Billing and Coding Guidelines

Title
Billing and Coding Guidelines for Transthoracic Echocardiography TTE (CV-026)

Effective Date
03/25/2009

AMA CPT/ ADA CDT Copyright

Text
The information in this article is meant to be used in conjunction with the WPS Local Coverage Determination (LCD) for Transthoracic Echocardiography (TEE). This LCD (L28565) can be accessed on our contractor website at www.wpsmedicare.com or can be found on the Medicare Coverage Database at http://www.cms.gov/center/coverage.asp

Coding Information
1. Submission should include an ICD-9-CMcode as listed in the "ICD-9-CM Codes that Support Medical Necessity" and incorporate secondary diagnosis as instructed by ICD-9-CM.
2. Submissions with an ICD-9-CM code other that those in "ICD-9-CM Codes that Support Medical Necessity" will be denied.
3. National Correct Coding Initiative guidelines should be followed.
4. It is medically inappropriate, and contradicts CPT descriptors, to submit CPT 93306, 93307 or 93308, preformed in conjunction with CPT 93350, as 93350 includes a 93306, 93307 or 93308 service.
5. CPT codes 93014, 93041, 93306, 93307 and 93308 should not be submitted on the same date of service. These are inclusive and do not represent independently identifiable services on a common date of service.
6. All diagnosis should be coded to the highest level of specificity.
7. Clinical scenarios deviating from those outlined in "Indications and Limitations of Coverage and/or Medical Necessity" will be denied.
8. Claims with inadequate medical necessity documentation will be denied on review.
9. Examination frequency exceeding those outlined in "Indications and Limitations of Coverage and/or Medical Necessity" when contemporaneous medical records inadequately support medical necessity, will be denied on review.
10. Screening and/or routine interval examinations will be denied.
11. Examinations performed in close proximity to, or alternating with diagnostic testing providing analogous information, e.g., nuclear medicine studies, MRI and CT, will be denied on review. Patterns suggesting parallel or alternating testing will be subject to medical necessity review.
12. Submissions at variance with conditionals enumerated in "Coding Guidelines" and "Documentation Requirements" will be denied on review.
13. Submit services for the contrast material on the same claim or on the same date of service as the echocardiogram.

14. If using Q9955, Q9956, Q9957 or A9700 (supply of injectable contrast material for use in echocardiography, per study) identify the contrast agent in the narrative record of the electronic format. List the name of the contrast imaging agent, route of administration and dosage.
15. I.V. contrast agents are not indicated for all patients undergoing echocardiogram. Overutilization will be monitored.
16. Claims for contrast echocardiography must be supported by documentation that conventional studies were inconclusive and that there was a need for the contrast enhancement.
17. Stress echocardiography when performed as the only procedure should be reported using 93350 (C8928 for OPPS billing).
18. Effective 01/01/2009, when a stress echocardiography test is performed with continuous electrocardiographic monitoring, physician supervision, interpretation and report by the same physician, then the procedure should be reported using CPT code 93351 (C8930 for OPPS, with or without contrast).
19. Use CPT code 93352 to report the administration of contrast with a stress echocardiogram. (CPT codes 93350 or 93351) for Carrier or Part B claims only.

OPPS Instructions for Cardiac Echocardiography with Contrast

Hospitals are instructed to bill for echocardiograms with contrast using the applicable HCPCS code(s) included in table 14 below. Hospitals should also report the appropriate units of the HCPCS codes for the contrast agents used in the performance of the echocardiograms. Codes in Table 14 should be read as either with contrast studies or without followed by with contrast studies. CPT codes should be used for without contrast studies only. In the without contrast followed by with contrast case, hospitals should not bill the CPT code for a without contrast study in addition to the C-code when they provide a without contrast followed by with contrast study.

Table 14 – HCPCS Codes For Echocardiograms with Contrast

HCPCS	Long Descriptor
C8921	Transthoracic echocardiography with contrast for congenital cardiac anomalies; complete
C8922	Transthoracic echocardiography with contrast for congenital cardiac anomalies; follow-up or limited study
C8923	Transthoracic echocardiography with contrast, real-time with image documentation (2D) with or without M-mode recording; complete
C8924	Transthoracic echocardiography with contrast, real-time with image documentation (2D) with or without M-mode recording; follow-up or limited study
C8928	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report
C8929	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, complete with spectral doppler echocardiography, and with color flow doppler echocardiography
C8930	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode

	recording, when performed during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continous electrocardiographic monitoring, with physician supervision

For claims submitted to the Fiscal Intermediary or Part A MAC:
Hospitals are required to report HCPCS codes for all services paid under the OPPS.

HCPCS codes C8921, C8922, C8923, C8924, C8928, C8929 and C8930 should be used to report transthoracic echocardiography services by OPPS hospitals. **The contrast HCPCS Q-codes associated with these services should be reported separately.*

Notes
An asterisk (*) indicates a revision to that section of the article.

Italicized font – represents CMS national policy language/wording copied directly from CMS Manuals or CMS Transmittals. Carriers are prohibited from changing national policy language/wording. Providers, through their associations/societies, should contact CMS to request changes to national policy through the Medicare Coverage Policy Process at www.cms.gov/center/coverage.asp

Other Versions

Original Effective Date
03/25/2009

Publication Date
*08/01/2009, Article; 06/01/2009, Article; 02/01/2009

Revision Effective Date
07/16/2012

Revision History/Number/Explanation
06/01/2012 - This guideline is effective for J-8 providers in Michigan MAC B 07/16/12, Michigan MAC A 07/23/12, Indiana MAC A 07/23/12 and Indiana MAC B 08/20/12.

*10/01/2010, Reformatted (four).

10/01/2009, Deleted sentence that stated "Facilities billing the C codes described above should not bill separately for contrast agents (Q9955, Q9956 or Q9957)." Added sentence from MM5999, that states; *The contrast HCPCS Q-codes associated with these services should be reported separately* (three).

08/01/2009, Revised Coding and Billing Guidelines to include new for 2009 CPT codes 93351 and 93352, Addition of sentences 16, 17, 18 and 19 found in coding section above, addition of section titled **"**For claims submitted to the Fiscal Intermediary or Part A MAC" (two);

06/01/2009, Clarification of instructions for use of contrast agents Q9955, Q9956, Q9957 and A9700. Correction of Article Effective Date.