Subcutaneous Cardiac Rhythm Monitor System

Remote Programming Billing Guide

For remote programming device evaluation of subcutaneous cardiac rhythm monitor (SCRM) system services, the use of an unlisted CPT® code is recommended. The current CPT code description for in-person programming device evaluation of SCRM contains terminology inconsistent with remote programming device evaluation services. In lieu of an appropriate code for remote programming device evaluation of SCRM services, the American Medical Association (AMA) recommends unlisted CPT codes for procedures or services without an appropriate CPT code classification.

- The use of an unlisted CPT code is not exclusive to remote programming device evaluation of SCRM services. All new and emerging technologies may be billed by reporting an “unlisted or non-specific” CPT code until a more specific code is established.

- There are no Relative Value Units (RVUs) assigned to unlisted codes; therefore, physicians generally select an existing procedure to use as a reference for benchmarking work and establishing charges for new procedures such as remote programming device evaluation of SCRM services.

- Listed below are possible CPT codes that could be used when reporting remote programming device evaluation of SCRM services performed by physicians during CY 2020. Boston Scientific strongly encourages providers to work with their local and regional payers to determine the most appropriate reporting requirements.

- There is associated Ambulatory Payment Classification (APC) payment with the above unlisted CPT code. Medicare assigns APCs based on clinical and resource similarities. In the case of unlisted codes payment may not be captured appropriately until these services move to a more defined coding classification for better tracking of resources.

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<thead>
<tr>
<th>Place of Service</th>
<th>CPT Code</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>Physician Office</td>
<td>93799</td>
<td>Unlisted cardiovascular service or procedure</td>
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<tr>
<td>Hospital Outpatient</td>
<td>93799</td>
<td>Unlisted cardiovascular service or procedure</td>
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Suggested Steps to Billing an Unlisted Code

1. Contact the Payer

It is important to contact the payer for appropriate billing instructions as commercial payers may have additional requirements for billing an unlisted code. Request a copy of all instructions in writing. Information may also be available on the payer’s website. Determine whether the claim and supporting documentation should be submitted electronically or by paper.

Some commercial payers may require prior authorization before performing a service associated with an unlisted code. Check the payer instructions for prior authorization requirements and follow the payer’s process if prior authorization is required.

2. Additional Documentation

Be prepared to submit supporting documentation from office notes, chart notes, or reports. The medical record must contain documentation to support medical necessity of the service. Clearly identify (such as by underlining or highlighting) the portion of the note or report that identifies the service associated with the unlisted code. Pertinent information should include:

- A clear description of the nature, extent, and need for the service
- Whether the procedure was performed with or independent from other services provided
- Any extenuating circumstances which may have complicated the service
- Time, effort, and equipment necessary to provide the service
- The number of times the service was provided

3. Determine Charges

Payers often determine the payment for unlisted codes by comparison to a similar service. Select an appropriate comparable service and CPT code. For example, CPT 93285 in-person programming device evaluation, may be used as a comparison service code. Gather the RVUs, charges and payment for the comparable service. Identify the differences between the comparable service and the service associated with the unlisted code that you have performed. Explain what makes the service similar work, more, or less difficult than the comparable service. Articulate the difference in work for the service associated with the unlisted code as a percentage increase or decrease of the work for the comparison service. Indicate the normal charge for the comparison service code and the charge for the unlisted code based on the percentage increase or decrease.

4. Submitting the Claim

For physician services, when an unlisted service or procedure code is reported, the Center for Medicare and Medicaid Services (CMS) requires that a concise description of the service or procedure be entered in Item 19 on the CMS-1500 claim form or electronic equivalent. Pertinent information includes a definition or description of the nature, extent, and need for the procedure and/or service, as well as the provider’s time, effort, and equipment necessary to provide the service. If the description does not fit in Item 19, an attachment describing the service or procedure shall be submitted with the claim. (Medicare Claims Processing Manual, Publication 100-04, Chapter 26)

Follow the payer’s instructions for submitting the claim and supporting documentation. Include a cover letter that outlines the service, rationale for reporting an unlisted code, medical necessity, and requested charges. Be prepared for payment delays due to more detailed review of the claim. Plan to appeal the payer’s decision if it is not in your favor.
Frequently Asked Questions for Understanding Unlisted Codes

Q: What is the best way to bill for a procedure when there is not a specific CPT code available?

A: According to the AMA CPT Editorial, providers should select the name of the procedure or service that accurately identifies the service performed. Do not select a CPT code that merely approximates the service provided. If no such specific code exists, then report the service using the appropriate unlisted procedure code. Any service or procedure should be adequately documented in the medical record. See AMA CPT Introduction, Instructions for Use of the CPT Codebook.

Q: How do I determine how much to “charge” for performing an unlisted procedure?

A: In general, providers may use reference procedures and/or building block method for establishing charges for new procedures. Often, providers will compare the amount of work, skill, intensity, and time that is required for a new procedure to another “similar” procedure that they are furnishing. Providers can compare and contrast the resources, including amount of time, skill and work to complete the new procedure to some of the existing procedures that they already perform. If no other procedure is similar, consider providing information about the most similar procedure but also how the procedures are different.

Q: What should I include on initial claim submission when there is no specific CPT code to describe the procedure?

A: When you submit the claim, you will need to submit an operative report and detailed letter of medical necessity. To expedite the claims process, consider including the following information:

- Patient’s primary diagnosis, including any prior treatments, medications or interventions related to his/her diagnosis
- Establish why the procedure was chosen and the medical justification for the procedure, including duration and severity of symptoms
- Difficulty of the procedure, including time involved and resources utilized
- Potential risks and complications involved if left untreated
- Notable findings during the procedure
- Other conditions for which the patient may be receiving treatment

Q: Should any other written documentation be included?

A: The physician should include:

- A brief cover letter that indicates they are not aware of a specific CPT code that adequately describes the procedure.
- A copy of the published clinical data on the procedure, supporting its safety and effectiveness in this patient population.
- Documentation to support coverage policy guidelines of the payer (if established)
- Request that the payer include the procedure in the list of covered procedures.

Q: Can I use modifiers with unlisted codes?

A: It is not appropriate to append any modifier to an unlisted code because modifiers are used to indicate that a service or procedure has been altered by some specific circumstance, but not changed in its definition or code. Unlisted codes do not describe a specific service; therefore, it is not necessary to utilize modifiers.
Coding Resources for Rhythm Management:

Reimbursement Help Desk:
CRM.Reimbursement@bsci.com
1-800-CARDIAC (227-3422) EXT. 24114

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Boston Scientific encourages providers to submit accurate and appropriate claims for services. It is always the provider's responsibility to determine medical necessity, the proper site for delivery of any services, and to submit appropriate codes, charges, and modifiers for services rendered.

It is also always the provider’s responsibility to understand and comply with Medicare national coverage determinations (NCD), Medicare local coverage determinations (LCD), and any other coverage requirements established by relevant payers which can be updated frequently. Boston Scientific recommends that you consult with your payers, reimbursement specialists, and/or legal counsel regarding coding, coverage, and reimbursement matters.

Boston Scientific does not promote the use of its products outside their FDA-approved label.

Payer policies will vary and should be verified prior to treatment for limitations on diagnosis, coding, or site of service requirements. The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. We recommend consulting your relevant manuals for appropriate coding options.

References
1. Medicare Claims Processing Manual, Publication 100-04, Chapter 26

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