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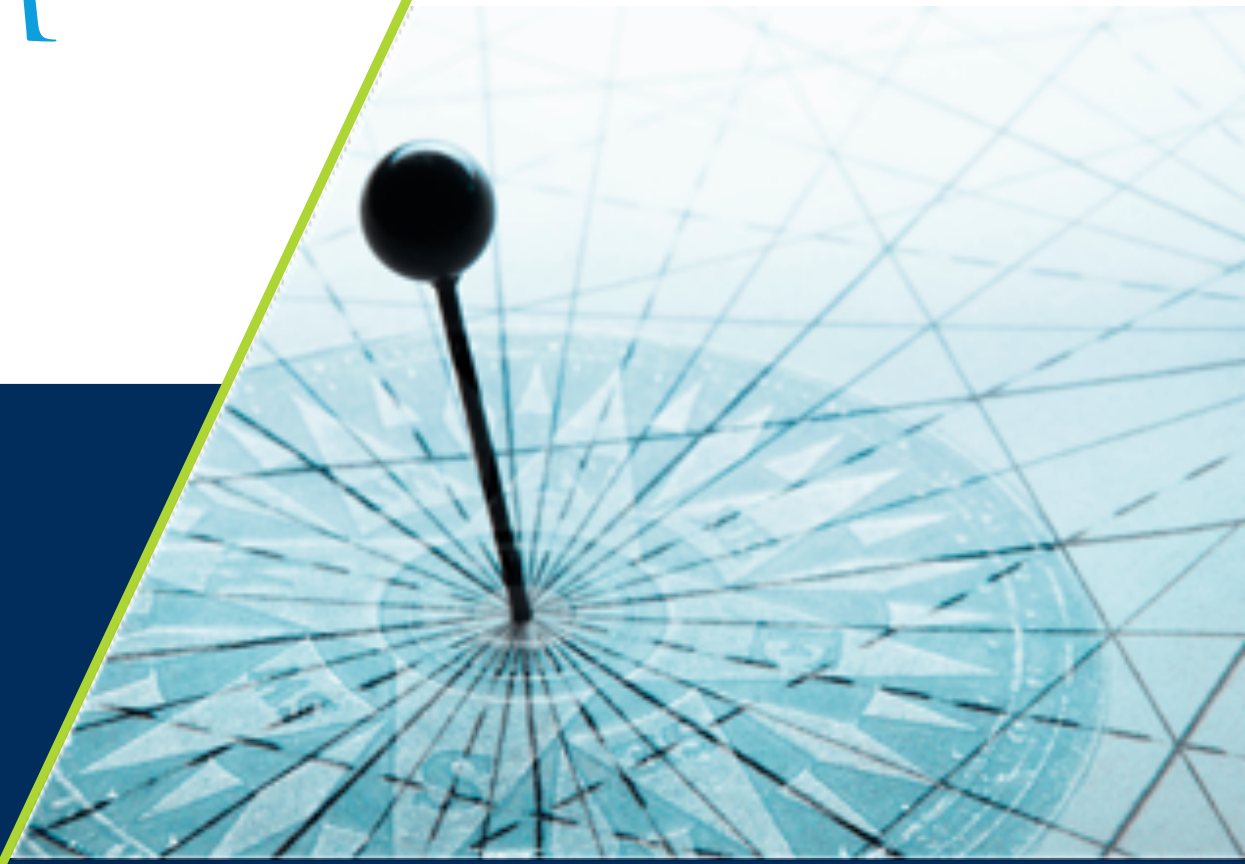

2020 CODING BOOTCAMP WEB SERIES

Session 2: 2021 CPT Coding Changes

December 15, 2020

- Jammie Quimby, CPC, CCC, CEMC, CCS-P, CPMA, CRC, CDEO, Revenue Cycle Solutions Consultant
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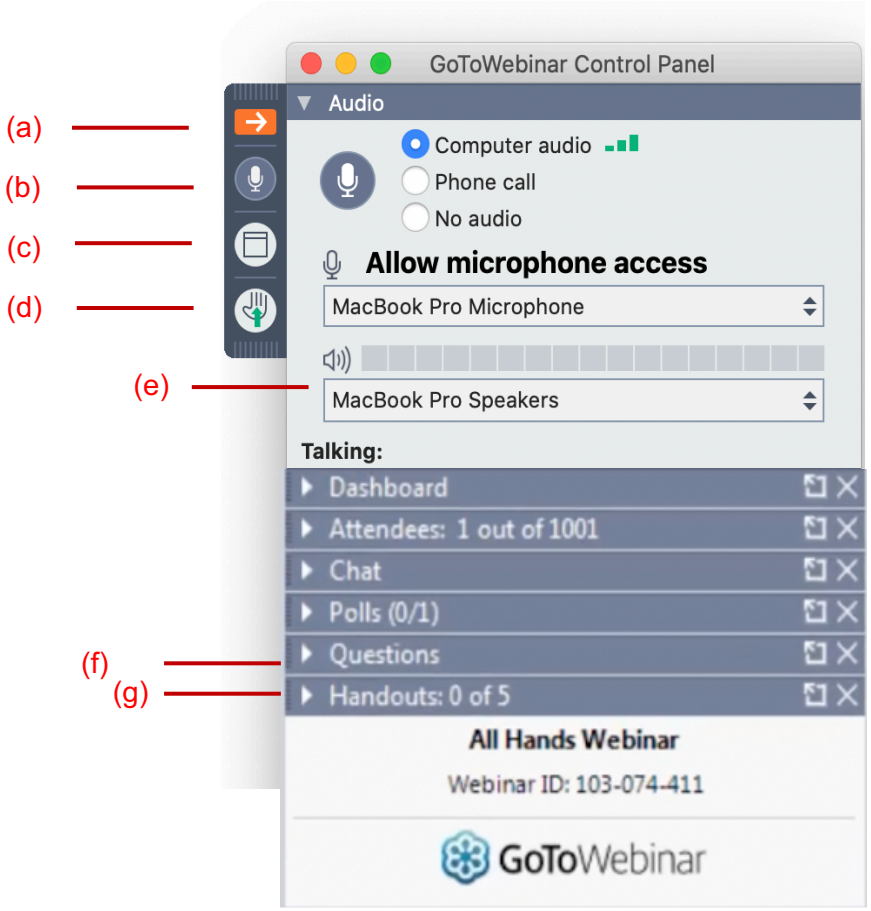
CONTROL PANEL



(a) - Grab Tab – click arrow to open/close Control Panel.

(b) - Mute – By default, attendees are muted (in listen-only mode) to minimize background noises.

(c) - View in **full screen mode**

(d) - Raise Hand – When vocal questions/comments are allowed, please select the hand icon to get the presenter's attention. A red arrow means your hand is raised.

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Objectives

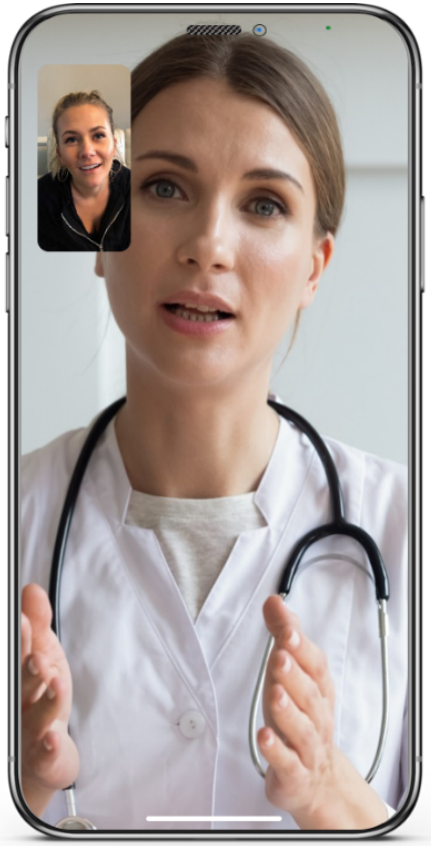
- Review of Medicare Physician Fee Schedule Final Rule highlights that impact Cardiovascular Services
- Overview of new, revised and deleted CPT codes for 2021 that impact Cardiovascular Services
- Quick review of newly added ICD-10-CM diagnosis codes just added, effective 01/01/2021
- Review guidelines and documentation requirements
- Review CPT guidance case examples

2021 Medicare Physician Fee Schedule Final Rule Highlights

Telehealth

Telehealth Origination Site Facility Fee Payment

- Calendar Year 2021 payment amount for Q3014 (Telehealth Originating Site Facility Fee) is $27.02



ADDING SERVICES TO THE MEDICARE TELEHEALTH SERVICES LIST

	Description
Category 1	Services **similar to** professional consultations, office visits, and office psychiatry services that are currently on the list of telehealth services
Category 2	Services **not similar to** the current list of telehealth services. Includes an assessment of whether the service is accurately described by the corresponding code when furnished via telehealth and whether the use of a telecommunications system to furnish the service produces demonstrated clinical benefit to the patient
Category 3	Services added to the Medicare telehealth list during the public health emergency (PHE) for the COVID-19 pandemic (that will remain on the list through the calendar year in which the PHE ends

Category 1 | Category 3

LIST OF MEDICARE TELEHEALTH SERVICES for PHE for the COVID-19 pandemic effective March 1 2020-updated December 1 2020 *** Not all inclusive see CMS link				
Code	**Short Descriptor**	**Status**	**Can Audio-only Interaction Meet the Requirements?**	**Medicare Payment Limitations**
93797 -93798	Cardiac rehab w/ or w/o monitoring	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 10/14/20		
93750	Interrogation vad in person	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 10/14/20		
99201- 99205	Office/outpatient visit new pt			
99211 - 99215	Office/outpatient visit est pt.			
99217	Observation care discharge	Available up Through the Year in Which the PHE Ends		
99218 - 99220	Initial observation care	Temporary Addition for the PHE for the COVID-19 Pandemic		
99221 - 99223	Initial hospital care	Temporary Addition for the PHE for the COVID-19 Pandemic		
99224 -99226	Subsequent observation care	Available up Through the Year in Which the PHE Ends		
99231 99233	Subsequent hospital care			
99234 - 99236	Observ/hosp same date	Temporary Addition for the PHE for the COVID-19 Pandemic		
99238 - 99239	Hospital discharge day	Available up Through the Year in Which the PHE Ends		
99281 - 99285	Emergency dept visit	Available up Through the Year in Which the PHE Ends		
99291 -99292	Critical care	Available up Through the Year in Which the PHE Ends		
99441 -99443	Phone e/m phys/qhp	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20	Yes	
99495 - 99496	Trans care mgmt			
99497 - 99498	Advanced care plan		Yes	
G0422 - G0423	Intens cardiac rehab w/ or w/o exerc	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 10/14/20		
G0424	Pulmonary rehab w exer	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 10/14/20		
G2211	Complex E/M visit add on		Yes	
G2212	Prolong outpt/office vis		Yes	

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

ADDITIONAL TELEHEALTH INFORMATION

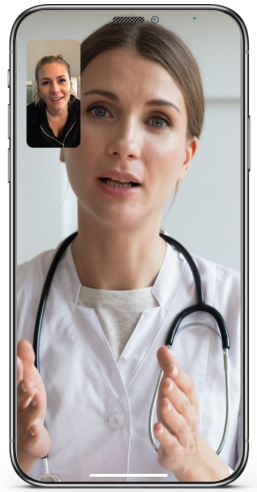
Finalized **frequency** of Nursing facility Subsequent visits via telehealth one visit every **14 days** versus 30-day frequency

Direct supervision may be provided using real-time, **interactive audio and video** technology through the PHE or December 31, 2021

Reiterating in this final rule that telehealth rules do not apply when the beneficiary and the practitioner are in the **same location** even if audio/video technology assists in furnishing a service

CMS finalized cease separate payment for CPT telephone E/M codes 99441-99443 once the PHE ends

For 2021, CMS created an interim code, G2252, for a "brief communication technology-based service (e.g., virtual check-in)" for established patients only. Priced at the same amount as telephone visit code 99442 and covers 11-20-minute "medical discussion" – comments for 2022 rulemaking



SUPERVISION OF DIAGNOSTIC TESTS BY CERTAIN NONPHYSICIAN PRACTITIONERS

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Finalizing proposal to make permanent following the PHE, the same policy that was finalized under the May 1, 2020 COVID-19 IFC (85 FR 27550 through 27629) for the duration of the PHE to **allow nurse practitioners (NPs), clinical nurse specialists (CNSs), physician assistants (PAs), and certified nurse-midwives (CNMs),to supervise the performance of diagnostic tests within their scope of practice and state law.**

We are adding certified registered nurse anesthetists **(CRNAs)** to this list. These practitioners must maintain the required statutory relationships under Medicare with supervising or collaborating physicians

SERVICES FOR TEACHING PHYSICIANS AND RESIDENTS

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Residency training sites of a teaching setting that are outside of a metropolitan statistical area (MSA)

Policy to allow teaching physicians to use interactive, real-time audio/video to interact with the resident to meet the requirement that they be present for the key portion of the service, including when the teaching physician involves the resident in telehealth services.

Allows teaching physicians involving residents in providing care at primary care centers .

These flexibilities do not apply in the case of surgical, high risk, interventional, or other complex procedures, services performed through an endoscope, and anesthesia services.

To ensure that the teaching physician renders sufficient personal and identifiable physicians' services to the patient to exercise full, personal control over the management of the portion of the case for which the payment is sought, in accordance with section 1842(b)(7)(A)(i)(I) of the Act, **the medical record must clearly reflect how the teaching physician was present to the resident during the key portion of the service. For example, the medical record could document the physical or virtual presence of the teaching physician during the key portion of the service**.

IMPACTS TO RPM

Remote Patient Monitoring (RPM) MPFS CY 2021 Final Rule
DURING PHE ONLY
Must be an established patient physician relationship for RPM services to be furnished.
16 days of data each 30 days must be collected and transmitted to meet the requirements to bill CPT codes 99453 and 99454
GENERAL
Finalized consent to receive RPM services may be obtained at the time that RPM services are furnished.
Auxiliary personnel may provide services described by CPT codes 99453 -54 under general supervision. May be contracted employees.
Clarified that the medical device supplied to a patient must be a medical device as defined by Section 201(h) FDA.
The device must be reliable and valid, and that the data must be electronically (i.e., automatically) collected and transmitted rather than self-reported.
Confirmed RPM can be ordered and billed only by physicians or non-physician practitioners who are eligible to bill Medicare for E/M services.
Clarified RPM services may be medically necessary for patients with acute conditions as well as patients with chronic conditions.
Clarified that for CPT codes 99457 and 99458, an “interactive communication” is a conversation that occurs in real-time and includes synchronous, two-way interactions that can be enhanced with video or other kinds of data as described by HCPCS code G2012.
Clarified 20-minutes of time required to bill for the services of CPT codes 99457 and 99458 can include time for furnishing care management services as well as for the required interactive communication
RPM services are not considered to be diagnostic tests; that is they cannot be furnished and billed by an Independent Diagnostic Testing Facility on the order of a physician.

CV Impacts from TABLE 28 MPFS: CY 2021 Work RVUs for New, Revised, and Potentially Misvalued Codes

	HCPCS	Descriptor	CY 2020 wRVU	Final CY 2021 wRVU
Echo	93306	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography	1.50	1.46
EP Add Ons	93623	Programmed stimulation and pacing after intravenous drug infusion	2.85	0.98
	93662	Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation	2.80	1.44
Venography Extremities	75820	Venography, extremity, unilateral, radiological supervision and interpretation	0.70	1.05
	75822	Venography, extremity, bilateral, radiological supervision and interpretation	1.06	1.48
PHE Supply	99072	Additional supplies materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a PHE	NEW	Bundled

New ICD-10-CM Codes

Effective 01/01/2021

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- J12.82 – Pneumonia due to coronavirus disease 2019
- M35.81 – Multisystem inflammatory syndrome
- M35.89 – Other specified systemic involvement of connective tissue
- Z11.52 – Encounter for screening for COVID-19
- Z20.822 – Contact with and (suspected) exposure to COVID-19
- Z86.16 – Personal history of COVID-19

COVID-19 INFECTIONS

Chapter 1 – I.C.1.g.1

a) Code only confirmed cases

- ✓ U07.1 – COVID-19
- ➢ If the provider documents "suspected," "possible," "probable," or “inconclusive” COVID-19, do not assign code U07.1. Assign a code(s) explaining the reason for encounter (such as fever) or Z20.828, Contact with and (suspected) exposure to other viral communicable diseases.
- ❖ ***No update to guidelines yet, may change to Z20.822 Contact with an (suspected) exposure to COVID-19*

b) Sequencing of codes

- ✓ When COVID-19 meets the definition of principal diagnosis, code U07.1, COVID-19, should be sequenced first, followed by the appropriate codes for associated manifestations

c) Acute respiratory illness due to COVID-19

1. (i) Pneumonia
   - ✓ U07.1 COVID-19 and
   - ✓ J12.89 Other viral pneumonia
   - ❖ ***No update to guidelines yet, may change to J12.82 Pneumonia due to coronavirus disease 2019*
2. (ii) Acute bronchitis
   - ✓ U07.1 COVID-19 and
   - ✓ J20.8 Acute bronchitis due to other specified organisms

   OR
   - ✓ If bronchitis is not specified, use J40 Bronchitis, not specified as acute or chronic
3. (iii) Lower respiratory infection
   - ✓ U07.1 COVID-19 and
   - ✓ J22 Unspecified acute lower respiratory infection NOS

   OR
   - ✓ J98.8 Other specified respiratory disorders
4. (iv) Acute respiratory distress syndrome
   - ✓ U07.1 COVID-19 and
   - ✓ J80 Acute respiratory distress syndrome
5. (v) Acute respiratory failure
   - ✓ U07.1 COVID-19 and
   - ✓ J96.0- Acute respiratory failure

d) Non-respiratory manifestations of COVID-19

- ✓ U07.1 COVID-19 and assign code(s) for the manifestation(s) as additional diagnoses

e) Exposure to COVID-19

- ✓ Z20.828 Contact with and (suspected) exposure to other viral communicable diseases
- ❖ ***No update to guidelines yet, may change to Z20.822 Contact with an (suspected) exposure to COVID-19*

f) Screening for COVID-19

- ✓ During COVID-19 pandemic, a screening code is not appropriate
- ❖ ***No update to guidelines yet, may change to Z11.52 Encounter for screening for COVID-19*

g) Signs/Symptoms (not confirmed)

- ✓ R05 Cough
- ✓ R06.02 Shortness of breath
- ✓ R50.9 Fever, unspecified

Exposed and confirmed/suspected –

- ✓ Z20.828 Contact with and (suspected) exposure to other viral communicable diseases

❖ ***No update to guidelines yet, may change to Z20.822 Contact with an (suspected) exposure to COVID-19*

h) Asymptomatic (tested positive)

- ✓ Would still assign code U07.1 COVID-19

i) Personal hx of COVID-19

- ✓ Z86.19 Personal history of other infectious and parasitic diseases
- ❖ ***No update to guidelines yet, may change to Z86.16 Personal history of COVID-19*

j) F/U after COVID-19 resolved

- ✓ Z09 Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm

AND

- ✓ Z86.19 Personal history of other infectious and parasitic diseases
- ❖ ***No update to guidelines yet, may change to Z86.16 Personal history of COVID-19*

k) Encounter for Antibody test

- ✓ Z01.84 Encounter or antibody response examination

2021 CPT Changes

WHAT'S CHANGED IN CPT 2021?

206 New Codes

54 Deleted Codes

69 Revised Codes

Changes by Section

CPT Section	New	Revised	Deleted
Evaluation and Management	2	17	1
Anesthesia	0	0	0
Surgery	11	28	11
Radiology	2	6	2
Pathology/Laboratory	37	9	2
Medicine	18	4	9
Category II	0	1	0
Category III	45	1	23
Proprietary Lab Analyses (PLA)	91	3	7

Medicine Section Changes

Cardiovascular Services

Cardiovascular Monitoring Services

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CPT AMA Definitions

Holter Monitors (93224-93227)	Long-Term Continuous Recorders (93241-93248)	Mobile Cardiac Monitors (93228, 93229)	Event Monitor (93268-93272)
Includes up to 48 hours of continuous recording	Continuously record and store for greater than 48 hours and up to 7 days or for greater than 7 days up to 15 days	Capability of transmitting a tracing at any time, always have internal ECG analysis algorithms designed to detect major arrhythmias. Transmit to an attended surveillance center.	Record segments of ECGs with initiation triggered either by patient activation or by an internal automatic, pre-programmed detection algorithm (or both) and transmit the recorded electrocardiographic data when requested. Cannot transmit immediately based upon the patient or algorithmic activation rhythm Require attended surveillance

Cardiovascular Monitoring Services

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DELETED	DELETED	DELETED	DELETED
~~0295T – External electrocardiographic recording for more than 48 hours up to 21 days by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation~~	~~0296T – recording (includes connection and initial recording)~~	~~0297T – scanning analysis with report~~	~~0298T – review and interpretation~~

Cardiovascular Monitoring Services

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Long-Term Continuous Recorders

- ✓ 93241 – External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation
- ✓ 93242 – recording (includes connection and initial recording)
- ✓ 93243 – scanning analysis with report
- ✓ 93244 – review and interpretation

- ✓ 93245 – External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation
- ✓ 93246 – recording (includes connection and initial recording)
- ✓ 93247 – scanning analysis with report
- ✓ 93248 – review and interpretation

CV Impacts from TABLE 28: CY 2021 Work RVUs for New, Revised, and Potentially Misvalued Codes

	HCPCS	Descriptor	CY 2020 Work RVU	Final CY 2021 Work RVU
Holter & Monitoring	93224	External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation by a physician or other qualified health care professional	0.52	**0.39**
	93227	External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; review and interpretation by a physician or other qualified health care professional	0.52	**0.39**
	93241	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation	NEW	C
	93242	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; recording (includes connection and initial recording)	NEW	0.00
	93243	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm scanning analysis with report recording and storage;	NEW	C
	93244	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; review and interpretation	NEW	0.50
	93245	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation	NEW	C
	93246	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; recording (includes connection and initial recording)	NEW	0.00
	93247	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; scanning analysis with report	NEW	C
	93248	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; review and interpretation	NEW	0.55

Cardiovascular Monitoring Services

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Rationale for Changes

- The prior Category III codes have been converted to a Category I service
- These codes have been added to define intermediate wear time and to define current clinical practice and the associated time or work to monitor, detect, and identify cardiac disease

CPT® Changes 2021

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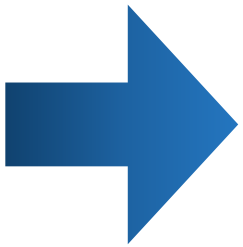
Clinical Example – 93244 (review and interp)

Clinical Example of 93244	Description of Procedure of 93244
A 72-year-old male with known structural heart disease, and a 10-year history of asymptomatic atrial fibrillation with controlled ventricular response, presents with frequent near-syncope episodes for the past month. Decision is made to proceed with a mid-term (greater than 48 hours up to 7 days) external electrocardiographic recording.	Review the reports created by the technician and create a final summary report. The physician reviews each of the seven 24-hour summaries including (1) heart rate trends (minimum, maximum, average) during waking and sleep hours (2) tabular summary of supraventricular and ventricular ectopy (3) any arrhythmias flagged by the technician (4) any pauses and/or bradyarrhythmias; and (5) event symptoms by the patient in the diary and the correlative ECG recordings to determine if an arrhythmia was present at the time of symptoms.

CMS



Revised and Released 2/1/19

Cardiovascular Monitoring Services

There are many different procedure codes that represent the cardiovascular monitoring services. These can be identified as professional components, technical components, or a combination of the two.

Some of these monitoring services may take place at a single point in time, others may take place over 24 or 48 hours, or over a 30-day period.

The determination of the date of service is based on the description of the procedure code and the time listed.

When the service includes a physician review and/or interpretation and report, the date of service is the date the physician completes that activity.

If the service is a technical service, the date of service is the date the monitoring concludes based on the description of the service.

For example, if the description of the procedure code includes 30 days of monitoring and a physician interpretation and report, then the date of service will be no earlier than the 30th day of monitoring and will be the date the physician completed the professional component of the service.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE17023.pd

Category III Code Changes

EP Devices/Pulmonary Artery

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0614T – Removal and replacement of substernal implantable defibrillator pulse generator

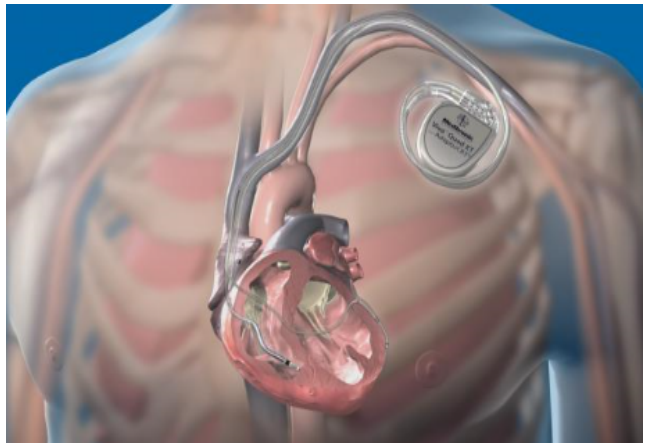
- (Do not report 0614T in conjunction with 33262, 0571T, 0572T, 0575T, 0576T, 0577T, 0580T)

Substernal ICD Implants

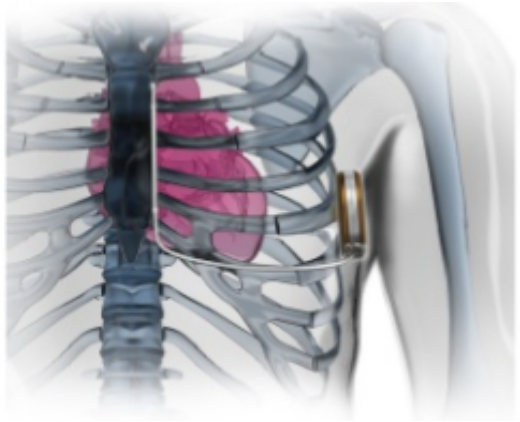
NEW CPT CODES FOR 2020 – CATEGORY III CODES

- 0571T Insertion or replacement system w/ substernal electrode(s)
- 0572T Insertion substernal electrode
- 0573T Removal substernal electrode
- 0574T Repositioning substernal electrode
- 0575T Programming Eval (in person)
- 0576T-0579T Device Evaluation
- 0580T Removal generator only

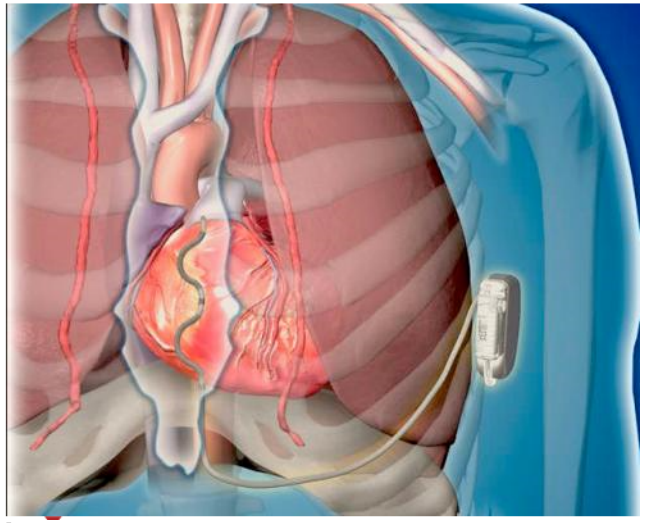
IMPLANTABLE CARDIOVERTER-DEFIBRILLATOR (ICD)



1 "Implantable" Transvenous ICD



2 Subcutaneous ICD



3 Extravascular ICD - Substernal

CPT Example 0614T

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Clinical Example 0614T

A 58-year-old male is undergoing replacement of a previously implanted substernal implantable defibrillator pulse generator, which was implanted 6 years ago, because of battery depletion. There has been no evidence of infection or malfunction of the substernal lead

Description of Procedure 0614T

Prepare the lateral left chest and administer anesthesia (local or general). Make an incision over the fifth-sixth ribs just below the left inframammary crease and carry down to the level of the capsule surrounding the generator. Perform subcutaneous dissection of the pulse generator and disconnect the lead from the generator. Dissect the existing generator free from fibrous scar tissue, with removal of scar tissue as necessary. Test the existing lead to assess the adequacy, including capture threshold, sensing, and impedance. Revise the pocket as needed to accommodate the new generator. Insert the new pulse generator into the pocket and connect to the existing lead. After closing the first tissue layer of the pocket, perform initial sensing, pacing, and lead impedance measurements. Close the pocket and dress the wound.

0623T	0624T	0625T	0626T
Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography data preparation and transmission, computerized analysis of data, with review of computerized analysis output to reconcile discordant data, interpretation and report	data preparation and transmission	computerized analysis of data from coronary computed tomographic angiography	review of computerized analysis output to reconcile discordant data, interpretation and report

CPT Example

CPT® Changes 2021

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Physician Interpretation 0626T

Clinical Example 0626T

A 60-year-old male presents to the primary care office with stable chest pain. He has intermediate pre-test likelihood of coronary artery disease. Coronary CT angiography (separately reported) is performed to evaluate for coronary artery disease and automated coronary analysis is ordered to gain additional information regarding severity of coronary atherosclerosis and for improved risk stratification.

Description of Procedure 0626T

The interpreting physician/QHP reviews the computer- generated report and images using interactive software validating that the computer assessments are correct. Compare the CCTA report to the computer-generated report and reconcile any discrepancies. The provider determines the final findings, adds clinical relevance, risk assessment, and may add clinical direction regarding decisions for coronary revascularization. Generate a final report that is stored in the patient permanent record. Relay critical results immediately to the referring physician.

Pulmonary Artery Denervation (PADN)

0632T – Percutaneous transcatheter ultrasound ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance

- (Do not report 0632T in conjunction with 36013, 36014, 36015, 75741, 75743, 75746, 93451, 93453, 93456, 93460, 93503, 93505, 93568)

CPT Example

Clinical Example 0632T

A 66-year-old female patient with precapillary pulmonary arterial hypertension (wedge pressure 15 mmHg) and high pulmonary vascular resistance (PVR3 Wood units), which are currently managed on pharmaceutical therapy with worsening exercise tolerance, elects to receive percutaneous transcatheter ultrasonic ablation of the nerves innervating the pulmonary arteries.

Description of Procedure 0632T

Perform a right heart catheterization under fluoroscopic guidance to verify the pulmonary artery hemodynamic measures. Advance a guide catheter through the sheath to the pulmonary artery over a guidewire using standard technique. Once an activated clotting time (ACT) of at least 245 seconds is achieved, introduce a multidirectional therapeutic ultrasound catheter into the pulmonary artery through the right heart under fluoroscopic guidance over the guidewire into the right pulmonary artery, using standard practice. After verifying the catheter position under fluoroscopy and once the automated safety parameters are met, deliver therapeutic ultrasound energy for 40 seconds to cause denervation of the pulmonary artery. Reposition the guide catheter and ultrasound catheter to perform the procedure in the main pulmonary trunk, left pulmonary artery, and right pulmonary artery. The number of treatment sites depends on the pulmonary artery anatomy and, therefore, cannot be strictly predefined; however, the target is 18 lesions, 8 in the right and main pulmonary arteries and no more than 2 in the left pulmonary artery. Verify the positioning of the catheter for each treatment site level by fluoroscopy. Following treatment, remove the device. Achieve hemostasis at the vascular access site using standard techniques. Concomitant with the pulmonary artery denervation procedure, administer antiplatelet and anticoagulant drugs to inhibit thrombus formation, and analgesic and sedative drugs are administered intravenously to reduce pain associated with the procedure

Category III Code Changes

Septal Shunt Device & Venous Arterialization

0613T – Percutaneous transcatheter implantation of interatrial septal shunt device, including right and left heart catheterization, intracardiac echocardiography, and imaging guidance by the proceduralist, when performed

- (Do not report 0613T in conjunction with 76937, 93313, 93314, 93318, 93355, 93451, 93452, 93453, 93456, 93457, 93458, 93459, 93460, 93461, 93462, 93530, 93531, 93532, 93533, 93662)

CPT Example 0613T

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Clinical Example 0613T

A 69-year-old male with chronic heart failure has left atrial pressure greater than 25 mm Hg. Patient elects to receive an interatrial shunt to reduce the left atrial pressure.

Description of Procedure 0613T

Prepare and drape the patient. **Perform a right heart catheterization to delineate the anatomy and physiology. Perform a trans-septal puncture across the central region of the fossa ovalis using needle or radiofrequency equipment. Place a guidewire across the newly created atrial septostomy into the left atrium, or alternatively, into a pulmonary vein. Then advance a delivery sheath and dilator over the wire and position in the left atrium. Slowly remove the dilator leaving the sheath in the left atrium. Then advance the delivery catheter and shunt system through the delivery sheath and deploy the left side of the device in the mid-left atrium. Withdraw the sheath and delivery catheter under echocardiographic and fluoroscopic visualization until the left atrial cone of the shunt touches the left side of the interatrial septum. Evaluate the position of the device by echocardiography and fluoroscopy prior to release of the right side of the device into the right atrium. If the device is in good position, activate the release mechanism, retract the delivery catheter and sheath, and fully deploy the device across the atrial septum.** After device position is confirmed using transesophageal echocardiography (TEE), intracardiac echocardiography (ICE), or angiography, remove the catheters and sheaths and achieve hemostasis.

Endovascular Venous Arterialization

0620T – Endovascular venous arterialization, tibial or peroneal vein, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed

- (0620T includes all ipsilateral selective arterial and venous catheterization, all diagnostic imaging for ipsilateral, lower extremity arteriography, and all related radiological supervision and interpretation)
- Do not report 0620T in conjunction with 37228, 37229, 37230, 37231, 37238, 37239, 37248, 37249 within the tibial-peroneal segment)

CPT Example 0620T

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Clinical Example 0620T

A 66-year-old female presents with pain at-rest and nonhealing ulcers on her right foot and toes. She has a known history of chronic total occlusion of the posterior tibial artery with prior failed attempts at revascularization. Prior diagnostic angiography demonstrated poor arterial run-off. The patient was determined to be a candidate for endovascular tibial vein arterialization.

Description of Procedure 0620T

Using standard technique, **obtain access to the ipsilateral common femoral artery and advance a sheath in antegrade fashion to the posterior tibial artery. After injecting contrast, perform arteriography to identify any obstructing lesions in the intervening arteries and to confirm the site of occlusion within the posterior tibial artery.** Advance a balloon catheter into the posterior tibial artery and, as indicated, perform preparatory balloon dilation of the posterior tibial artery proximal to the occlusion using standard angioplasty techniques to enable passage of instruments. After removal of the balloon catheter, advance the arterial-crossing catheter through the femoral artery sheath to a site just proximal to the occlusion in the posterior tibial artery. Separately, using standard technique, obtain a second access to the posterior tibial vein and insert a sheath in retrograde fashion. After injecting contrast, perform venography to confirm vessel patency. As indicated, perform preparatory balloon dilation of the posterior tibial vein using standard angioplasty techniques to enable passage of instruments. Advance the venous corresponding catheter through the tibial vein to a level adjacent to the occlusion in the posterior tibial artery.

Using standard imaging techniques, align the crossing catheter in the posterior tibial artery with the corresponding

CPT Example 0620T Continue

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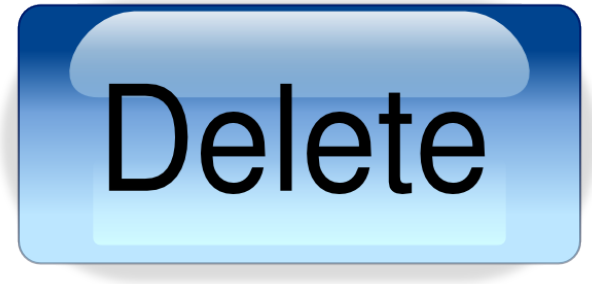
catheter in the posterior tibial vein. Extend the crossing needle from the arterial catheter through the sidewall of the posterior tibial artery and through the sidewall of the adjacent posterior tibial vein to establish a connection between the artery and the vein. Advance a guidewire to cross from the posterior tibial artery through the arteriovenous connection and into the posterior tibial vein and dilate the connection using standard over-the-wire angioplasty techniques.

After advancing the wire through the venous arch in the foot, insert an over-the-wire valvulotome through the arteriovenous connection and into the posterior tibial vein under fluoroscopic guidance. Pass the valvulotome the length of the vein to the plantar aspect of the foot, using back-and-forth motion and rotation to render the valves incompetent and enable arterial blood flow to the foot via the vein. After removing the valvulotome, pass a balloon to gently pre-dilate the length of the vein. **Under fluoroscopic guidance, deliver and deploy a self-expanding stent-graft within the vein beginning at the level of the ankle. In an overlapping fashion, deliver and deploy additional self-expanding stent-grafts throughout the vein up to the level of the arteriovenous connection. Through the connection, deploy a conical self-expanding stent-graft from the posterior tibial artery into the posterior tibial vein to establish a permanent arteriovenous anastomosis**. Post-dilate the entire length of stent-grafts using standard technique. Confirm revascularization of the foot via completion angiography and measure blood flow via duplex testing. Remove sheaths and close the groin with a standard closure technique

Surgery Changes

Deleted Code Biopsy of Lung



~~32405 Biopsy, lung, mediastinum~~

Core Needle Biopsy

- 32408

➡ Core needle biopsy, lung or mediastinum, percutaneous including imaging guidance when performed – Report once per lesion sampled in a single session

CPT Guidance

32408

- Image Guidance 76942, 77002, 77012, 77021 is included – Do not code
- When core needle biopsy is performed with another core biopsy - separate site than lung - code both including the imaging of the other non lung biopsy with a 59 modifier
- Use modifier 59 for each lesion second and each additional biopsy

CPT Guidance Continued

Core Biopsy (32408) & Fine Needle Aspiration (Codes 10004 – 10012, 10021)

When fine needle aspiration (FNA) is performed with core needle of lung/mediastinum on the same lesion at same session and **same type of imaging** – report both codes but reduce the FNA with a 52 modifier

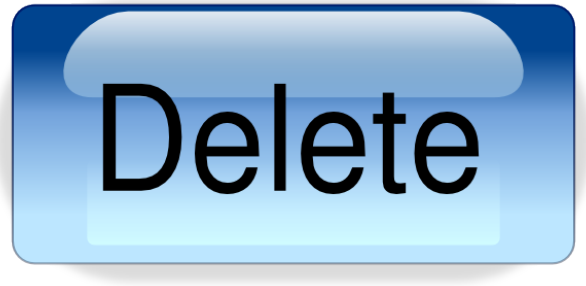
When FNA is performed with core needle of lung/mediastinum on the same lesion at same session with **different type of imaging** – report both codes and FNA (column 2 code) with the 59 modifier

When FNA biopsy is performed on one lesion and core is performed on a separate lesion- same session same day – **using same type of imaging** – report both codes and FNA (column 2 code) with a 59 modifier

When FNA biopsy is performed on one lesion and core is performed on a separate lesion- same session same day – **using different types of imaging** – report both codes and FNA (column 2 code) with a 59 modifier

Deleted Codes Atrial Septectomy -Septostomy

Rashkind Type or Park Septostomy



~~92992 Atrial septectomy or septostomy; transvenous method, balloon (e.g. Rashkind type) (includes cardiac catheterization~~

~~92993 blade method (Park septostomy) (includes cardiac catheterization~~

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 (e.g., Rashkind, Sang-Park, balloon, cutting balloon, blade) – Do not report with modifier 63
- **Work RVU 14.00**

Included in 33741

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Not Separately Billable

- Percutaneous access
- Placing of access sheath
- Advancement of the delivery system
- Creation of effective intracardiac blood flow
- Ultrasound guidance (when performed) for vascular access
- Fluoroscopic guidance for the intervention

Cardiac Catheterization with 33741

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CPT Guidance

Do Not Report When:

Diagnostic Right and Left Heart Catheterization (93451,93452, 93453, 93456, 93458, 93460, 935630, 93531, 93532, 93533)

1. Used to report fluoroscopic guidance for the intervention
2. Limited hemodynamic and angiographic data is used for the sole purposes of accomplishing the intervention (e.g. , measurement of atrial pressures before or after septostomy, atrial injections to determine appropriate cath placements)

Cardiac Catheterization with 33741

CPT Guidance

Not Typically Performed but Do Report When:

Diagnostic Congenital Right and Left Heart Catheterization (93530, 93531, 93532, 93533)

1. No prior study is available, and a full diagnostic study is performed or
2. A prior study is available, but as documented in the medical record:

   a. There is inadequate visualization of the anatomy and/or pathology or

   b. The patient's condition with respect to the clinical indication has changed since the prior study,

   or

   c. There is a clinical change during the procedure that requires a more thorough evaluation.

Diagnostic Cardiac Angiography with 33741

CPT Guidance

For Evaluation Separate and Distinct from the Shunt Creation, Contrast Injections Performed are Reported with

+93563 Injection during cardiac cath for selective coronary angiography during a congenital heart cath **(use with 93530-93533)**

+93565 for selective left ventricular or left atrial angiography **(use with 93530-93533)**

+93566 for selective right ventricular or right atrial angiography **(use with 93451, 93453, 93456, 93457, 93460, 93461, 93530-93533)**

+93567 for supravalvular aortography **(use with 93451-93461, 93530-93533)**

CPT Example 33741

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Clinical Example 33741

A 1-day-old premature male infant with transposition of the great arteries is severely cyanotic and in cardiogenic shock following delivery. He is felt to be too small and hemodynamically unstable to proceed for definitive surgical repair. He is taken to the cardiac catheterization laboratory for transcatheter palliative therapy prior to definitive repair

Description of Procedure (33741) Cardiac catheterization during this procedure refers solely to the placement of a unique, therapeutic, septostomy catheter from the venous sheath into the right atrium, and further across to the left atrium. Any additional diagnostic right or left cardiac catheterization following the septostomy procedure is separately reportable. Local anesthetic may be used.

Obtain access percutaneously, typically into the femoral vein. Alternatively, the umbilical vein may be used. Use ultrasound evaluation and real-time guidance as needed for percutaneous needle entry of the femoral vein. Pass a thin guidewire through the needle into the vessel. Place a venous sheath over a wire into either the femoral or umbilical vein. Remove the wire and flush the sheath. Pass the therapeutic septostomy catheter through the sheath and direct from the venous system into the right atrium and across the restrictive atrial communication to the left atrium. This is performed under fluoroscopic and/or transthoracic echocardiographic guidance. Transthoracic echocardiographic guidance is typically performed by another provider, and additionally reportable.

CPT Example 33741 Con't.

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Often, the anatomy may be complicated and require the use of a diagnostic end-hole catheter and guidewire to help cross the atrial communication and establish a secure wire position in the left heart. Position the wire in one of the left pulmonary veins. Remove the guide catheter and advance the septostomy catheter over the wire into the left atrium. Confirm position by transthoracic echocardiography as well as fluoroscopically. **Inflate the balloon with a predetermined amount of contrast and saline mixture and then carefully but quickly pull across to the right atrium under continuous fluoroscopic and/or echocardiographic observation. Once on the right side of the heart, deflate the balloon so as not to obstruct the systemic venous return. Perform a transthoracic echocardiogram to evaluate adequacy of the communication. Often, the balloon is advanced across to the left side once again and the process repeated to further enlarge the communication. At times, the septal tissue is too thick and necessitates the use of a specialized septostomy blade catheter.**

Similar to the balloon method, **advance the blade catheter into the left atrium, expose the cutting blade, and pull the catheter slowly across the atrial septum, creating an incision of the septal tissue. Alternatively, a static septoplasty may also be performed. This involves passage of a larger diameter, high pressure, angioplasty balloon catheter across the**

atrial communication and enlarging the communication by static inflation of the balloon to stretch/tear the communication to a larger size. Following the procedure, remove the catheter and achieve compression hemostasis in the catheterization laboratory, prior to taking the patient back to the intensive care unit (ICU). If the umbilical vein was used for the procedure, pass a guidewire through the sheath, prior to removal and exchange the sheath for an umbilical venous catheter to be used for ongoing inpatient care, as is typical.

Transcatheter Intracardiac Shunt (TIS)

- 33745
- +33746

- 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 (e.g., atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles;) initial intracardiac shunt - **Work RVU 20.00**
- +33746 each additional intracardiac shunt location –

  Work RVU 8.00 and MUE of 1

Included in 33745

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Not Separately Billable

- Ultrasound Guidance (when performed)
- Fluoroscopic guidance for the intervention
- Intracardiac stent placement
- Target zone angioplasty – preceding or after stent implantation
- Diagnostic cardiac cath is performed at the same session and the code descriptor includes this work

Separately Billable w/33745

CPT Guidelines

- +93563 Coronary Angiography
- +93565 Left Ventricular or Left Atrial Angiography
- +93566 Right Ventricular or Right Atrial Angiography
- +93568 Pulmonary Angiography

Use 59 modifier for the above codes

- +93462 Transseptal Puncture

1

Potential Reporting Problems:

- These are add-on codes
- You cannot report primary cath codes with the 33745
- Parenthetical notes for the add-on codes do not include 33745

2

CPT Example 33745

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Clinical Example (33745)

A 10-year-old male with hypoplastic left heart syndrome, status post-Fontan procedure 7 years prior, develops worsening single ventricular function and increased pulmonary arterial and Fontan pressures. He is felt to be a poor (high-risk) candidate for surgical Fontan revision. He is taken to the cardiac catheterization laboratory for relief of the obstruction at the Fontan fenestration with stent implant.

Description of Procedure (33745) Obtain access percutaneously from two venous sites, (eg, internal jugular, subclavian, femoral vein) and a femoral artery. Initially place a sheath in the veins and artery to establish secure access. Multiple sheath exchanges are often needed during the procedure to allow for maintaining as small of an introducer as possible for the majority of the procedure and yet facilitate the stenting procedure. **Perform catheter introductions through these sheaths and manipulate into the necessary positions. Record baseline pressures as necessary and conduct blood sampling in each of the right and left heart structures to be used for planning the intervention**. Once baseline hemodynamic data is collected, remove the diagnostic catheter and insert an angiographic catheter and **use for any additional necessary angiography of chambers or vessels (each separately reported). Place wire across the stenotic fenestration, into the atrium, and further direct into either the pulmonary vein or ventricle to establish a secure position. Then exchange the short sheath initially placed for the diagnostic portion over the wire for a larger, and longer therapeutic sheath, which is advanced into the atrium. Typically, the fenestration is too small to allow for passing the larger sheath into the atrium and may require the performance of initial high- pressure target zone angioplasty with a small-diameter angioplasty balloon to do so. Occasionally, the fenestration has completely closed and may require performance of a transseptal perforation, which is additionally reportable (93462.) With the long sheath in the Fontan conduit, advance the angioplasty balloon catheter over the wire and partially across the fenestration**

CPT Example 33745 Continued

Inflate the balloon to stretch the fenestration, then, as it is deflated, advance the sheath over the deflating balloon, which acts as a dilator to allow the sheath to be advanced into the heart. Once the sheath is in position, prepare the appropriate stent on the back table, mount on an appropriate sized balloon (when performed), and deliver over the wire up to the sheath tip. Then withdraw the entire system partially so that the stent is centered over the fenestration. This procedure requires landing an intra-cardiac stent with precise positioning such that the distal half of the stent is free floating within the atrium, and the proximal half free floating in the Fontan conduit. **Partially pull back the sheath, exposing the distal half of the stent. Slowly inflate the balloon, flaring the distal half of the stent open inside the atrium. Then withdraw the sheath further, fully exposing the stent, which allows the proximal half to also be flared open, effectively dog- boning the stent. The balloon is then further inflated as needed to adjust the central portion diameter to the desired size.**

Remove the balloon catheter with great care so as not to dislodge the stent. Inside a guide catheter and advance carefully across the stent and use to remove the wire, after which, the catheter within the atrium is used to perform an angiogram and record pressures. Carefully remove the catheter from the heart and perform a final angiogram with an angiographic catheter in the Fontan conduit. Complete right and left heart catheterization is typically repeated following the intervention to establish new baseline measurements and further assess the intervention or if further intervention is needed. Following the completion of the procedure, remove all catheters and sheaths and achieve compression hemostasis in the catheterization laboratory, prior to the patient being taken to recovery.

CPT Example 33476

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Clinical Example (33746)

A 5-day-old male presents with hypoplastic left heart syndrome with mitral atresia, restrictive atrial septum, and pulmonary vein stenosis, and a high-risk surgical candidate. He develops worsening cardiac output, renal insufficiency, and progressive cyanosis. He is taken to the cardiac catheterization laboratory to improve the obligatory left to right shunting with stenting of the atrial septum as well as stent placement to relieve the pulmonary venous obstruction to the left atrium.

Description of Procedure (33746)

Following completion of the initial stent deployment, use a diagnostic guide catheter along with a soft guidewire, to selectively catheterize the second lesion. Address the more distal lesion first, so as not to risk causing dislodgement of the initial stent with any further catheter manipulation in the vicinity. However, if doing so causes hemodynamic instability, the more proximal lesion may have to be addressed first, increasing the complexity of the subsequent stent delivery. To avoid significant torque on the catheter, which may cause propping open of one or more of the heart valves, use a series of long sheaths and catheters to safely access the second lesion.

Once a guide catheter is placed into the second lesion, exchange the soft guidewire for a stiffer support wire and remove the diagnostic guide catheter. Then insert a long sheath, or other appropriate delivery guide catheter, over the wire and advance into position across the second lesion. Prepare the second stent and advance over the wire and into position across the lesion. Perform angiography through the sheath to ensure proper positioning. Due to the position within a beating heart, this may require numerous fine adjustments and multiple angiograms. Then inflate the balloon and deploy the stent. Carefully remove the balloon catheter with extreme caution so as not to dislodge the stent. Perform a post-stent angiogram to evaluate the position and rule out any adverse effects. Reinsert a guide catheter and use to carefully remove the support wire, again, taking care not to dislodge the stent. Measure a final pressure gradient as the remaining guide catheter is then removed from the heart. Following the completion of the procedure, remove all catheters and sheaths and achieve compression hemostasis in the catheterization laboratory, prior to the patient being taken to recovery.

Percutaneous Ventricular Assist Devices

VADS Insertions

• 33995	▲ 33990	▲ 33991
Insertion of ventricular assist device percutaneous, including radiological supervision and interpretation; right heart venous access only	**left heart,** arterial access only	**left heart,** both arterial and venous access, with transseptal puncture

Percutaneous Ventricular Assist Devices

VADS Removal/Repositioning

33992	33997	33993
Removal of percutaneous **left heart** ventricular assist device **arterial or arterial and venous cannula(s)** at separate and distinct session from insertion	Removal of percutaneous right heart ventricular assist device with imaging guidance at separate and distinct session from insertion	Repositioning of percutaneous **right or left heart** ventricular assist device with imaging guidance at separate and distinct session from insertion

CV Impacts from TABLE 28 MPFS: CY 2021 Work RVUs for New, Revised, and Potentially Misvalued Codes				
	HCPCS	Descriptor	CY 2020 wRVU	Final CY 2021 wRVU
VAD Code Updates and New Codes	33990	Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; left heart, arterial access only	7.90	6.75
	33991	Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; left heart, both arterial and venous access, with transseptal puncture	11.63	8.84
	33992	Removal of percutaneous left heart ventricular assist device, arterial or arterial and venous cannula(s), separate and distinct session from insertion	3.75	3.55
	33993	Repositioning of percutaneous right or left heart ventricular assist device, with imaging guidance, at separate and distinct session from insertion	3.26	3.10
	93750	Interrogation of ventricular assist device (VAD), in person, with physician or other qualified health care professional analysis of device parameters (e.g., drivelines, alarms, power surges), review of device function (e.g., flow and volume status, septum status, recovery), with programming, if performed, and report	0.92	0.75
	33995	Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; right heart, venous access only	NEW	6.75
	33997	Removal of percutaneous right heart ventricular assist device, venous cannula, separate and distinct session from insertion	NEW	3.00

CPT Example 33995

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Clinical Example (33995)

A 66-year-old female presents to the emergency department with an inferior ST-elevation myocardial infarction. Diagnostic tests show she is hypotensive, suffering from right ventricular failure, and has a completely occluded proximal right coronary artery. Despite successful stent placement to the occluded proximal right coronary artery, she manifests persistent hypotension, malperfusion, right ventricular dysfunction, and elevated central venous pressure (CVP). A decision is made to insert a right heart percutaneous ventricular assist device (PVAD) to provide temporary right ventricular support

Description of Procedure (33995)

Obtain a peripheral intravenous (IV) access site. If general anesthesia is induced, intubate the patient and connect to a mechanical ventilator. If conscious sedation is used, secure oxygen saturation monitoring. Insert a radial artery catheter for hemodynamic monitoring. Monitor heart rate and rhythm throughout the procedure. **Transesophageal echocardiography (TEE) or transthoracic echocardiography (TTE) may be used by an echocardiographer to confirm the ejection fraction and to rule out ventricular thrombus. (If performed, TEE/TTE is reported separately.)** Prepare and drape the patient. Infiltrate local anesthesia into the groin.

Obtain venous access in the common femoral vein using ultrasound to assess the entry site. Place a micropuncture needle into the vein and use the micropuncture dilator to place a 0.035 guidewire. Place a 5-8 French (Fr) introducer to pre-dilate the vessel. Then use 8-, 12-, 16- and 20-Fr dilators to further dilate the vessel. Then place the 23-Fr sheath into the vein. Active the console, place a purge cassette, and connect the system to the catheter. Purge the catheter and test to ensure purge fluid is exiting properly. Administer heparin and when ACT is 250 seconds, remove the dilator from the introducer**. Place a flow-directed balloon tipped catheter into the 23-Fr introducer and advance over a guidewire to the pulmonary artery. Curve the placement guidewire and insert deep into the left or right pulmonary artery until it prolapses. Then remove the balloon-tipped catheter. Wet the cannula with sterile water and backload on to the placement wire, which usually requires technician assistance. Advance the guidewire into the catheter and take care to stabilize the cannula and not allow distal movement of the placement wire. Advance the catheter into the inferior vena cava (IVC) and calibrate the sensor. Then advance it through the hemostatic valve into the femoral vein and rotate as it advances into the right ventricle to get the tip upward and toward the pulmonary valve going across. Place the outlet 4 cm distal to the pulmonary valve.**

CPT EXAMPLE 33995 CONTINUED

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Remove the placement guidewire. Verify position with fluoroscopy and echocardiography (either transthoracic or transesophageal). The console then activates the catheter and support is provided at increasing levels. The catheter position is reassessed. The repositioning sheath is then flushed, and a stopcock placed. Remove the 23-Fr peel- away introducer from the vein and advance the repositioning sheath. Secure the entry site with sutures and apply sterile dressings.

CPT Example 33997

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Clinical Example (33997)

A 66-year-old female presents with an inferior ST-elevation myocardial infarction. Diagnostic tests show she is hypotensive, suffering from right ventricular failure, and has a completely occluded proximal right coronary artery. Despite successful stent placement to the occluded proximal right coronary artery, she manifests persistent hypotension, malperfusion, right ventricular dysfunction, and elevated central venous pressure (CVP). A right heart percutaneous right heart ventricular assist (PVAD) is implanted emergently. The PVAD is maintained in place for prolonged hemodynamic support post procedure. Three days later, she has clinically improved with right ventricular recovery and decreased CVP. She remains stable during weaning of the PVAD and the device is removed successfully.

Description of Procedure (33997)

For venous approach devices, turn off the heart pump console.

Withdraw the left atrial catheter from the pulmonary artery and right ventricle, into the inferior vena cava and, once the activated clotting time (ACT) is reduced to less than 150 seconds, withdraw the device from the femoral vein under direct fluoroscopic or echocardiographic guidance. Apply prolonged manual compression to the exit site to achieve hemostasis. A deep skin suture may also be applied to the area around the cannulation site to enhance hemostasis. Record the patient's vital signs every hour until release to the step- down unit with checks of the groin by the nursing staff every hour for the next 4 hours then every 2 hours as directed.

Summary CMS Updates Coverage Policies

Artificial Hearts and Ventricular Assist Devices (VADs)

Effective Date December 1, 2020 – CMS finalized updates to Medicare coverage for artificial hearts and ventricular assist devices. Medicare will allow for more standard coverage determination process where coverage decisions are made by local Medicare Administrative Contractors (MACs.) Only a small number of Medicare patient's receive artificial hearts and the technology can help save lives for certain end stage heart failure patient's awaiting transplant. The final NCD also includes updated coverage criteria for VADs that better align with current medical practices which should expand coverage to reach a greater number of patients.

Here is the link for the final decision:

https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=298&type=Closed&bc=AIgAAAAACAAA&

Resources

- 2021 Medicare Physician Fee Schedule Final Rule

https://www.cms.gov/files/document/12120-pfs-final-rule.pdf

- Summary of 2021 MPFS Final Rule

https://www.cms.gov/files/document/mm12071.pdf

- Covered Telehealth Services for the COVID-19 PHE

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

- ICD-10-CM New COVID-19 Diagnoses

https://www.cdc.gov/nchs/icd/icd10cm.htm

https://www.cdc.gov/nchs/data/icd/Announcement-New-ICD-code-for-coronavirus-19-508.pdf

- CMS Updates Coverage Policies for Artificial Hearts and Ventricular Assist Devices (VADs) https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=298&type=Closed&bc=AIgAAAAACAAA&

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Q&A

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