Impedance Cardiography (ICG)

This guide provides coding and coverage information regarding diagnostic impedance cardiography services. SonoSite provides this information as a courtesy to assist providers in determining the appropriate coding and other information for reimbursement purposes. It is the provider's responsibility to determine and submit appropriate codes, modifiers, and claims for services rendered. SonoSite makes no guarantees concerning reimbursement or coverage. Please feel free to contact the SonoSite reimbursement staff at 1-888-482-9449.

Coding:
The CPT code recommended for cardiac output monitoring by thoracic electrical bioimpedance is: 93701 - Bioimpedance-derived physiologic cardiovascular analysis

National Medicare Coverage:
Under the Medicare National Converge Determination (20.16) Medicare coverage for cardiac output monitoring by thoracic electrical bioimpedance is indicated for:

- Differentiation of cardiogenic from pulmonary causes of acute dyspnea when medical history, physical examination, and standard assessment tools provide insufficient information, and the treating physician has determined that TEB hemodynamic data are necessary for appropriate management of the patient.
- Optimization of atrioventricular (AN) interval for patients with AN sequential cardiac pacemakers when medical history, physical examination, and standard assessment tools provide insufficient information, and the treating physician has determined that TEB hemodynamic data are necessary for appropriate management of the patient.
- Monitoring of continuous inotropic therapy for patients with terminal congestive heart failure, when those patients have chosen to die with comfort at home, or for patients waiting at home for a heart transplant.
- Evaluation for rejection in patients with a heart transplant as a predetermined alternative to a myocardial biopsy. Medical necessity must be documented should a biopsy be performed after TEB.
- Optimization of fluid management in patients with congestive heart failure when medical history, physical examination, and standard assessment tools provide insufficient information, and the treating physician has determined that TEB hemodynamic data are necessary for appropriate management of the patient.

Local Medicare Coverage:
The National Coverage Determination allows for Contractor discretion on coverage for the use of TEB for the management of drug-resistant hypertension is reasonable and necessary. Drug resistant hypertension is defined as failure to achieve goal blood pressure in patients who are adhering to full doses of an appropriate 3-drug regimen that includes a diuretic.

Please contact your local Medicare Administrative Contractor regarding coverage for the indication of drug-resistant hypertension.

Payment Information
The following chart provides payment information that is based on the national unadjusted Medicare physician fee schedule for the ultrasound services discussed in this guide. Payment will vary by geographic region. Use the "Professional Payment" column to estimate reimbursement to the physician for services provided in facility settings.

Ambulatory Payment Classification (APC) codes and payments are used by Medicare to reimburse ASCS under the Hospital Outpatient Prospective Payment System (OPPS). Payment is based on the national unadjusted OPPS amounts for ASC. The actual payment will vary by location.

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Reimbursement rates shown for payment of services under the Physicians Fee Schedule reflect a conversion factor of $34.02 as provided for in the American Taxpayer Relief Act of 2012 which became law on January 2, 2013.

The information in this handout is intended to assist providers in determining appropriate codes and the other information for reimbursement purposes. It represents the information available to SonoSite as of the date listed above. Subsequent guidance might alter the information provided. SonoSite disclaims any responsibility to update the information provided. The only persons authorized by SonoSite to supply information regarding any reimbursement matter not reflected in a circular such as this are members of SonoSite's reimbursement staff.

It is the provider's responsibility to determine and submit appropriate codes, modifiers, and claims for the services rendered. Before filing any claims, providers should verify current requirements and policies with the applicable payer. SonoSite makes no guarantees concerning reimbursement or coverage. A provider should not rely on any information provided by SonoSite in submitting any claim for payment, without confirming that information with an authoritative source.