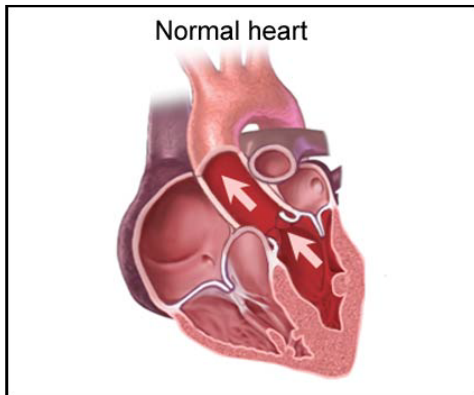


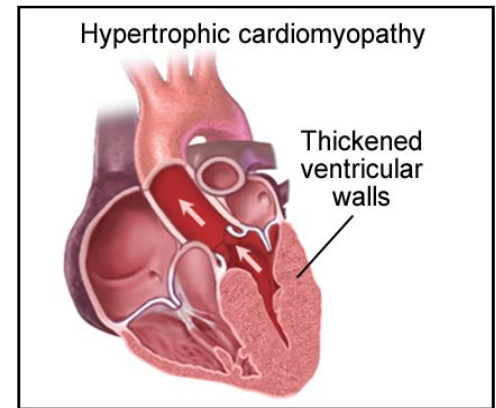
**Special Heart Failure Edition** December 2009, Volume 5, Issue 12



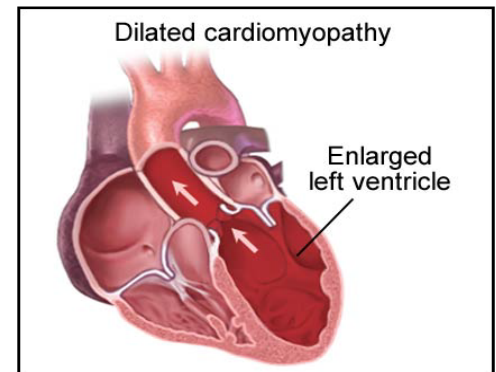
Heart failure can generically be thought of as the heart's failure to keep up with the body's demand for circulation. It is a condition that sets in over an extended period of time and is frequently triggered by damage to the heart muscle: coronary disease, hypertension, myocardial infarction, etc.

When the right side of the heart is impacted by heart failure it will fail to pump enough blood to the lungs for oxygenation and blood will back up in the venous system. This is commonly associated with peripheral edema and weight gain. When the left side of the heart is impacted, it will fail to pump enough oxygenated blood to the body and blood will back up in the lungs; this is referred to as pulmonary edema and is frequently associated with shortness of breath.

In some cases, patients will have left sided heart failure as a lone condition. However, as the



A Trigger for Diastolic Heart Failure



A Trigger for Systolic Heart Failure

(Next Pg.)

## Heart Failure Management (Physiologic Monitoring)

When managed effectively, many patients with heart failure can lead relatively normal lives. However, without diligent attention to diet, exercise, and medication compliance patients can trigger a downward spiral of conditions that frequently progresses to the point of hospital admission. In fact, heart failure is so prevalent that it is currently the number one cause of admission for all Medicare patients and it consumes approximately 46 cents of every Medicare dollar that is spent.

As a patient's chronic heart failure begins to exacerbate, certain physiologic variables (weight, blood pressure, respiratory rate, and lung water volume) will fluctuate. For example, at earliest onset of heart

(Continued on Page 3)

left side of the heart fails to keep up with circulatory demand and blood backs up in the lungs, it makes it much harder for the right side of the heart to pump blood into the lungs. This constant strain on the right side of the heart will frequently cause it to fail. Therefore, it is most common for patients to have a combination of left and right sided heart failure.

For those patients who have lone left sided heart failure, it would be most appropriate to report their condition with diagnosis code 428.1 (LEFT HEART FAILURE). However, in most cases, one of the other diagnosis codes from the 428.0 – 428.43 range would be more specific.

Perhaps the most generic appearing diagnosis code from this range of options is 428.0 (CONGESTIVE HEART FAILURE UNSPECIFIED). The word “congestive” presented at the beginning of this code definition simply means that blood is abnormally pooling somewhere in the patient’s body. Because abnormal pooling of blood is so closely linked to heart failure, many clinicians use the terms “heart failure” and “congestive heart failure” interchangeably.

With great emphasis on reporting conditions to the

ultimate level of specificity, it would seem logical that this generic appearing diagnosis code should be rarely used.

However, according to the ICD-9-CM Official Guidelines for Coding and Reporting, “More than one code from category 428 may be assigned if the patient has systolic or diastolic failure and congestive heart failure.” Therefore, it should be common for us to report code 428.0 in addition to a more specific heart failure diagnosis code when the patient’s heart failure is congestive in nature.

The specificity of heart failure diagnosis coding lies in how physicians classify the patient’s heart failure as being chronic, acute, systolic, and/or diastolic. Since effective circulation of blood requires all chambers of the heart to function appropriately, many patients will have a mix of these four qualifiers.

### **Acute vs. Chronic**

When first diagnosed with heart failure, a patient may present during an acute episode. This would be associated with specific signs and symptoms that present considerable discomfort to the patient. Once the patient is diagnosed with heart failure they will effectively carry the diagnosis for life.

If the patient is not having acute signs or symptoms, we should classify them as having chronic heart failure. When the patient’s heart failure exacerbates and causes acute signs/symptoms, they are classified as having chronic heart failure with an acute exacerbation. In diagnosis coding terms, this would be called “acute on chronic heart failure”. Because of the “fluid” (pun intended) nature of heart failure, it is not always accurate to carry forward the heart failure diagnosis code that was used during the patient’s last visit.

### **Systolic vs. Diastolic**

The systolic phase of the cardiac cycle is when the ventricles contract to squeeze blood out. The diastolic phase is when the ventricles expand to allow blood to flow into them. If the patient’s ventricles cannot effectively contract they are said to have systolic heart failure. This is what most of us naturally think of as heart failure because the heart is failing to contract effectively. You could accurately refer to systolic heart failure as being a weakened heart.

Up to half of all heart failure patients have diastolic heart failure; a condition in which the

heart chambers do not expand sufficiently to allow blood to flow in. You could refer to diastolic heart failure as being a stiff heart. The fact that the heart does not fully expand during the diastolic phase will substantially decrease cardiac output because there is not enough blood in the ventricle when the systolic phase begins.

Hospitalization rates and mortality among patients with diastolic and systolic heart failure are virtually identical.

A dozen diagnosis codes are available in the 428.20 – 428.43 range of diagnosis codes to classify the patient’s heart failure status as being: unspecified, acute, chronic, acute on chronic, systolic, diastolic, or combined (systolic & diastolic) in nature.

As you can see, accurate coding of this condition is dependent on physician

understanding of how the code structure classifies heart failure. Since physicians do not intuitively reference the patient’s heart failure as being “acute on chronic, systolic and diastolic” coding to the ultimate level of specificity is often a challenge. However, incorporating a grid of the available heart failure diagnosis codes into your charge

capture form (see example) will increase the probability of having accurate data at the time of charge entry.

<b>Heart Failure Diagnosis Codes</b>				
	Acute on			
	Chronic	Acute	Chronic	Unspec.
Systolic:	428.22	428.21	428.23	428.20
Diastolic:	428.32	428.31	428.33	428.30
Combined:	428.42	428.41	428.43	428.40

## Physiologic Monitoring Continued

failure exacerbation, fluid begins to pool in the patient’s lungs and lower extremities because the heart is not effectively keeping up with the circulatory demand. This accumulation of fluid triggers a sudden and significant increase in weight (example:5 pounds over night).

While these physiologic variables are accurate indicators of heart failure exacerbation, many patients are unaware of them until it is too late. Without appropriate care, patients frequently de-compensate during the 24 – 72 hour period following the earliest physiologic indicators of exacerbation.

Effective monitoring of these patients with constant, remote surveillance (93297 – professional component & 93299 – technical component) allows physicians to more effectively manage these patients, it generates considerable revenue for the physician, and it ultimately decreases the cost of providing care for these patients.

Many pacemakers and defibrillators can identify the earliest onset of heart failure exacerbation by using internal and/or external sensors that monitor physiologic data. Early awareness of heart failure exacerbation frequently allows the physician to manage the patient’s condition medically over the phone or in the office. Some

patients will still require hospital admission, but the length of stay and risk of re-admission in the immediate future is typically reduced with early detection of exacerbation.

The remote physiologic monitoring codes mentioned above were introduced with only limited guidance in CPT 2009. CPT indicated that the codes include physiologic monitoring for a span of 30 days, that we must perform at least one interrogation in the 30-day monitoring period, and that patients must be monitored for at least 10 days prior to billing for the 30-day monitoring period. No guidance was

offered regarding which date(s) of service to report for these 30-day monitoring periods: the first day of the period, the last day of the period, or one of the dates that an interrogation was performed.

Tremendous confusion has been created and perpetuated by the lack of clarification on issues such as the appropriate date of service for billing, the “contractor priced” reimbursement amount for code 93299 and the lack of clear coverage guidance for these services. Therefore, many physicians have been deterred from providing remote physiologic monitoring for patients who would clearly benefit from monitoring.

Before initiating a dialogue with CMS representatives about the issues causing confusion, I extensively researched the available publications specific to these codes. There were a handful of coverage policies which addressed the new services but none of them specified which date(s) of service should be reported on the claim form.

I then researched the available reporting instructions for the services which are most comparable to remote physiologic monitoring. Similar

to physiologic monitoring, Holter and event monitoring services involve monitoring remotely captured data for periods of time that span more than one calendar date: Holter monitoring typically spans a period of 24 hours over the course of two calendar days, event monitoring involves up to 30 days of monitoring. While the data monitored with Holter and event monitors is ECG derived and physiologic data is not ECG derived, obvious parallels exist between these services.

In side bars, I have excerpted two policies that addressed the date of service issue. The National Government Services event monitoring policy indicated that the “from” date on the claim form should be the start of the monitoring period

**Cigna Publication**, “For global tests only, e.g. Holter monitor that is billed with the global code only (for example, CPT code 93224), the date of service would be when the test was completed (i.e. interpreted). Whether a 24 hour Holter or 30 day cardiac event monitor, the date of service to report would be equal to the date the service as described by the code was completed.”

**National Government Services, Inc., Article ID Number: A45929** (Specific to 30 day Event recorders) “The service should be billed with the date the patient was hooked up to the monitor as the “from date” and the day the patient was disconnected as the “through date.””

and the “through” date should be the end of the monitoring period.

The Cigna policy indicates that the date the 30-day monitoring period is completed should be reported as the date of service.

In regards to the date of service that should be reported, these carriers are in direct conflict with each other.

The results of my research were shared with CMS representatives at the beginning of 2009. I requested clarification regarding which date of service physicians should report for 90-day remote device monitoring and for 30-day remote physiologic monitoring. The response received included the clarification that “In the absence of a national policy, physicians should follow the guidelines from their contractors.”

I then attempted to secure guidance from every Medicare contractor in an effort to provide definitive guidance to CardiologyCoder.Com members.

While many contractors responded to my inquiries, only two of them addressed

the question that was presented. In keeping with the previously summarized theme, the two responses I received were in direct conflict with each other:

and related services, we are retiring LCD L27533 with the May updates. Please watch our website for the notification of the retirement of this policy.”

most likely causing thousands of Medicare patients to experience heart failure exacerbations that could have been prevented or mitigated. I also stressed that the cost of caring for these patients, after they have these exacerbations, is increased.

**Pinnacle Business Solutions:**

“There are no published guidelines on which dates of service should be reported for the codes in question. However, our medical staff recommends using the beginning date as the date of service and enter the entire date span in the HAO record.”

**CIGNA:**

“The procedure codes in question should only be reported after the monitoring period is completed. Therefore, it is appropriate to submit the services using the last date of monitoring as the date of service. For example, a 30-day monitoring procedure begins on April 1, 2009, and ends on April 30, 2009. The date of service displayed on the claim should be April 30, 2009. Only one date of service should be entered. The service dates should not be spanned when entered on the claim.”

Noridian: forwarded their policy for 30 day, external event monitors (an unrelated service).

“WPS Medicare does not have any information published pertaining to guidance on what dates of service should be reported for these CPT codes.”

Trailblazer: “Services are billed to Medicare utilizing the date of service which they are performed.”

All of the other responses did not provide guidance specific to the issue. Following are representative excerpts:

“Palmetto GBA does not have a Local Coverage Determination (LCD) for these services. We suggest that you bill the services according to the rules and guidelines that are set forth by the American Medical Association in the Current Procedural Terminology (CPT) codebook.”

Highmark: “Due to the large number of new, more specific and complex CPT codes that have been developed for these

More recently I contacted a CMS official in follow-up to this effort. I pleaded for clarification on this issue by stressing that properly identifying the date of service is an important factor in generating and submitting accurate claims. I also illustrated how the lack of clarification on date of service reporting and the “contractor priced” reimbursement rate for the technical component of remote physiologic monitoring is deterring many practices from adopting remote monitoring. I stressed that the confusion perpetuated by these issues is

**My follow-up request to CMS illustrated how much of the confusion regarding coding and billing for these services could be eliminated with two efforts by CMS:**

- 1. Apply the guidance that CIGNA gave regarding the date of service (listed above) to all carriers.**
- 2. Set a national reimbursement rate for code 93299 at the same rate as code 93297.**

I also forwarded my request to the American College of Cardiology, the Heart Failure Society of America, and the Heart Rhythm Society with a request for support of the above two requests. No responses have been received from these societies.

However, Medicare provided the following response:

**“While we do not have a national policy on this, our sense is that the DOS should be the date of completion. If**

**the service is furnished for less than the specified time of the code descriptor then the time span should be indicated on the claims form.”**

In addition to the practicalities associated with tracking 30 day monitoring periods, the above CMS guidance effectively establishes the reporting methodology summarized in the side bar as

the optimal way to report physiologic monitoring:

Remote monitoring programs can typically run reports detailing every patient that is being monitored and when the most recent interrogation was performed. Integrating these reports into your charge capture efforts will eliminate the need to keep track of remote monitoring

interrogations in your practice management/billing system.

This charge capture approach will eliminate a tremendous amount of administrative burden, it will be accurate, and it will result in a definitive paper-trail illustrating compliance with the applicable reporting guidelines.

## Member Q & A

### Question:

Is it still acceptable for our general cardiologists to request internal consultations from their electrophysiology or peripheral vascular specialized partners?

### Answer:

It is acceptable to request internal consultations from physicians in these well-recognized sub-specialties of cardiology. However, for Medicare patients it will be necessary to report the consultations as new or established patient office visits rather than consultations when provided in the office setting. In the hospital setting, these consultations should be reported as initial inpatient care.

Since Medicare is no longer paying for consultative services we must report office-based

### Optimal Billing Methodology:

#### Remote Heart Failure Monitoring

- ◆ Consider your practice to be “on call” for the patient’s heart failure status all year long.
- ◆ Rather than reporting remote monitoring on the date that interrogations are performed, set twelve billing dates on your calendar that apply practice wide.
- ◆ The date of service for each 30-day monitoring period is the last day of the period.
- ◆ Within each of the 30-day periods you must perform at least one remote interrogation. However, if you perform more than one interrogation it does not impact billing; you still bill once at the end of each 30-day monitoring period.
- ◆ For newly enrolled patients, make sure that the patient was enrolled in your remote monitoring program for at least ten days prior to including them in the practice wide billing process.
- ◆ If newly enrolled patients are monitored for more than 10 days but less than 30 days, indicate the number of days that the patient was enrolled in remote monitoring in the comment section of your claim form (the electronic equivalent of box 19 from the CMS-1500).

consultative services as either new patient visits (99201 – 99205) or established patient office visits (99211 – 99215). According to the Medicare Carrier’s Manual, “Interpret the phrase “new patient” to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous 3 years.” Page 5 of AMA’s Professional Edition of CPT 2010 contains a “Decision Tree for New vs. Established Patients” which clarifies that if the receiving physician is in a different sub-specialty than the physician who sent the patient, then the receiving physician should report his/her care as a new patient visit rather than an established patient visit. Therefore, if the patient had not yet been seen by a different electrophysiologist or peripheral vascular specialist from the same group, in the last three years, the service should be reported as a new patient visit rather than an established patient visit.

Since some consultations will now be reported as established patient visits, physicians may consider creating an abbreviated follow-up visit note rather than a full consultative note. It is not advisable to follow different standards of documentation (or care) based on Medicare’s potentially temporary prohibition on consultation reimbursement.

Instead, I recommend that physicians continue requesting, rendering, and documenting consultations the same way they have for years; this is obviously in the best interest of patient care. To minimize this distraction from patient care I also recommend that physicians continue assigning consultative service codes at the time of service.

Coding staff can then cross-walk from the physician assigned consultative codes to the appropriate admission, subsequent hospital care, new patient office visit, or established patient office visit code based on current payer guidelines. I guarantee that these guidelines, and the payer mix that they apply to, will be in a state of flux at least into June of 2010 (probably longer unless physicians find a way to unite and present a unified message to CMS).

## It’s Time to Pull Out the Big Guns

I am at a stand-still with CMS trying to secure a set fee for the technical component of remote physiologic monitoring (CPT code 93299). CMS frequently defers to the specialty societies when it comes to pricing and coverage issues. The specialty societies have yet to respond to my requests as summarized in this newsletter.

If you agree that we need a set reimbursement rate for code 93299 please contact your specialty society today and encourage them to support my efforts. Failure to usher in these services will hurt financially and hinder care.

Thank you for your consideration of this request.

Jim Collins, CCC, CPC, CHCC  
President CardiologyCoder.Com



**Question:**

You said that the modifier 26 should be added whenever a device company representative performs a device interrogation/programming evaluation. For office based services this is pretty clear but what constitutes the technical portion of the new remote monitoring services?

**Answer:**

According to previously published guidelines from the Heart Rhythm Society, “The essential elements of the technical component for remote monitoring may consist of access and use of the network services to receive, review and/or manipulate transmitted device data. The physician or his/her staff is responsible for scheduling of device evaluations, printing, storing and maintaining patient device data.”

Effectively, if your staff logs onto the remote monitoring web site, downloads the data, and prepares it for physician review, you can bill for the technical portion of remote monitoring. Since most practices have internet access, it is really the standard of practice to have a practice employee manage remote monitoring services and to bill for both portions of the service: technical and professional.

**Question:**

What is the best way to bill an attempted pta of an occluded SFA. For example, peripheral angiograms are obtained which show an occluded SFA. Multiple catheters and wires are used and attempts made to cross the occlusion for 1 hr, but are unsuccessful, so procedure is terminated. I have been told that you can bill a reduced service modifier on a SFA PTA (35474-52), or is there a better way?

**Answer:**

For the aborted superficial femoral artery percutaneous angioplasty (SFA PTA), your claim would be dependent upon the operative report; the access site and the extent of vasculature that is visualized will impact coding. However, following are the two most common scenarios:

**Assuming a contralateral approach and a unilateral lower extremity study, I would code it as follows:**

36247 - Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family

75710-26-59 - Angiography, extremity, unilateral, radiological supervision and interpretation

35474-53-22 - Transluminal balloon angioplasty, percutaneous; femoral-popliteal

75962-26-53-22 - Transluminal balloon angioplasty, peripheral artery, radiological supervision and interpretation

**Assuming an ipsilateral Common Femoral approach and a unilateral lower extremity study, I'd code the following:**

36245 Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family

75710-26-59 - Angiography, extremity, unilateral, radiological supervision and interpretation

35474-53-22 - Transluminal balloon angioplasty, percutaneous; femoral-popliteal

The 53 modifier (on code 35474) accurately reports that the service was discontinued, the 22 modifier indicates that it was difficult. Both of these assertions should be clearly supported by the operative report in lay person terms. Best results..

are obtained when doctors have a separate paragraph titled "Complexities Associated With Case." In this section of the report, be very clear as to the difficulties of the case and avoid complex clinical jargon.

Most payers, including Medicare, will review the operative report before processing any claims with the 53 or 22 modifier. Record re requests are made on remittance notices; typically a \$0 payment for the line item will be accompanied by a remark code indicating that additional documentation is necessary to adjudicate the claim. This is the only request you will receive for the operative report. Make sure payment posters know how to effectively copy and return the operative report and a cover letter explaining the scenario and directing the payers attention to the "complexities" paragraph.

If your payers allow you to submit documentation at the time of billing it is ideal to take advantage of it. If you can get the supporting documentation to the payer concurrently with, or in advance of, claim submission you can effectively shave 45-60 days off of your accounts receivable time and reduce the risk of the claim falling through the cracks.

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