CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2743	**Date: July 25 2013**
	Change Request 8330

NOTE: Transmittal 2743 is being reissued to correct the implementation date in the manual instruction. The transmittal number, the issue date and all other information remain the same.

SUBJECT: Coding Changes to Ultrasound Diagnostic Procedures for Transesophageal Doppler Monitoring

I. SUMMARY OF CHANGES: Effective for claims with dates of service on or after January 1, 2013, contractors shall recognize and accept HCPCS Code G9157 when billed for Esophageal Doppler monitoring.

EFFECTIVE DATE: January 1, 2013
IMPLEMENTATION DATE: August 26, 2013

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N	32/310/Table of Contents
N	32/310/Transeophageal Doppler Used for Cardiac Monitoring
N	32/310.1/Coding Requirements for Transesophageal Doppler Cardiac Monitoring Furnished Before January 1, 2013
N	32/310.2/Coding Requirements for Transesophageal Doppler Cardiac Monitoring Furnished On or After January 1, 2013
N	32/310.3/Correct Place of Service (POS) Code for Transesophageal Doppler Cardiac Monitoring Services on Professional Claims

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is

not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2743	Date: July 25, 2013	Change Request: 8330

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SUBJECT: Coding Changes to Ultrasound Diagnostic Procedures for Transesophageal Doppler Monitoring

EFFECTIVE DATE: January 1, 2013
IMPLEMENTATION DATE: August26, 2013

I. GENERAL INFORMATION

A. Background: On May 17, 2007, CR 5608/TR76 Ultrasound Diagnostic Procedures, was released by the Centers for Medicare & Medicaid Services, effective 30 days from issuance of the CR. CR 5608 explained that effective for claims with dates of service on and after May 17, 2007, CMS determined that esophageal Doppler monitoring of cardiac output for ventilated patients in the ICU and operative patients with a need for intra-operative fluid optimization was reasonable and necessary. Therefore, the NCD Manual was amended at section 220.5 of Publication 100-03 by adding "Monitoring of cardiac output (Esophageal Doppler)" for ventilated patients in the ICU and operative patients with a need for intra-operative fluid optimization" to Category I (covered procedures), and deleting "Monitoring of cardiac output (Esophageal Doppler)" from Category II (non-covered procedures).

B. Policy: The following Esophageal Doppler monitoring new HCPCS code will be used in place of unlisted code 76999 (Unlisted ultrasound procedure (eg, diagnostic, interventional)) effective for claims with dates of service on or after January 1, 2013:

The code G9157 is a diagnostic procedure indicated for ventilated patients in the ICU and operative patients with a need for intra-operative fluid optimization and is only covered when furnished in an inpatient hospital place of service (POS) 21. The services under code G9157 include the insertion, placement, and repositioning of the esophageal Doppler probe in addition to the assessment(s) with report, image acquisition(s), and interpretation(s) per course of treatment.

Code G9157 will have a procedure status indicator of A on the Medicare Physician Fee Schedule (MPFS). This indicator denotes that the professional services are separately payable for a maximum of once per course of treatment. The code reflects physician work involved in probe placement, image acquisition, and interpretation per course of treatment for monitoring purposes. (See note below).

Please refer to CR 5608, transmittal 76 - Ultrasound Diagnostic Procedures for any further information. Please note that no changes are being made to the current policy for esophageal Doppler Monitoring. This service is only covered in a hospital setting, and is part of the existing Inpatient Prospective Payment System payment.

NOTE: A new HCPCS code, G9157 (Transesophageal doppler measurement of cardiac output (including probe placement, image acquisition, and interpretation per course of treatment) for monitoring purposes), will be effective January 1, 2013, and has been included in the January 2013 update of the Medicare Physician Fee Schedule Database (MPFSDB) with a procedure status indicator of "B," payments for covered services are always bundled into payment for other services which are not specified. A revised procedure status indicator of "A," indicating codes are separately payable under the MPFS, will be included on the April 2013 update to the MPFSDB effective January 1, 2013. Claims with dates of service on or before December 31, 2012, will continue to process with unlisted code 76999.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8330.1	Effective for claims with dates of service on or after January 1, 2013, contractors shall recognize and accept HCPCS Code G9157 when billed for Esophageal Doppler monitoring.		X				X						
8330.1.1	Effective for claims with dates of service on and after January 1, 2013, through March 31, 2013, contractors shall apply contractor pricing to claim lines containing G9157.		X				X						
8330.1.2	Contractors shall note that G9157 will appear on the April 2013 MPFSDB update with a type of service (TOS) “1.”		X				X						
8330.2	Effective for claims with dates of service on or after January 1, 2013, contractors shall deny claim lines containing HCPCS code 76999 when billed for Esophageal Doppler monitoring according to this NCD.		X				X						
8330.3	Contractors shall use the following messages when denying HCPCS code 76999 when billed for Esophageal Doppler monitoring: Claim Adjustment Reason Code (CARC) 189: “’Not otherwise classified’ or ‘unlisted’ procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service.” Remittance Advice Remark Code (RARC) M20: “Missing/incomplete/invalid HCPCS.” Medicare Summary Notice (MSN) 16.13: “The code(s) your provider used is/are not valid for the date of service billed.” Spanish version: “El/los código(s) que usó su proveedor no es/son válido(s) en la fecha de servicio facturada.” Group Code: Contractual Obligation (CO)		X				X						

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8330.4	Contractors shall deny HCPCS G9157 when billed in any POS other than 21.		X				X						
8330.4.1	Contractors shall use the following messages: CARC 58: "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. MSN 16.2: This service cannot be paid when provided in this location/facility. Group Code: CO		X				X						
8330.5	Contractors do not need to search their files for claims that may have been processed in error with dates of service between January 1, 2013, and March 31, 2013. However, contractors may adjust claims that are brought to their attention.		X				X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
8330.6	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article		X				X		

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
	shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.								

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Wanda Belle, 410-786-7491 or wanda.belle@cms.hhs.gov , Kimberly Long, 410-786-5702 or Kimberly.Long@cms.hhs.gov (Coverage) , Cynthia Thomas, 410-786-8169 or cynthia.thomas@cms.hhs.gov (Practitioner Part B) , Joscelyn Lissone, 410-786-5116 or Joscelyn.lissone@cms.hhs.gov (Practitioner Part B) , Patricia Brocato-Simons, 410-786-0261 or patricia.brocatosimons@cms.hhs.gov (Coverage)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets.

Section B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual
Chapter 32 – Billing Requirements for Special Services

Table of Contents
(Rev.2743, Issued: 07-25-13)

310 - Transesophageal Doppler Used for Cardiac Monitoring

310.1 – Coding Requirements for Transesophageal Doppler Cardiac Monitoring Furnished Before October 1, 2012

310.2 – Coding Requirements for Transesophageal Doppler Monitoring Furnished On or After October 1, 2012

310.3 – Correct Place of Service (POS) Code for Transesophageal Doppler Cardiac Monitor Services on Professional Claims

310 - Transesophageal Doppler Used for Cardiac Monitoring
(Rev. .2743, Issued: 07-25-13, Effective: 07-01-01-13, Implementation, 08-26-13)

Effective May 17, 2007, Transesophageal Doppler used for cardiac monitoring is covered for ventilated patients in the ICU and operative patients with a need for intra-operative fluid optimization was deemed reasonable and necessary. See National Coverage Determinations Manual (Pub. 100-03) §220.5, for complete coverage guidelines.

A new Healthcare Common Procedure Coding System (HCPCS) code, G9157, Transesophageal Doppler used for cardiac monitoring, will be made effective for use for dates of service on or after January 1, 2013.

310.1 - Coding Requirements for Transesophageal Doppler Cardiac Monitoring Furnished Before January 1, 2013
(Rev. .2743, Issued: 07-25-13, Effective: 07-01-01-13, Implementation, 08-26-13)

Prior to January 1, 2013, the applicable HCPCS code for Transesophageal Doppler cardiac monitoring is:

HCPCS 76999 (billed with modifier -26) when performed in a hospital setting for ventilated patients in the ICU or for operative patients with a need for intra-operative fluid optimization.

If globally billed using code 76999, it shall be returned as unprocessable to the provider using a claim adjustment reason code (CARC) such as:

CARC 58: "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."

HCPCS 76999 (billed with modifier -TC) shall be denied when performed in a hospital setting for ventilated patients in the ICU or for operative patients with a need for intra-operative fluid optimization with a message such as:

CARC 58: "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."

RARC M77: "Missing/incomplete/invalid place of service."

MSN 17.9: "Medicare (Part A/Part B) pays for this service. The provider must bill the correct Medicare contractor." (English version) or "Este servicio es pagado por Medicare (Parte A/Parte B). El proveedor debe enviar la facture al contratista de Medicare correcto."(Spanish version).

HCPCS 76999 (billed globally or with -26 or -TC) when performed in an ASC setting for operative patients with a need for intra-operative fluid optimization, ultrasound diagnostic procedures are covered when performed by an entity other than the ASC.

310.2 - Coding Requirements for Transesophageal Doppler Cardiac Monitoring Furnished On or After January 1, 2013

(Rev. .2743, Issued: 07-25-13, Effective: 07-01-01-13, Implementation, 08-26-13)

After January 1, 2013, the applicable HCPCS code for Transesophageal Doppler cardiac monitoring is:

HCPCS G9157: Transesophageal Doppler used for cardiac monitoring

Contractors shall allow HCPCS G9157 to be billed when services are provided in POS 21 for ventilated patients in the ICU or for operative patients with a need for intra-operative fluid optimization. Contractors shall deny HCPCS 76999 when billed for Esophageal Doppler for ventilated patients in the ICU or for operative patients with a need for intra-operative fluid optimization using the following messages:

CARC 189: "'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service."

RARC M20: "Missing/incomplete/invalid HCPCS."

MSN 16.13: "The code(s) your provider used is/are not valid for the date of service billed." (English version) or "El/los código(s) que usó su proveedor no es/son válido(s) en la fecha de servicio facturada." (Spanish version).

Group Code: Contractual Obligation (CO)

310.3 - Correct Place of Service (POS) Code for Transesophageal Doppler Cardiac Monitoring Services on Professional Claims

(Rev. .2743, Issued: 07-25-13, Effective: 07-01-01-13, Implementation, 08-26-13)

Contractors shall pay for Transesophageal Doppler cardiac monitoring, G9157, only when services are provided at POS 21.

Contractors shall deny HCPCS G9157 when billed globally in any POS other than 21 for ventilated patients in the ICU or for operative patients with a need for intra-operative fluid optimization using the following messages:

CARC 58: "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

MSN 16.2: This service cannot be paid when provided in this location/facility.

Group Code: CO