QUARTERLY NEWSLETTER

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CERTIFIED INTERVENTIONAL CODERS (CIC) NEWSLETTER

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INSIDE THIS ISSUE:

REPEALED???
CMS DECIDES TO REPEAL THE CHANGE REGARDING MULTIPLE PROCEDURES IN THE SAME VESSEL

In October 2007, CMS revised the Correct Coding Initiative guidelines regarding multiple therapeutic interventional procedures performed in the same vessel.

This change created shockwaves throughout the interventional community. Earlier this year, several societies and organizations appealed to CMS to repeal this change for various reasons. One specific reason was based on the fact that the relative value units assigned to these procedures were built on a foundation of allowing separate procedures to be reported as had been the case since 1996.

When we contacted the CCI group earlier this year, we were told that CMS made the changes to be more consistent with guidelines for reporting other similar procedures when performed in conjunction with each other.

In August 2008, CMS responded to my email regarding the request for repeal. The response is excerpted below:

Dear Ms. Stanley:
I thank you for your email dated August 8, 2008 in which you comment about Chapter V (Surgery: Respiratory, Cardiovascular, Hemic and Lymphatic Systems), Section D (Cardiovascular System), Paragraph 16 of the National Correct Coding Initiative Policy Manual for Medicare Services, version 13.3 effective October 1, 2007 ("Manual"). We discussed your letter with CMS (Centers for Medicare and Medicaid Services) which owns NCCI and makes all decisions about its contents.

When NCCI was implemented by CMS in 1996, the Manual included a paragraph addressing performance of percutaneous angioplasty and percutaneous (or open) atherectomy in the same vessel at the same patient encounter. The paragraph stated that if a percutaneous angioplasty was followed by an atherectomy generally due to insufficient improvement in blood flow from the angioplasty alone in the same vessel at the same patient encounter only the atherectomy should be reported. Since its initial publication in 1996, no national healthcare organization or provider ever objected to this paragraph.

In 2007 the NCCI received an inquiry from a physician who teaches interventional vascular coding asking whether the same principle discussed in this paragraph applied to other interventional procedures also. After reviewing his request and other information in the Manual, CMS decided to revise the paragraph to clarify that the same principle applies to atherectomy, angioplasty, and stenting.

This paragraph in version 13.3 states:
"16. If an atherectomy fails to adequately improve blood flow and is followed by an angioplasty at the same site/vessel during the same patient encounter, only the successful angioplasty may be reported. Similarly if an angioplasty fails to adequately improve blood flow and is followed by an

(Continued on page 2)

Gary Burns will be holding one-day seminars across the country on interventional coding. The sessions are priced at $225.00 per person.

Check our website for a location near you. Contact Khalilah Ross for more information: 404-346-1900, ext. 219

(Continued from page 1)

atherectomy at the same site/vessel at the same patient encounter, only the successful atherectomy may be reported. If atherectomy and/or angioplasty fail to adequately improve blood flow and are followed by a stenting procedure at the same site/vessel during the same patient encounter, only the successful stenting procedure may be reported. These principles apply to percutaneous or open procedures."

As explained above, this paragraph replaced a paragraph that had been present in the Manual since 1996. CMS will temporarily rescind the new paragraph and replace it with the one originally published in 1996 which states:

"When percutaneous angioplasty of a vascular lesion is followed at the same session by a percutaneous or open atherectomy, generally due to insufficient improvement in vascular flow with angioplasty alone, only the most comprehensive atherectomy that was performed (generally the open procedure) is reported (see sequential procedure policy, Chapter I, Section M)."

This change will be retroactive to October 1, 2007. The original paragraph will appear in version 14.3 of the Manual scheduled for publication on October 1, 2008. The change will also occur in the online version of the Manual published on the CMS website as early as possible.

CMS remains concerned about this issue and has encouraged national healthcare organizations to work with other interested parties to address coding for reporting atherectomy, angioplasty, and stenting in noncoronary arteries.

CMS and we appreciate you writing us about this issue.

WHAT DOES THE CMS' REPEAL MEAN?

Essentially, CMS has removed the guideline that caused so much controversy. The ruling reverts back to the way it was prior to October 2007. At that time, the only guideline that addressed these interventions was this one:

"When percutaneous angioplasty of a vascular lesion is followed at the same session by a percutaneous or open atherectomy, generally due to insufficient improvement in vascular flow with angioplasty alone, only the most comprehensive atherectomy that was performed (generally the open procedure) is reported (see sequential procedure policy, Chapter I, Section M)."

For coding purposes, when angioplasty and atherectomy are performed on the same vessel, only atherectomy is reported.

When angioplasty and stenting are both performed on the same vessel, we will follow the rules that were in place prior to October 2007:

1. *Angioplasty when used as a method of stent deployment—do not separately report*
2. *Angioplasty to pre-dilate a vessel in order to facilitate stenting—do not separately report*
3. *Angioplasty when used to further expand a stent—do not separately report*
4. *Successful angioplasty performed , with a sub-optimal result, thereby necessitating stenting—both angioplasty and stenting are reported.*
5. *Angioplasty or stenting performed on a vessel, causing a dissection or other complication, thereby requiring additional therapeutic intervention, both interventions are reported.*

Because the ruling is retroactive to October 2007, there will be procedures that were performed that were not separately reported during this interim period. Providers will have to make a decision about re-billing these procedures. Keep in mind, that you cannot simply report all angioplasty procedures that were not reported during this period.

"I received your update about CMS repealing the ruling about angioplasties and stents, but I am still confused. Can you explain it for me?".

-Interventional Coder

Make certain, that any re-billed procedures meet the guidelines listed above. Specifically, the physician must document a sub-optimal result which necessitates stenting, in order to report the angioplasty procedure separately.

2009 CPT CODE CHANGES

Listed below are the new CPT codes that will be effective January 1, 2009. There were no major changes to the specialty of interventional radiology. All revised text changes are listed in bold print and underlined.

VASCULAR

34806 Transcatheter placement of wireless physiologic sensor in aneurysmal sac during endovascular repair, including radiological supervision and interpretation, instrument calibration, and collection of pressure data (List separately in addition to code for primary procedure)

35535 Bypass graft, with vein; hepatorenal

35570 Bypass graft, with vein; tibial-tibial, peroneal-tibial, or tibial/peroneal trunk-tibial

35633 Bypass graft, with other than vein; ilio-mesenteric

35634 Bypass graft, with other than vein; iliorenal

BIOPSIES

55706 Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance

NERVE

62267 Percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes

64455 Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's neuroma)

CARDIOVASCULAR CODE CHANGES

New Codes:

93279 Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; single lead pacemaker system

93280 Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; dual lead pacemaker system

93281 Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; multiple lead pacemaker system

93282 Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; single lead implantable cardioverter-defibrillator system

93283 Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; dual lead implantable cardioverter-defibrillator system

93284 Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; multiple lead implantable cardioverter-defibrillator system

93285 Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; implantable loop recorder system

93286 Peri-procedural device evaluation and programming of device system parameters before or after a surgery, procedure, or test with physician analysis, review and report; single, dual, or multiple lead pacemaker system

93287 Peri-procedural device evaluation and programming of device system parameters before or after a surgery, procedure, or test with physician analysis, review and report; single, dual, or multiple lead implantable cardioverter-defibrillator system

93288 Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead pacemaker system

93289 Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead implantable cardioverter-defibrillator system, including analysis of heart rhythm derived data elements

(Continued on page 9)

THE CERTIFIED INTERVENTIONAL CODER (CIC) CREDENTIAL IS BEING GRANDFATHERED INTO THE AAPCS NEW CIRCC CREDENTIAL

In 2001, Medical Asset Management, Inc. created a new coding credential for interventional radiology: Certified Interventional Coder (CIC). The creation of the certification came as a result of a request from a company that wanted to send their employees for training and wanted some indication of their proficiency in the specialty. They complained that they were sending their employees to different seminars, but when they came back, they had no idea how much they knew about coding this very complex specialty. They asked if we could test their employees and provide them with the feedback. So we set about crafting a curriculum and an examination to do just that.

In February 2001, the first one-week coding session was held and at the end of the session, each attendee was offered the proficiency examination. These individuals wanted credit for passing the examination, which had a passing mark of 80% (which at time was 10% higher than most coding credentials).

Over the past seven years, the certification has enjoyed a tremendous reputation. Many employers require the CIC certification for certain job positions. The individuals that passed this very rigorous examination have proudly worn their credential and received great respect for their efforts in this field.

It was never the intention of Medical Asset Management, Inc to become a credentialing company. The CIC designation continued to grow and with it came responsibilities to the members who achieved the designation. To support the members, the CIC newsletter was also created as a medium to communicate about the difficult coding issues facing this specialty. We are very pleased that our members have enjoyed success with the credential.

This summer, the AAPC announced that it was launching a new credential for the specialty of interventional and cardiovascular coding—CIRCC. Shortly thereafter, we met with Reed Pew, the president of the AAPC to discuss their new credential. As a result of our talks, we made the decision to discontinue our credential and support the new CIRCC credential.

What Happens Next?

In order to make a smooth transition, we are setting December 31, 2008 as the transition date. Therefore, we are encouraging all CICs to get their 2008 CEUs in before December 31st. All CICs that have met their 2008 CEU requirement of twelve CEUs (interventional only), will be transitioned to the AAPC's credential. Effective January 1, 2009, you will be able to start using the new credential. Each CIC in good standing will receive a letter from us and the AAPC explaining the process in detail.

Both Gary Burns and I will be on the curriculum team that evaluates and crafts future CIRCC examinations. Medical Asset Manaement, Inc. is one of three companies that have been selected to hold interventional training seminars and offer products that qualify for CIRCC continuing education credits.

The CIC credential will be suspended effective December 31, 2008. We are encouraging all CIC's to get their CEU's in before the end of the year. We plan to continue offering the CIC newsletter, but it will not be a part of the CIRCC membership fee.

CERTIFIED INTERVENTIONAL CODER (CIC) CREDENTIAL

CIRCC TRANSITION POLICY

October 1, 2008

Early this summer the American Academy of Professional Coders (AAPC) announced a beta test for a new interventional coding credential - Certified Interventional Radiology and Cardiovascular Coder ("CIRCC"). Upon hearing about this new certification, we met with the President of the AAPC, Reed Pew. During our meetings we discussed our existing credential (CIC) and the new CIRCC credential. As a result of these discussions, we decided to join forces with the AAPC and support one credential, the new CIRCC.

The American Academy of Professional Coders (AAPC) is the largest trade association for medical coders with more than 71,000 members worldwide.

What Does This Mean To The CIC Credential?

Medical Asset Management, Inc. as the owner of the CIC credential has agreed to suspend offering our credential. All current CIC members will be "grandfathered" into the CIRCC credential (if they choose to be). In order to be grandfathered, the member has to be in good standing with their CIC credential. If a CIC agrees to be grandfathered, they will need to become a member of the AAPC and comply with AAPC's ethics requirements.

Transition Details

CEUs

All CICs are required to obtain twelve (12.0) CEUs in the specialty of interventional coding each year. Since this transition is taking place at the end of this calendar year, all CEUs obtained toward this requirement will be applied to the CIC credential. You will not be required to obtain more credits than were anticipated for the 2008 period as a CIC holder.

The formal transition will take place on December 31, 2008. All CICs that have met their CEU requirement as of this date will be transitioned in good standing. Individuals that completed the One Week Intensive Course in 2008 (24.0 CEUs), have satisfied the CEU requirement for 2008.

What Happens on January 1, 2009?

On January 1, 2009, all CICs that are in good standing will become CIRCCs.

Effective January 1, 2009, each CIC that is transitioned to the CIRCC under this "grandfather arrangement" can begin to utilize the CIRCC credential. See attached letter from the AAPC for more details.

You will receive a certificate from the AAPC with the new credential.

We will utilize your CIC renewal date as your renewal date with the AAPC. For example, if your CIC membership is set to expire on 03/31/09, your renewal date with the AAPC will also be 03/31/09. At that time your CEUs for the AAPC will be pro-rated.

If CIRCC Is Your Only Credential with the AAPC

After obtaining the CIRCC certification, 18 CEUs are required annually to maintain your certification if the CIRCC certification is your only credential. Twelve (12) of the eighteen (18) CEUs must be in interventional radiology or cardiovascular coding.

How Does This Affect You?

If the CIRCC is your only credential with the APPC, your certification renewal date will be the same as your CIC renewal date. For the period between January 1, 2009 (your CIRCC transition date) and your CIC/CIRCC renewal date, you will be required to obtain 1.5 credits per month in CEUs, with 2/3 of the CEUs in interventional or cardiovascular coding. *All interventional seminars held by Medical Asset Management, Inc. are approved for CIRCC CEUs.*

(Continued on page 6)

(Continued from page 5)

If CIRCC Is Not Your Only Credential with the AAPC

If you hold any other AAPC certification on top of the CIRCC certification, twelve (12) CEUs are required annually to maintain your certification. All CEUs must be in interventional radiology or cardiovascular coding. *All interventional seminars held by Medical Asset Management, Inc. are approved for CIRCC CEUs.*

How does this affect you?

If the CIRCC is not your only credential with the APPC, your certification renewal date will be the same as your CIC renewal date. For the period between January 1, 2009 (your CIRCC transition date) and your CIC/CIRCC renewal date, you will be required to obtain 1.0 CEU per month in interventional or cardiovascular coding.

Here is Your Specific Information *(your individual letter that is mailed to your address will contain information related to your renewal date):*

According to our records, your renewal date for the CIC credential is _____. If the CIRCC will be your only credential through the AAPC, _ CEUs will be required for renewal of the CIRCC credential.

If the CIRCC is not your only credential through the AAPC, ___ CEUs will be required for renewal of the CIRCC credential.

CIC Newsletter

All current CIC's will continue to receive the CIC newsletter free of charge through the January 2009 edition.

What Should You Do Next?

As soon as you meet the 2008 CIC CEU requirement, please send this information to Khalilah Ross at Khalilah.ross@medicalassetmanagement.com or by fax to 404-759-2306. We encourage all CICs to get their CEUs in before December 31st. All CICs in good standing as of December 31, 2008 will be transitioned to the CIRCC with an effective date of January 1, 2009.

Please see attached letter from Reed Pew regarding the new CIRCC credential.

Belinda Stanley, CIC

CIC MEMBERSHIP REMINDER EFFECTIVE THROUGH DECEMBER 31, 2008

In order to qualify for transition to the CIRCC, you must do the following by December 31st:

Demonstrate that you have received a minimum of twelve (12) credit hours of instruction regarding interventional coding.

For individuals who attended the one-week intensive course after June 2007 have already satisfied their CEU requirement for this period. The course includes 25 hours of instruction (which exceeds the required 12 CEU minimum).

CEUs:

All CEU's must be received by December 31st. Cases are posted throughout the year to assist each CIC in attaining the minimum number of credits (12 CEUs). Evidence of CEU's not received by the end of this calendar year will affect your standing for conversion to the CIRCC credential.

What happens when your credentials lapse? **You must take the CIRCC examination in order to hold a valid interventional credential**.

Note: It is our intention for all current CIC's to maintain their certification. In support of this, we have crafted a fair and affordable process. As always, your feedback is appreciated.

CERTIFIED INTERVENTIONAL CODERS

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CIC Newsletter

This quarterly newsletter is made available to all certified interventional coders free of charge. The annual subscription can be purchased by non-certified interventional coders for a fee of $75.00 per year (electronic) and $125.00 (hard copy). For more information, visit our website at: www.medicalassetmanagement.com. Click on CIC Exam.

CIC Newsletter Editor:

The editor of the CIC Newsletter is Belinda Stanley, CPC, CIC. The purpose of the newsletter is to inform CIC's about specific issues related to interventional coding.

ASK BELINDA:

Q: Will the CICs have to retake the CIRCC examination in order to be grandfathered?

A. No, to be grandfathered means that your CIC credential will be converted to the CIRCC credential. If you CIC credential is in good standing on December 31st, and you are grandfathered, you will not have to be tested in order to receive the CIRCC credential in January 2009.

(Continued from page 3)

2009 CPT CODE CHANGES

93290 Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; implantable cardiovascular monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors

93291 Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; implantable loop recorder system, including heart rhythm derived data analysis

93292 Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; wearable defibrillator system

93293 Transtelephonic rhythm strip pacemaker evaluation(s) single, dual, or multiple lead pacemaker system, includes recording with and without magnet application with physician analysis, review and report(s), up to 90 days

93294 Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system with interim physician analysis, review(s) and report(s)

93295 Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead implantable cardioverter-defibrillator system with interim physician analysis, review(s) and report(s)

93296 Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system or implantable cardioverter-defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results

93297 Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, physician analysis, review(s) and report(s)

93298 Interrogation device evaluation(s), (remote) up to 30 days; implantable loop recorder system, including analysis of recorded heart rhythm data, physician analysis, review(s) and report(s)

93299 Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system or implantable loop recorder system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results

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

93307 Echocardiography, transthoracic, real-time with image documentation (2D), **includes** M-mode recording, **when performed**, complete, **without spectral or color Doppler echocardiography**

93308 Echocardiography, transthoracic, real-time with image documentation (2D), **includes** M-mode recording, when performed, follow-up or limited study

93350 Echocardiography, transthoracic, 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;

93351 Echocardiography, transthoracic, 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 continuous electrocardiographic monitoring, with physician supervision

93352 Use of echocardiographic contrast agent during stress echocardiography (List separately in addition to code for primary procedure)

CPT Codes 93727-93736, 93741-93744, 93760-93762 have been deleted.