Catheter Ablation and Related Procedures

Frequently Used CPT® Codes – Hospital Outpatient and Physician Services

Hospital Name ______________________ Procedure Date ______________________

Physician Name ______________________ Physician Signature ______________________

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EP Study

COMPREHENSIVE

_____ 93619 Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording, including insertion and repositioning of multiple electrode catheters, without induction or attempted induction of arrhythmia (Do not report in conjunction with 93600, 93602, 93610, 93612, 93618, or 93620-93622)

_____ 93620 Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording (Do not report in conjunction with 93600, 93602, 93610, 93612, 93618 or 93619)

_____ +93621 with left atrial pacing and recording from coronary sinus or left atrium (List separately in addition to code for primary procedure) (Use in conjunction with 93620)

_____ +93622 with left ventricular pacing and recording (List separately in addition to code for primary procedure) (Use in conjunction with 93620)

_____ +93623 Programmed stimulation and pacing after intravenous drug infusion (List separately in addition to code for primary procedure) (Use in conjunction with 93619, 93620)

_____ 93624 Electrophysiologic follow-up study with pacing and recording to test effectiveness of therapy, including induction or attempted induction of arrhythmia

LIMITED

_____ 93600 Bundle of His recording
_____ 93602 Intra-atrial recording
_____ 93603 Right ventricular recording
_____ 93610 Intra-atrial pacing
_____ 93612 Intraventricular pacing

Note: Because arrhythmia induction occurs via the same catheter(s) inserted for the electrophysiologic study(ies), catheter insertion and temporary pacemaker codes are not additionally reported.

Mapping

_____ +93609 Intraventricular and/or intra-atrial mapping of tachycardia site(s) with catheter manipulation to record from multiple sites to identify origin of tachycardia (List separately in addition to code for primary procedure) (Use in conjunction with 93620, 93651, 93652) (Do not report in addition to 93613)

_____ +93613 Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure) (Use in conjunction with 93620, 93651, 93652) (Do not report in addition to 93609)

Intracardiac Catheter Ablation Procedures

_____ 93650 Intracardiac catheter ablation of atrioventricular node function, atrioventricular conduction for creation of complete heart block, with or without temporary pacemaker placement

_____ 93651 Intracardiac catheter ablation of arrhythmogenic focus; for treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathways, accessory atrioventricular connections or other atrial foci, singly or in combination

_____ 93652 Intracardiac catheter ablation of arrhythmogenic focus; for treatment of ventricular tachycardia

Note: CPT 93651 and 93652 should be reported once regardless of the number of arrhythmias ablated. When a transseptal approach is used, append modifier -22 (Unusual procedural services).

Echocardiography

_____ +93662 Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure) (Use in conjunction with 92987, 93527, 93532, 93580, 93581, 93621, 93622, 93651, or 93652, as appropriate) (Do not report 92961 in addition to 93662)

Imaging Services

_____ 76377 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; requiring image postprocessing on an independent workstation (Use in conjunction with code[s] for base imaging procedure[s])

Note: Do not report separately with CTA or MRA procedures.

Add-on Codes

Add-on codes are always performed in addition to the primary service or procedure and must never be reported as a stand-alone code. These codes are designated with the symbol +.

Modifiers

Providers can indicate that a service or procedure has been altered by a specific circumstance but has not changed in its definition or code. For example, modifiers may be used to report:

- multiple procedures performed at the same session by the same provider (-51)
- that a portion of a service or procedure is reduced or eliminated at the physician's discretion (-52)
- that a procedure was discontinued (-53 for physician reporting; -73 or -74 for hospital reporting)
- that the service provided was greater than that usually required for the listed procedure (-22)

Consult the current CPT and/or HCPCS manual for a complete listing of modifiers, their definitions and guidelines.

References

American Medical Association. Current Procedural Terminology (CPT) 2009. Professional Edition. Chicago, IL: 2008.

Disclaimer

This information is provided to assist the recipient to understand the alternative codes and payment amounts that may be available when St. Jude Medical products are used. Note that codes, coverage, and payment can vary from setting to setting, and from insurer to insurer. This information does not guarantee that use of any particular codes will result in coverage or payment at any specific level. Insurers make reimbursement decisions according to the insurer's evaluation of the patient's medical needs. The hospital and physician should select the code or codes that most accurately describe the patient's conditions and the procedures performed and products used. The recipient should fully comply with the insurer requirements in submitting claims.

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