PHYSICIAN BILLING CODES

Clinicians use Current Procedural Terminology (CPT[1]) codes to bill for procedures and services. Each CPT code is assigned unique relative value units (RVUs), which are used to determine payment by the Centers for Medicare & Medicaid Services (CMS). Some commonly billed CPT codes used to describe procedures related to Edwards Lifesciences' Critical Care technologies (e.g. Swan-Ganz catheter, FloTrac sensor, PreSep and PediaSat oximetry catheters) are listed below.[2] This list may not be comprehensive or complete. These procedures may be subject to the CMS multiple procedure reduction rule. When applicable, a payment reduction of 50% is applied to all payment amounts except the procedure with the greatest RVUs, which is paid at 100% unless exempt by CPT instructions or payer policy.

CPT Code	Description	Medicare National Average Physician Payment[3]
36555	Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age	$121
36556	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older	$125
36620	Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous	$53
93503	Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes	$132
99221	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.	$103
99222	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.	$138
99223	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s)	$205

CPT Code	Description	Medicare National Average Physician Payment[3]
99223 (cont.)	requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.	
99231	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.	$39
99232	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.	$73
99233	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.	$105
99291	Critical Care Evaluation and Management of the critically ill or critically injured, first 30-74 minutes	$226
99292	Critical Care Evaluation and Management of the critically ill or critically injured, each additional 30 minutes (List separately in addition to code for primary service)	$113

INPATIENT HOSPITAL BILLING CODES

Medicare inpatient hospital reimbursement is based upon the Medicare Severity-Diagnostic Related Group (MS-DRG) classification system, which assigns MS-DRGs based on ICD-9-CM diagnosis and procedure codes. The following codes generally describe procedures associated with the use of Edwards Lifesciences' Critical Care technologies.

ICD-9-CM Procedure Code[4]	Description
38.91	Arterial catheterization
38.93	Venous catheterization, not elsewhere classified
89.62	Central venous pressure monitoring
89.64	Pulmonary artery wedge monitoring
89.68	Monitoring of cardiac output by other technique

REVENUE CODES[5] AND HCPCS CODES

Revenue codes help hospitals categorize services provided by revenue center. Medicare utilizes revenue codes for cost reporting purposes. It may be appropriate for hospitals to capture the cost for some of Edwards Lifesciences' Critical Care technologies for payer reporting or cost accounting purposes as expenses within Revenue Code 0278 (Medical/Surgical – Other Implants) on the hospital's UB-04 billing form. C codes do not apply to inpatient surgical procedures, but should be added to the hospital's chargemaster to report device costs used in the outpatient setting. Medicare created C codes to track device cost information for future APC rate-setting purposes. No additional facility payment is associated with these codes. CMS may reject hospital claims if the appropriate code is not identified on the claim. C codes may not be recognized by commercial payers.

C Code	Description
C1751	Catheter, infusion, inserted peripherally, centrally or midline, other than hemodialysis
C1769	Guide wire
C1894	Sheath introducer, other than guiding, other than intracardiac electrophysiological, non-laser

DISCLAIMER

Reimbursement information provided by Edwards Lifesciences is gathered from third-party sources and is presented for informational purposes only. Edwards makes no representation, warranty or guarantee as to the timeliness, accuracy or completeness of the information and such information is not, and should not be construed as reimbursement, coding or legal advice. Any and all references to reimbursement codes are provided as examples only and are not intended to be a recommendation or advice as to the appropriate code for the a particular patient, diagnosis, product or procedure or a guarantee or promise of coverage or payment, nor does Edwards Lifesciences warranty that codes listed are appropriate in all related clinical scenarios. It is the responsibility of the provider to determine if coverage exists and what requirements are necessary for submitting a proper claim for reimbursement to a health plan or payer, including the appropriate code(s) for products provided or services rendered. Laws, regulations, and payer policies concerning reimbursement are complex and change frequently; service providers are responsible for all decisions relating to coding and reimbursement submissions. Medicare's Correct Coding Initiative and commercial payer policies are reviewed and updated several times each year. Accordingly, Edwards strongly recommends consultation with payers, reimbursement specialists and/or legal counsel regarding appropriate product or procedure codes, coverage, and reimbursement matters.

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[2] Not all codes provided are applicable for the clinical scenarios in which Edwards Lifesciences' Critical Care technologies are used. The provider is responsible for selecting the most appropriate code(s) for the patient's clinical presentation. When radiologic guidance is used for catheter placement, it may be appropriate to add applicable codes according to the service provided following correct coding guidelines. Services that are considered a component of another procedure may not always be coded and billed separately.

[3] For all Medicare Payments for physician, hospital outpatient, and ASC services, the multiple procedure reduction rule may apply. Consult with coding and billing staff, and payer policy for further guidance. National average Medicare payment is calculated using the Conversion Factor of $35.7547. It is likely that Congress will pass another temporary physician payment fix in order to avert the Sustainable Growth Rate (SGR) payment cut for when these rates expire on March 31, 2015. Federal Register Volume 79, Number 219, November 13, 2014. National average is based on factors such as geography, teaching vs. non-teaching hospital, rural vs. urban area, etc. and your payment may be different based on these factors. This payment will differ for commercial payers. Payments are effective January 1, 2015-March 31, 2015.

[4] International Classification of Diseases, 9th Revision, Clinical Modification 6th Edition, 2014 ICD-9-CM for hospitals, volume 1, 2 & 3.

[5] National Uniform Billing Committee, American Hospital Association.

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