## Reporting Transcatheter Aortic Valve Replacement (TAVR) Procedures in 2013

There are nine new CPT codes effective January 1, 2013, for reporting TAVR procedures. Five of these codes are Category I codes that define the approach and placement for the transcatheter valve, one is a Category III code that describes transapical placement of the valve, and the remaining three are add-on codes used to report cardiopulmonary bypass support if utilized during a case. The new codes and related values are as follows:

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>Global Period</th>
<th>Medicare National Total RVU</th>
<th>Medicare National Total Payment</th>
<th>Report with -62 modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>33361</td>
<td>Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach</td>
<td>000</td>
<td>39.75</td>
<td>$1,352.41</td>
<td>Yes</td>
</tr>
<tr>
<td>33362</td>
<td>open femoral artery approach</td>
<td>000</td>
<td>43.49</td>
<td>$1,479.66</td>
<td>Yes</td>
</tr>
<tr>
<td>33363</td>
<td>open axillary artery approach</td>
<td>000</td>
<td>45.03</td>
<td>$1,532.06</td>
<td>Yes</td>
</tr>
<tr>
<td>33364</td>
<td>open iliac artery approach</td>
<td>000</td>
<td>47.91</td>
<td>$1,630.04</td>
<td>Yes</td>
</tr>
<tr>
<td>33365</td>
<td>transaortic approach (eg, median sternotomy, mediastinotomy)</td>
<td>000</td>
<td>52.54</td>
<td>$1,787.57</td>
<td>Yes</td>
</tr>
<tr>
<td>0318T</td>
<td>Implantation of catheter-delivered prosthetic aortic heart valve, open thoracic approach (eg, transapical, other than transaortic)</td>
<td>Carrier Decision</td>
<td>Carrier Priced</td>
<td></td>
<td></td>
</tr>
<tr>
<td>+33367</td>
<td>cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels) (List separately in addition to code for primary procedure)</td>
<td>ZZZ</td>
<td>18.45</td>
<td>$627.72</td>
<td>No</td>
</tr>
<tr>
<td>+33368</td>
<td>cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels) (List separately in addition to code for primary procedure)</td>
<td>ZZZ</td>
<td>22.36</td>
<td>$760.75</td>
<td>No</td>
</tr>
<tr>
<td>+33369</td>
<td>cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery) (List separately in addition to code for primary procedure)</td>
<td>ZZZ</td>
<td>29.52</td>
<td>$1,004.36</td>
<td>No</td>
</tr>
</tbody>
</table>
To select the appropriate code, identify the approach used to deliver the aortic valve using the transcatheter technique. If cardiopulmonary bypass is utilized during the procedure, then you would select the correct method of bypass implemented (peripheral, open or percutaneous, or central) and report the corresponding add-on code in addition to the approach code used. For example, if the aortic valve was placed using a transcatheter technique via a transaortic approach and central arterial and venous cannulation was performed for cardiopulmonary bypass, you would report the following codes:

33365-62 (reported by both the cardiothoracic surgeon and the interventional cardiologist)
33369

When reporting the placement codes (33361 – 33365, 0318T) to Medicare, the following information must be included on the claim:

- Place of Service (POS) code - 21 (no other place of service will be recognized for these procedures)
- Modifier -62 (co-surgeons) must be appended to codes 33361 – 33365, 0318T (payment will be denied if submitted without the -62 modifier)
- Two physicians are required to perform the procedure: a cardiothoracic surgeon and an interventional cardiologist
- Modifier Q0 (zero) (Investigational clinical service provided in a clinical research study that is an approved clinical research study) must be appended to codes 33361 – 33365, 0318T
- Codes 33361 – 33365, 0318T should be reported with a secondary diagnosis of V70.7 - General Medical Examination > Examination Of Participant In Clinical Trial - Examination of participant or control in clinical research

Billing and Documentation Recommendations
For this series of codes, it is important that physicians pay attention to their documentation and the care leading up to the procedure.

As indicated in the National Coverage Determination (NCD), the decision to perform TAVR is based on the decision of the heart team, specifically independent face-to-face evaluation of the patient by two cardiothoracic surgeons to determine suitability for TAVR. This means that there should be two E&M services performed and billed by two independent cardiothoracic surgeons. In addition, these data must be reviewed by the heart team to make a final decision. This means that the second review cannot be done the day of the TAVR—both reviews must be done prior to the surgery with time for the heart team to review and make a decision based on the results.

There is nothing in the NCD that indicates that the cardiothoracic surgeons who evaluate the patient must be in different groups. However, if the cardiothoracic surgeons doing the evaluations are in the same group, each cardiothoracic surgeon must do them independently, with each dictating their findings and recommendations. If the two cardiothoracic surgeons that provide the review are in the same group, keep in mind that there are limitations to reporting multiple E/M services on the same day from the same group from the same specialty.

For the operative note for the services related to the joint approach and delivery of the valve, dictation should be provided in a joint manner—it is not necessary for one physician to report one aspect of the procedure and the other physician to report the rest. Rather, the dictation should reflect the complete procedure and the joint nature involved. So use language such as “Dr. X and I jointly performed the procedure and all its critical components” and terms like “we” instead of “I” when describing the detail of
the procedure. Don’t attribute any step to one or the other co-surgeons, such as “The aortic valve was
crossed with a guide wire and...”
This procedure is unique in that the collaborative approach should be documented to reflect the
complete involvement of both physicians throughout, not separating out the individual work performed
by each physician. It would be beneficial to coordinate the documentation of these procedures with the
cardiologist so that they are identical or closely resemble each other. The exception to this would be the
documentation provided for the cardiopulmonary bypass add-on codes (33367 – 33369), where it would
be appropriate for the cardiologist to dictate “Dr. X established cardiopulmonary bypass, the details of
which will appear in his/her note” and for the surgeon to dictate the detail.

Codes 33361 – 33365, 0138T include the following work, when it is performed:

- Percutaneous access
- Placing the access sheath
- Balloon aortic valvuloplasty
- Advancing the valve delivery system into position
- Repositioning the valve as needed
- Deploying the valve
- Temporary pacemaker insertion for rapid pacing (33210)
- Closure of the arteriotomy when performed. Codes 33361-33365, 0318T include open arterial or
  cardiac approach
- Angiography
- Radiological supervision, and interpretation performed to guide TAVR/TAVI (e.g., guiding valve
  placement, documenting completion of the intervention, assessing the vascular access site for
closure)
- The diagnostic left heart catheterization codes (93452, 93453, 93458-93461) and the
  supravalvular aortography code (93567) should not be used with TAVR/TAVI services (33361-
  33365, 0318T) to report:
  1. Contrast injections, angiography, roadmapping, and/or fluoroscopic guidance for the
     TAVR/TAVI;
  2. Aorta/left ventricular outflow tract measurement for the TAVR/TAVI; or
  3. Post-TAVR/TAVI aortic or left ventricular angiography, as this work is captured in the
     TAVR/TAVI services codes (33361-33365, 0318T).

Services that may be separately reported in addition to the TAVR codes, if applicable, include the
following:

- Diagnostic coronary angiography performed at the time of TAVR/TAVI may be separately
  reportable if:
  1. No prior catheter-based coronary angiography study is available and a full diagnostic study is
     performed, or
  2. A prior study is available, but as documented in the medical record:
     a. The patient’s condition with respect to the clinical indication has changed since the prior
        study, or
     b. There is inadequate visualization of the anatomy and/or pathology, or
     c. There is a clinical change during the procedure that requires new evaluation.
     d. For same session/same day diagnostic coronary angiography services, report the
        appropriate diagnostic cardiac catheterization code(s) appended with modifier 59
        indicating separate and distinct procedural service from TAVR/TAVI.
• Diagnostic coronary angiography performed at a separate session from an interventional procedure
• Other cardiac catheterization services when performed for diagnostic purposes not intrinsic to TAVR/TAVI
• Percutaneous coronary interventional procedures, when performed

Tip: These codes all have a 000 day global period, which means that all care provided after the day of the procedure is separately billable and documentation supporting the level of service must be provided for reimbursement.

Current FDA PMA Approval for Transfemoral TAVR
• Edwards SAPIEN™ Transcatheter Heart Valve, model 9000TFX, sizes 23 mm and 26 mm and accessories
• Indications:
  – Transfemoral delivery in patients with
    • Severe symptomatic native aortic valve stenosis who have been determined by a cardiac surgeon to be inoperable for open aortic valve replacement and in whom existing co-morbidities would not preclude the expected benefit from correction of the aortic stenosis by TAVR (effective Nov. 2, 2011).
    • Severe symptomatic calcified native aortic valve stenosis without severe aortic insufficiency and with ejection fraction > 20% who have been examined by a heart team including an experienced cardiac surgeon and a cardiologist and found to either be: (effective Oct. 19, 2012)
      – Inoperable and in whom existing co-morbidities would not preclude the expected benefit from correction of the aortic stenosis by TAVR, or
      – Be operative candidates for aortic valve replacement but who have a STS-predicted operative risk score ≥ 8% or are judged by the heart team to be at a ≥ 15% risk of mortality for surgical AVR.

Current FDA PMA Approval for Transapical TAVR
• Edwards SAPIEN™ Transcatheter Heart Valve, model 9000TFX, sizes 23 mm and 26 mm and accessories
• Indications:
  – Transapical delivery in patients with
    • Severe symptomatic calcified native aortic valve stenosis without severe aortic insufficiency and with ejection fraction > 20% who have been examined by a heart team including an experienced cardiac surgeon and a cardiologist and found to be operative candidates for AVR but who have a STS operative risk score ≥ 8% or are judged by the heart team to be at a ≥ 15% risk of mortality for surgical AVR.

NCD Coverage Criteria for TAVR Procedures as of January 7, 2013
CMS has published a National Coverage Decision (NCD) for TAVR – NCD 20.32. Transmittal 2628 was the updated communication to the payers updating coverage criteria for 2013. Medlearn Matters has also published an educational article for reporting the new TAVR procedures.

The NCD outlines specific criteria that must be met to receive reimbursement for TAVR, which is covered under Coverage with Evidence Development (CED). The following provides a summary of the NCD criteria.

A. TAVR is covered for the treatment of symptomatic aortic valve stenosis when furnished according to a Food and Drug Administration (FDA)-approved indication and when all of the following conditions are met:

1. A complete system that has received FDA PMA for that system's FDA-approved indication is used.

2. Two cardiac surgeons have independently examined the patient face-to-face and evaluated the patient’s suitability for open AVR surgery; rationale is documented by both and available to the heart team.

3. The patient is managed pre- and post-operatively under the care of a heart team.

4. The procedure is furnished in a hospital with appropriate infrastructure. Hospital infrastructure requirements include, but are not limited to:
   - Onsite heart valve surgery program;
   - Cardiac cath lab or hybrid OR/cath lab equipped with a fixed radiographic imaging system with flat-panel fluoroscopy, quality imaging;
   - Non-invasive imaging (e.g., echo, vascular US, CT, MR)
   - Sufficient space in sterile environment to accommodate equipment and cases without complications;
   - Post-procedure intensive care facility with personnel experienced in managing patients with open heart valve procedures; and
   - Appropriate volume requirements per applicable qualifications.

The NCD also includes two sets of qualifications that the hospital must meet: one for hospital programs and heart teams without previous TAVR experience, and the other for those with TAVR experience. See the NCD for the specific qualifications for each.

5. The heart team’s interventional cardiologist(s) and cardiac surgeon(s) must jointly participate in the intra-operative technical aspects of TAVR.

6. The heart team and hospital must be participating in a prospective, national, audited registry. Currently, the only approved registry is the STS/ACC Transcatheter Valve Therapy (TVT) Registry.

B. TAVR is also covered for uses that are not expressly listed as an FDA-approved indication when performed within a clinical study that fulfills specific criteria. See the NCD for the detailed criteria. Two of the criteria included in this portion of the coverage are 1) that the heart team’s interventional cardiologist(s) and cardiac surgeon(s) still must jointly participate in the intra-operative technical aspects of TAVR, and 2) approved studies will be identified on the CMS Website at www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/Transcatheter-Aortic-Valve-Replacement-TAVR-.html.
The current CMS-approved TAVR Clinical Studies include the following:

- PARTNER II Trial (Placement of AoRTic TraNscathetER Valves Trial II); Edwards Lifesciences
- Medtronic CoreValve U.S. Pivotal Trial; Medtronic
- Medtronic CoreValve Continued Access Study; Medtronic
- Medtronic CoreValve Expanded Use Study; Medtronic
- Medtronic CoreValve Surgical Replacement and Transcatheter Aortic Valve Implantation (SURTAVI); Medtronic

For 2012, procedures were reported using Category III codes. The initial effective date of the NCD was May 1, 2012, so coverage prior to that date was applicable on a payer-by-payer basis.

The 2012 CPT codes are as follows:

- 0256T – Implantation of catheter-delivered prosthetic aortic heart valve; endovascular approach
- 0257T – open thoracic approach (eg, transapical, transventricular)
- 0258T – Transthoracic cardiac exposure (eg, sternotomy, thoracotomy, subxiphoid) for catheter-delivered aortic valve replacement; without cardiopulmonary bypass
- 0259T – with cardiopulmonary bypass

The same reporting criteria required for 2013 also applied to the 2012 Category III codes:

- Place of Service (POS) code - 21 (no other place of service will be recognized for these procedures)
- Modifier -62 must be appended to codes 0256T or 0257T (codes will be denied if submitted without the -62 modifier)
- Two physicians are required to perform the procedure: a cardiothoracic surgeon and an interventional cardiologist
- For TAVR services provided as part of a clinical trial, report with modifier Q0 (zero) - Investigational clinical service provided in a clinical research study that is an approved clinical research study
- For TAVR services provided as part of a clinical trial, report with a secondary diagnosis of V70.7 - General Medical Examination > Examination Of Participant In Clinical Trial - Examination of participant or control in clinical research

If you have additional questions on reporting TAVR in 2013, please contact Julie Painter at jpainter@physiciancoding.com or (303) 209-7357.

The material presented here is, to the best of our knowledge, accurate and factual to date. The information and suggestions are provided as guidelines for coding and reimbursement, however, and should not be construed as organizational policy. The Society of Thoracic Surgeons disclaims any responsibility for the consequences of actions taken, based on the information presented in the Coding & Reimbursement Corner section of this website.

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