Cardiovascular CPT® Coding Update
2015

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CPT® Symbol Table

▲ Revised code
- New code
► Contains new or revised text
# Resequenced code
+ Add-on Code
Evaluation and Management

Code Changes

Care Management Services

Care Management Services for 2015 include:
• One new code
• Two revised codes
• New Introductory Language

These codes are reported only once per calendar month and may only be reported by the single physician or other qualified health care professional who assumes the care management role.
Chronic Care Management (CCM)

- **99490** – Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:
  - Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
  - Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
  - Comprehensive care plan established, implemented, revised, or monitored.

Complex Chronic Care Management Services Revised Codes

▲ **99487** – Complex chronic care management services, with the following required elements:
  - multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
  - Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
  - Establishment or substantial revision of a comprehensive care plan;
  - Moderate or high complexity medical decision making;
  - 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

▲ **+99489** - each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)
## Example

<table>
<thead>
<tr>
<th>Total Duration of Staff Care Management Services</th>
<th>Complex Chronic Care Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 60 Minutes</td>
<td>Not reported separately</td>
</tr>
<tr>
<td>60 to 89 minutes</td>
<td>99487</td>
</tr>
<tr>
<td>90 – 119 minutes</td>
<td>99487 and 99489</td>
</tr>
<tr>
<td>120 minutes</td>
<td>99487 and 99489 x 2 (and 99489 for each additional 30 minutes)</td>
</tr>
</tbody>
</table>

## Advanced Care Planning

- **99497** – Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
- **99498** - each additional 30 minutes

(List separately in addition to code form primary procedure)
Surgery Section
Cardiovascular

Pacemaker/Implantable Defibrillator Revisions ▲

CPT® codes
• 33215 – 33220,
• 33223 – 33225,
• 33240 – 33264,
• 33243 - 33249 (#)

Revisions were made to the phrase *pacing cardioverter-defibrillator*.
The new language is *implantable defibrillator*. 
Implantable Defibrillator

Two general categories of implantable defibrillators exist:
1. Transvenous implantable pacing cardioverter-defibrillator Subcutaneous implantable defibrillator

The following new codes for Subcutaneous Implantable Defibrillator use a single subcutaneous electrode to treat ventricular tachyarrhythmias.

Subcutaneous Implantable Defibrillator Codes

• **33270** – Insertion or replacement of permanent subcutaneous implantable defibrillator system, with subcutaneous electrode, including defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters, when performed
• **33271** – *Insertion* of subcutaneous implantable defibrillator electrode

• **33272** – *Removal* of subcutaneous implantable defibrillator electrode

• **33273** – Repositioning of previously implantable defibrillator electrode

Subcutaneous implantable defibrillators differ from transvenous implantable pacing cardioverter-defibrillators in that subcutaneous defibrillators do not provide antitachycardia pacing or chronic pacing.
Changes

Defibrillator threshold testing (DFT) during ICD insertion or replacement may be separately reportable. DFT testing during subcutaneous implantable defibrillator system insertion is not separately reportable.

Transcatheter Mitral Valve Repair (TMVR)

• **33418** – Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis

  + • **33419** - additional prosthesis(es) during same session (List separately in addition to code for primary procedure)
**Coding Guidelines**

- Codes 33418 and 33419 are used to report TMVR. Code 33419 should only be reported once per session.

- Codes 33418 and 33419 include the work, when performed, of percutaneous access, placing the access sheath, transseptal puncture, advancing the repair device delivery system into position, repositioning the device as needed, and deploying the device(s).

- Angiography, radiological supervision, and interpretation performed to guide TMVR (e.g., guiding device placement and documenting completion of the intervention) are included in these codes.

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**Extracorporeal Membrane Oxygenation (ECMO) or Extracorporeal Life Support Services (ECLS)**

*CPT® Guidelines*

There are two methods:

1. **Veno-arterial**
   - Supports both the heart and lungs.
   - Requires two cannula(e)
     - one in a large vein
     - one in a large artery.

2. **Veno-venous**
   - Support lung only
   - Requires one or two cannula(e)
     - placed in a vein
• Services directly related to the ECMO/ECLS
  – Cannulation
  – Cannula management - repositioning, removal, or adding cannula(e)
  – Initiation of the circuit
  – Daily Management of the circuit
  – Decannulation
  – Daily overall management of the patient

The daily overall management of the patient is a factor that will vary greatly depending on the patient’s age, disease process, and condition.

ECMO Codes

• Initiation
• Daily Management
• Cannulation (Further defined by age)
  – Insertion
  – Repositioning
  – Removal
Reporting Guidelines

- Repositioning of the ECMO/ECLS cannula(e) at the same session as insertion is not separately reportable
- Replacement of ECMO/ECLS cannula(e) in the same vessel should only be reported using the insertion code
- If cannula(e) are removed from one vessel and new cannula(e) are placed in a different vessel, report the appropriate cannula(e) removal and insertion codes

- Extensive repair or replacement of an artery may be additionally reported
- Fluoroscopic guidance used for cannula(e) repositioning is included in the procedure when performed and should not be separately reported
- If provided, the same physician may report the appropriate codes for the services they performed
  - Cannula insertion
  - ECMO/ECLS initiation
  - Overall patient management
• If different physicians provide parts of the service, each physician may report the correct code(s) for the service(s) they provided, except as noted
  – Daily Management may not be reported same day as initiation
  – Repositioning may not be reported the same day as initiation

Initiation

• **33946** - Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-venous

• **33947** - initiation, veno-arterial
Daily Management

- **33948** - daily management, each day, veno-venous
- **33949** - daily management, each day, veno-arterial

Cannula Insertion
(Birth – 5 years)

- **33951** insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)
- **33953** insertion of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age
- **33955** insertion of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age
Cannula Insertion
(6 years +)

- 33952 insertion of peripheral (arterial and/or venous) cannula(e), **percutaneous**, 6 years and older (includes fluoroscopic guidance, when performed)
- 33954 insertion of peripheral (arterial and/or venous) cannula(e), **open**, 6 years and older
- 33956 insertion of central cannula(e) by sternotomy or thoracotomy, 6 years and older

Cannula Repositioning
(Birth – 5 years)

- 33957 reposition peripheral (arterial and/or venous) cannula(e), **percutaneous**, birth through 5 years of age (includes fluoroscopic guidance, when performed)
- 33959 reposition peripheral (arterial and/or venous) cannula(e), **open**, birth through 5 years of age (includes fluoroscopic guidance, when performed)
- # 33963 reposition of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age (includes fluoroscopic guidance, when performed)
## Cannula Repositioning
(6 years+)

- **33958** reposition peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed)
- **33962** reposition peripheral (arterial and/or venous) cannula(e), open, 6 years and older (includes fluoroscopic guidance, when performed)
- **33964** reposition central cannula(e) by sternotomy or thoracotomy, 6 years and older (includes fluoroscopic guidance, when performed)

## Cannula Removal
(Birth – 5 years)

- **33965** removal of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age
- **33969** removal of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age
- **33985** removal of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age
Cannula Removal
(6 years+)

• 33966 removal of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older

• 33984 removal of peripheral (arterial and/or venous) cannula(e), open, 6 years and older

• 33986 removal of central cannula(e) by sternotomy or thoracotomy, 6 years and older

Add-On Code

• +33987 - Arterial exposure with creation of graft conduit (eg, chimney graft) to facilitate arterial perfusion for ECMO/ECLS (List separately in addition to code for primary procedure)

(Use 33987 in conjunction with 33953, 33954, 33955, 33956)
Deleted ECMO Codes

33960 - Prolonged extracorporeal circulation for cardiopulmonary insufficiency; initial day

33961 - each subsequent day

36822 - Insertion of cannula(s) for prolonged extracorporeal circulation for cardiopulmonary insufficiency (ECMO) (separate procedure)

Left Heart Vent Codes

# • 33988 - Insertion of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS

# • 33989 - Removal of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS
Fenestrated Endovascular Repair of the Visceral and Infrarenal Aorta

- **34839** – Physician Planning of a patient-specific fenestrated visceral aortic endograft requiring a minimum of 90 minutes of physician time.

Code 34839 is used to report the physician planning and sizing for a patient-specific fenestrated visceral aortic endograft. The planning includes review of high resolution cross-sectional images (eg, CT, CTA, MRI) and utilization of 3D software for iterative modeling of the aorta and device in multiplanar views and center line of flow analysis. Code 34839 may only be reported when the physician spends a minimum of 90 total minutes performing patient-specific fenestrated endograft planning. Physician planning time does not need to be continuous and should be clearly documented in the patient record. Code 34839 is reported on the date that planning work is complete and may not include time spent on the day before or the day of the fenestrated endovascular repair procedure (34841, 34842, 34843, 34844, 34845, 34846, 34847, 34848) nor be reported on the day before or the day of the fenestrated endovascular repair procedure.
Cervicocerebral Arteries
Addition to the Introductory Language

► Code 36228 is an add-on code to report unilateral selective arterial catheter placement and diagnostic imaging of the initial and each additional intracranial branch of the internal carotid or vertebral arteries. Code 36228 is reported in conjunction with 36223, 36224, 36225 or 36226. This includes any additional second or third order catheter selective placement in the same primary branch of the internal carotid, vertebral, or basilar artery and includes all the work of accessing the additional vessel, placement of catheter(s), contrast injection(s), fluoroscopy, radiological supervision and interpretation. It is not reported more than twice per side, regardless of the number of additional branches selectively catheterized.

► Do not report 36218 or 75774 as part of diagnostic angiography of the extracranial and intracranial cervicocerebral vessels. It may be appropriate to report 36218 and 75774 for diagnostic angiography of upper extremities and other vascular beds of the neck and/or shoulder girdle performed in the same session as vertebral angiography (e.g., workup of a neck tumor that requires catheterization and angiography of the vertebral artery as well as other brachiocephalic arteries).
Revisions to the Transcatheter Placement of Intravascular Stent Codes

▲37215 - Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection

▲ 37216 - without distal embolic protection

▲37217 - Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery by retrograde treatment, open ipsilateral cervical carotid artery exposure, including angioplasty, when performed, and radiological supervision and interpretation

•(For open or percutaneous transcatheter placement of intravascular cervical carotid artery stent[s], see 37215, 37216) •

•(For open or percutaneous antegrade transcatheter placement of innominate and/or intrathoracic carotid artery stent[s], use 37218) •

•(For open or percutaneous transcatheter placement of extracranial vertebral artery stent[s], see 0075T, 0076T) •
New Transcatheter placement of Intravascular Stent

- **37218** - Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery, open or percutaneous antegrade approach, including angioplasty, when performed, and radiological supervision and interpretation.

**(37218 includes all ipsilateral extracranial intrathoracic selective innominate and carotid catheterization, all diagnostic imaging for ipsilateral extracranial intrathoracic innominate and/or carotid artery stenting, and all related radiologic supervision and interpretation. Report 37218 when the ipsilateral extracranial intrathoracic carotid arteriogram (including imaging and selective catheterization) confirms the need for stenting. If stenting is not indicated, report the appropriate codes for selective catheterization and imaging)**

**(Do not report 37218 in conjunction with 36222, 36223, 36224 for the treated carotid artery)**

**(For open or percutaneous transcatheter placement of intravascular cervical carotid artery stent[s], see 37215, 37216)**

**(For open or percutaneous transcatheter placement of extracranial vertebral artery stent[s], see 0075T, 0076T)**

**(For transcatheter placement of intracranial stent[s], use 61635)**
- Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery

Each additional artery (List separately in addition to code for primary procedure)

- (For stent placement(s) in iliac, femoral, popliteal, or tibial/peroneal artery(s) for occlusive disease, see 37221, 37223, 37226, 37227, 37230, 37231, 37234, 37235)

- (For open or percutaneous antegrade transcatheter placement of intrathoracic carotid/innominate artery stent(s), use 37218)

- (For open or percutaneous transcatheter placement of extracranial vertebral artery stent(s), see Category III codes 0075T, 0076T)

Introductory Language Addition

Codes 37236-37239 are used to report endovascular revascularization for vessels other than lower extremity artery(s) for occlusive disease (ie, 37221, 37223, 37226, 37227, 37230, 37231, 37234, 37235), cervical carotid (ie, 37215, 37216), intracranial (ie, 61635), intracoronary (ie, 92928, 92929, 92933, 92934, 92937, 92938, 92941, 92943, 92944), innominate and/or intrathoracic carotid artery through an antegrade approach (37218), extracranial vertebral (ie, 0075T, 0076T) performed percutaneously and/or through an open surgical exposure, or open retrograde intrathoracic common carotid or innominate (37217).
Vascular Embolization and Occlusion

The embolization codes include all associated radiological supervision and interpretation, intraprocedural guidance and road-mapping, and imaging necessary to document completion of the procedure. They do not include diagnostic angiography and all necessary catheter placement(s). Code(s) for catheter placement(s) may be separately reported using selective catheter placement code(s), if used consistent with guidelines. Code(s) for diagnostic angiography may also be separately reported, when performed according to guidelines for diagnostic angiography during endovascular procedures, using the appropriate diagnostic angiography codes. Report these services with an appropriate modifier (eg, modifier 59). Please see the guidelines on the reporting of diagnostic angiography preceding 75600 in the Vascular Procedures, Aorta and Arteries section.
Implantable and Wearable Cardiac Device Evaluations

Changes to the Introductory Language for Implantable and Wearable Cardiac Device Evaluations.

1. Replaced implantable cardioverter-defibrillator with implantable defibrillator.
2. Accommodate the two new codes for subcutaneous defibrillator into coding guidelines.

Example

2014 – Implantable cardioverter-defibrillator: Programmed parameters, lead(s), battery, capture and sensing function, presence or absence of therapy for ventricular tachyarrhythmias and underlying heart rhythm.

2015 – Implantable defibrillator: Programmed parameters, lead(s), battery, capture and sensing function, presence or absence of therapy for ventricular tachyarrhythmias and underlying heart rhythm.
New and Revised Codes

93279 - Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead pacemaker system

93280 - dual lead pacemaker system
93281 - multiple lead pacemaker system
▲ 93282 - single lead transvenous implantable defibrillator system
▲ 93283 - dual lead transvenous implantable defibrillator system
▲ 93284 - multiple lead transvenous implantable defibrillator system

# • 93260 - implantable subcutaneous lead defibrillator system

93285 - implantable loop recorder system

93288 - Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead pacemaker system

▲ 93289 - single, dual, or multiple lead transvenous implantable defibrillator system, including analysis of heart rhythm derived data elements

# • 93261 - implantable subcutaneous lead defibrillator system

93290 - implantable cardiovascular monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors
Revised Codes

93294 - Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional

▲ 93295 - single, dual, or multiple lead implantable defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional

▲ 93296 - single, dual, or multiple lead pacemaker system or implantable defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results

Echocardiography

• 93355 - Echocardiography, transesophageal (TEE) for guidance of a transcatheter intracardiac or great vessel(s) structural intervention(s) (eg, TAVR, transcatheter pulmonary valve replacement, mitral valve repair, paravalvular regurgitation repair, left atrial appendage occlusion/closure, ventricular septal defect closure) (peri-and intraprocedural), real-time image acquisition and documentation, guidance with quantitative measurements, probe manipulation, interpretation, and report, including diagnostic transesophageal echocardiography and, when performed, administration of ultrasound contrast, Doppler, color flow, and 3D

*(To report placement of transesophageal probe by separate physician, use 93313)*

*(Do not report 93355 in conjunction with 76376, 76377, 93312, 93313, 93314, 93315, 93316, 93317, 93318, 93320, 93321, 93325)*
Introductory Language Addition

- Code 93355 is used to report transesophageal echocardiography (TEE) services during transcatheter intracardiac therapies. Code 93355 is reported once per intervention and only by an individual who is not performing the interventional procedure. Code 93355 includes the work of passing the endoscopic ultrasound transducer through the mouth into the esophagus, when performed by the individual performing the TEE, diagnostic transesophageal echocardiography and ongoing manipulation of the transducer to guide sizing and/or placement of implants, determination of adequacy of the intervention, and assessment for potential complications. Real-time image acquisition, measurements, and interpretation of image(s), documentation of completion of the intervention, and final written report are included in this code. A range of intracardiac therapies may be performed with TEE guidance. Code 93355 describes TEE during advanced transcatheter structural heart procedures (e.g., transcatheter aortic valve replacement [TAVR], left atrial appendage closure [LAA], or percutaneous mitral valve repair). See 93313 for separate reporting of the probe insertion by a physician other than the physician performing the TEE.

Intracardiac Electrophysiological Procedures/Studies

- 93642 - Electrophysiologic evaluation of single or dual chamber transvenous pacing cardioverter-defibrillator includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters

- 93644 - Electrophysiologic evaluation of subcutaneous implantable defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)
Cerebrovascular Arterial Studies

- **93895** - Quantitative carotid intima media thickness and carotid atheroma evaluation, bilateral

Category III Codes
Category III Mitral Valve Code

- **0345T** – Transcatheter mitral valve repair percutaneous approach via the coronary sinus
(For transcatheter mitral valve repair percutaneous approach including transseptal puncture when performed, see 33418, 33419)
(Do not report 0345T in conjunction with 93451, 93452, 93453, 93456, 93457, 93458, 93459, 93460, 93461 for diagnostic left and right heart catheterization procedures intrinsic to the valve repair procedure)
(Do not report 0345T in conjunction with 93453, 93454, 93563, 93564 for coronary angiography intrinsic to the valve repair procedure)

2015 Work RVUs
### Subcutaneous Implantable Defibrillator

<table>
<thead>
<tr>
<th>CPT/ HCPCS</th>
<th>Mod</th>
<th>Status</th>
<th>Description</th>
<th>Work RVUs</th>
<th>Non-Facility RVUs</th>
<th>Facility RVUs</th>
<th>Mal-Practice RVUs</th>
<th>Total Non-Facility RVUs</th>
<th>Total Facility RVUs</th>
<th>Global</th>
</tr>
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<tbody>
<tr>
<td>33270</td>
<td>A</td>
<td></td>
<td>Ins/rep subq defibrillator</td>
<td>9.10</td>
<td>4.78</td>
<td>NA</td>
<td>3.12</td>
<td>16.70</td>
<td>NA</td>
<td>090</td>
</tr>
<tr>
<td>33271</td>
<td>A</td>
<td></td>
<td>Insq subq implant defb elctrd</td>
<td>7.50</td>
<td>3.65</td>
<td>NA</td>
<td>1.21</td>
<td>12.36</td>
<td>NA</td>
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<tr>
<td>33272</td>
<td>A</td>
<td></td>
<td>Rmvl of subq defibrillator</td>
<td>5.42</td>
<td>2.52</td>
<td>3.75</td>
<td>2.90</td>
<td>10.84</td>
<td>12.07</td>
<td>090</td>
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<tr>
<td>33273</td>
<td>A</td>
<td></td>
<td>Repos prev implmt/subq defb</td>
<td>6.50</td>
<td>2.11</td>
<td>3.85</td>
<td>1.01</td>
<td>10.02</td>
<td>11.36</td>
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### Revised Codes

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<th>Status</th>
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<th>Work RVUs</th>
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<tr>
<td>33215</td>
<td>A</td>
<td></td>
<td>Reposition pacing-defib lead</td>
<td>4.92</td>
<td>NA</td>
<td>2.91</td>
<td>1.01</td>
<td>NA</td>
<td>8.84</td>
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<td></td>
<td>Insert 1 electrode pm-defib</td>
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<td>NA</td>
<td>3.88</td>
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<td>33217</td>
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<td></td>
<td>Insert 2 electrode pm-defib</td>
<td>5.84</td>
<td>NA</td>
<td>3.70</td>
<td>1.20</td>
<td>NA</td>
<td>10.74</td>
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<td>Repair lead pace-defib one</td>
<td>6.07</td>
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<td>Repair lead pace-defib dual</td>
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<td>4.05</td>
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<td>NA</td>
<td>11.47</td>
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<td>Relocate pocket for defib</td>
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<td>1.35</td>
<td>NA</td>
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<td>Insert pacing lead &amp; connect</td>
<td>9.04</td>
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<td>3.84</td>
<td>1.86</td>
<td>NA</td>
<td>14.74</td>
<td>000</td>
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<td></td>
<td>L ventric pacing lead add-on</td>
<td>8.33</td>
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<td>1.71</td>
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Work RVU’s stayed the same for these revised CPT codes 33215 – 33225, 33230 - 33264

Implantable and Wearable Cardiac Device Evaluations

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CMS accepted the RUC recommended work RVU
### EP

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CMS did not accept the RUC recommended value of 3.65 for the work RVU.

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### TMVR

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CMS accepted the RUC recommended value.
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CMS accepted the RUC recommended value

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ECMO continued

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CMS did not accept all of the work values that the RUC recommended.

Resources

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