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Comments and Responses Regarding Draft Local Coverage Determination: Cardiac Catheterization and Coronary Angiography

As an important part of Medicare Local Coverage Determination (LCD) development, National Government Services solicits comments from the provider community and from members of the public who may be affected by or interested in our LCDs. The purpose of the advice and comment process is to gain the expertise and experience of those commenting.

We would like to thank those who suggested changes to the draft Cardiac Catheterization and Coronary Angiography LCD. The official notice period for the final LCD begins on April 15, 2009, and the final determination will become effective on July 1, 2009.

Comment: A commenter disagreed with the NGS coding guideline that it is inappropriate to bill HCPCS C1760 (percutaneous vascular closure device) with a cardiac catheterization procedure. She stated that Medicare encourages hospitals to bill the "N" status codes so that the true cost of the procedure is reported to calculate an accurate APC payment for the procedure to which the supply code is bundled.

Response: We appreciate this commenter's review of the LCD, and recommended correction to the coding instruction. The insertion of the percutaneous closure device (G0269) is a bundled service and not separately billable by the physician. However, this does not preclude the facility billing for the device on the UB-92 claim but as a non-reimbursable supply. We will revise the coding document accordingly.

Comment: A physician from the Indiana CAC stated that he reviewed the policy and found the changes in the LCD acceptable.

Response: We appreciate the participation and effort of the CAC representatives in reviewing these LCDs, and for their support of the process.

Comment: The cardiology representative to the New York Medical Society Interspecialty Committee stated that the LCD does not support an angiographer to make independent decisions if a secondary problem is discovered during a coronary angiogram. He maintained that by virtue of performing a cardiac catheterization the performing physician is now a consulting or treating physician and does not require a referral or order for performing additional tests and requested that extra-cardiac angiography not require an order from the referring physician. If the appropriate criteria for additional diagnostic testing are present before or emerge during the procedure (i.e. super high BP on meds etc) then the additional testing should be allowed as best care. If an angiographer was allowed to proceed with additional procedures/interventions without a second request from the primary physician, this would avoid a second stick or possible complications. This would require supporting documentation for the additional services. He did agree with NGS that a flush aortogram is during pullback of the catheter is a screening procedure and should not be covered.

A New York interventional cardiologist subsequently commented, "...if the appropriate criteria for additional diagnostic testing are present before or emerge during the procedure (i.e. super high BP on meds etc) then the testing should be allowed as best care (i.e. saving another stick). This needs careful documentation..."

Response: Diagnostic tests are a covered benefit under Medicare when ordered by a treating or consulting physician (or qualified non-physician practitioner) and the results are used in the management of the problem for which the test was performed (42CFR 410.32).

In the *Medicare Benefit Policy Manual (publication 100-2) Chapter 15, Section 80.6.1*, CMS clarifies the definition of a treating physician. *A "treating physician" is a physician, as defined in §1861(r) of the Social Security Act (the Act), who furnishes a consultation or treats a beneficiary for a specific medical problem, and who uses the results of a diagnostic test in the management of the beneficiary's specific medical problem....A radiologist performing a therapeutic interventional procedure is considered a treating physician. A radiologist performing a diagnostic interventional or diagnostic procedure is not considered a treating physician.*

Extracardiac angiography is reimbursable if the test is ordered by the physician referring the patient for the cardiac catheterization and there is a need for the information available for the test in the patient's care. The LCD requires that these tests would be reimbursable if there is documentation that it addresses a condition for which the patient would have undergone angiography even if the cardiac catheterization had not been performed at this time. This presumes that the treating/referring physician has anticipated using the results of these tests in the plan of care for the patient. There is no

substantial evidence that the repair of asymptomatic renal artery stenosis in patients without severe uncontrolled hypertension or progressive renal failure affects outcomes.

Comment: A commenter asked what is the least timeframe allowed on repeat angiography in staged procedures? Should there be restrictions and why? Another commenter responded that a two week minimum is reasonable as additional contrast loads in that time frame present a hazard. Obviously if symptoms drive it sooner and prior further revascularization is necessary then it should be allowed with appropriate documentation.

Response: The LCD does not restrict the interval between interventions performed as staged procedures. This is left to the discretion of the treating physician. It is frequently an option for physicians to perform interventional procedures at the time of diagnostic angiography. The LCD does require that physicians must include documentation of the medical decision making when interventional procedures are not performed during the same session as the diagnostic procedures.

In the absence of new signs or symptoms of change in a patient's cardiac status, it is probably not necessary to repeat diagnostic angiography within six months of a prior study. In those instances in which a diagnostic angiogram is followed by an interventional procedure at another time, any angiography occurring with the intervention is bundled into the intervention and is not separately reimbursable. Under such circumstances, repeat diagnostic studies would not be reimbursable.

In the absence of (1) signs or symptoms suggesting failure of previous intervention, or (2) a known adverse outcome or event having been recognized at the time of the previous intervention (e.g., coronary dissection), re-study of the vessel would be considered routine and not separately reimbursable.

Comment: One commenter noted that the LCD did not include indications and diagnosis coding supporting 93508 for coronary/bypass angiography without left heart catheterization.

Response: We inadvertently left this CPT code without identifying ICD-9 codes supporting its medical necessity. We believe that this code is only appropriately used when coronary or bypass angiography is performed and there is no indication for cardiac/aortic hemodynamic measurement or identification of ventricular or valve function or of intracardiac shunts. We will revise the LCD to include appropriate diagnosis codes.