural Heart Disease Imaging

ICE and TEE Coding Questions & Tips[1,2]

Can ICE and TEE be billed together?

This will depend on the procedure, provider, etc. We recommend consulting CPT guidelines, NCCI edits and payer requirements. In general:

- TEE and ICE are not billable together if TEE is performed to confirm the findings of ICE.
- ICE is an add-on code that may only be performed in conjunction with primary procedures listed in this guide. TEE codes 93312 – 93318 and 93355 are considered primary codes. As long as there are no NCCI edits restricting TEE, and documentation supports the procedure and medical necessity is met, TEE may be billable.

ICE and TEE

- Report CPT code 93355 (intraoperative monitoring) if utilized to measure and guide valvuloplasty or percutaneous valve replacement procedures. CPT code +93662 (ICE) is reported with mitral valvuloplasty (92987), PFO closure (93580) and VSD closure (93581). ICE is not reported with transcatheter valve procedures involving valve placements, replacements, repair or other valvuloplasties.
- ICE is bundled with TMVI (code 0483T); TEE (93355) may be separately reportable if utilized.

ICE (+93662)

- ICE may be billed in addition to PFO or VSD closure if used to guide safe placement of the device and perform bubble studies to evaluate for residual shunting during the procedure.

TEE – Intraoperative Monitoring (CPT 93355)

- Report CPT code 93355 for TEE procedures during percutaneous structural heart interventions. Do not report CPT code 93319 with CPT code 93355 as 3D reconstructions are bundled with 93355.
- CPT code 93355 bundles Doppler, color flow, 3D reconstruction, and all echo imaging related to the evaluation, performance and completion of a percutaneous structural heart intervention.
- **CPT code 93355 must be performed by a physician NOT performing the structural heart intervention.**
- In order to bill CPT code 93355, TEE providers must meet the minimum threshold of BOTH placing the probe AND performing the interpretive study. Any other modalities, such as the use of Doppler or color flow mapping, will be bundled into 93355. **CMS has recently published a decision which allows the billing of 93355 only when it is performed by someone who is not also providing anesthesia on the case**. In other words, an anesthesiologist can bill for 93355 as long as someone else, i.e., his/her partner, was providing the anesthesia.[3]

1. Zhealth Publishing, Cardiothoracic Surgery Coding Reference. 2021 and 2022
2. Zhealth Publishing, Diagnostic & Interventional Cardiovascular Coding Reference. 2021 and 2022.
3. TEE Documentation Requirements for Anesthesia Providers. https://www.anesthesiallc.com/publications/anesthesia-provider-news-ealerts/1389-tee-documentationrequirements-for-anesthesia-providers

TEE

- Coding for TEE is based on the same basic logic as radiology and ultrasound procedures: there is one code for placement of the probe (93313), one code for interpretation of the images (93314), and one for the comprehensive service (93312). There are also codes for enhanced services: Doppler echocardiography pulsed wave and/or continuous wave with spectral display (93320), follow-up Doppler study (93321), color flow velocity mapping (93325), and 3D rendering with interpretation and reporting of CT, MRI, ultrasound or other tomographic modality (76376).
- While TEE is often billed in conjunction with anesthesia and invasive monitoring for cardiovascular cases, it may be performed as a stand-alone diagnostic service. If TEE is being performed by an anesthesiologist or a cardiologist as a separate diagnostic service, it may require a MAC anesthetic, which is also separately billable.
- Codes 93312 and 93315 describe the complete procedure and include placement of the probe with supervision and interpretation of findings of the TEE.
- Codes 93313 and 93316 describe placement of the probe only. These would be used if two physicians were involved, one placing the probe and the other supervising the scanning and performing interpretation of the results.
- Codes 93314 and 93317 describe supervising the scanning and the interpretation only. Placement of the probe is performed by another physician.
- Hospitals should report either the code describing a complete procedure (96312 or 96315) or placement of only the probe (93313 or 93316). Codes 99314 and 93317 are reportable by hospitals but are not paid separately.
- Use CPT code 93318 for continuous TEE monitoring during surgical and other invasive endovascular procedures that requires constant monitoring of cardiovascular function and when used to assist in making therapeutic decisions during these procedures.
- CPT code +93319 was added effective 1/1/22. This add-on code describes the clinical work involved in 3D echocardiographic imaging and post-processing during TEE, or during TEE for congenital cardiac anomalies and includes the assessment of cardiac structures and function. It is important to note that this is not an add-on code for CPT code 93355 since this code already includes 3D imaging for guidance of a structural intervention. CPT codes 76376 and 76377 are not add-on codes and are appropriate for reporting 3D-rendering services provided on a date separate from the base-imaging study.[4]

Ablation

- Effective 1/1/22, CPT code 93656 includes +93662 - do not bill separately for ICE.

-77 Repeat Procedure by Another Physician[5]

- This modifier defines a repeat procedure by another physician during the same patient encounter. It is approved for physician and hospital use. As an example, when a TEE procedure is repeated by another physician, the second exam would require use of the -77 modifier and assumes that the second physician was aware this was a repeat procedure. For example, if a different physician acquires additional images, interprets, and prepares a report in addition to the preoperative TEE, then 93314 (image acquisition, interpretation/report) or 93317 (congenital image acquisition, interpretation/report) can be reported with modifier -77. This indicates that the additional image acquisition and interpretation was provided by a different physician. The medical record should reflect the medical necessity for repeating these procedures.

4. New Add-on CPT Code and Value for Three-Dimensional Echocardiography. https://www.asecho.org/newadd-on-cpt-code-and-value-for-three-dimensional-echocardiography/
5. American Society of Echocardiography. 2017 Coding and Reimbursement Newsletter. https://pdf4pro.com/amp/view/2017-coding-and-reimbursement-newsletter-1fe319.html

Third-party and References

Third-party sources

- 2016 CPT Changes, An Insider's View
- 2017 CPT Changes, An Insider's View
- CPT Assistant
- 2022 ICD-10-CM and ICD-10-PCS: The Complete Official Codebook
- 2022 CPT-4 Professional Edition
- ZHealth Publishing
- American Society of Echocardiography

References

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- Medicare Inpatient Prospective Payment System 2022 Final Rule with Correction Notice. Table 5 CN. Payment rates assume full update amount for hospitals which have submitted quality data and hospitals have a wage index greater than 1.
- Medicare Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs. 2022 Final Rule, OPPS Addendum B.
  - *Status J1: Comprehensive APC – accounts for all costs and component services typically involved in the provision of the complete primary procedure; Status N: No separate APC payment. Packaged into payment for other services; Status Q2: T-Packaged Codes - Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator "T" or "J1". In other circumstances, payment is made through a separate APC payment.*
- Medicare Physician Fee Schedule. Final Policy, Payment, and Quality Provisions in the Medicare Physician Fee Schedule for Calendar Year 2022 (CSM-1751-F). Addendum B (12/16/21 update) using MPFS 2022 conversion factor 34.6062.
  - *RVU: Relative Value Units assigned under the Medicare Physician Fee Schedule, Addendum B. For each CPT code, RVUs are assigned to account for the relative resource costs used to provide the service.*

Questions

Contact Philips Reimbursement Resource Center
Phone: **(858) 720-4030**
Email: IGTDReimbursement@philips.com

Philips
3721 Valley Centre Drive, Suite 500
San Diego, CA 92130 USA
www.philips.com/IGTdevices