Frequently Asked Questions - Billing and Payment for the CardioQ™ Esophageal Doppler Monitor (EDM)

▪ Is use of EDM reimbursed by Medicare and other health insurers?

Medicare has determined that use of an esophageal Doppler monitor (EDM) is “reasonable and necessary” in two clearly defined patient populations (see below) and therefore eligible for professional reimbursement. A variety of private insurers have also started to reimburse claims for this service.

▪ What determines whether or not EDM is medically necessary?

Medicare has issued a National Coverage Decision (NCD) that specifies the situations in which CardioQ is appropriate. The NCD can be downloaded from:

https://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=196

In summary, use of EDM is covered for:

“Monitoring of cardiac output (Esophageal Doppler) for ventilated patients in the ICU and operative patients with a need for intra-operative fluid optimization’.

Documentation in the patient's medical record should record that the patient fits the criteria specified by the Medicare policy. Example documentation is provided on Deltex Medical’s website.

▪ How is use of EDM coded and reported?

Currently no specific CPT code for the use of EDM exists. Medicare has stated in a communication to all regional Medicare carriers that CPT code 76999 (misc. ultrasound procedure) should be used. The Medicare directions are available at:


▪ How should the level of service be quantified?

CMS has not specified how to report the use of EDM in either the ICU or surgical setting. One option for billing the service is to claim one occurrence of 76999 each time a patient is hemodynamically assessed and optimized using EDM. For each optimization ‘cycle’ the physician is required to place and focus the esophageal probe, establish a base-line value for key hemodynamic parameters (for billing purposes ‘stroke volume’ should suffice) and then deliver serial boluses of intravenous fluid until the stroke volume value change is less than ten percent, indicating that the patient is optimized. A subsequent fall in stroke volume of greater than ten percent would trigger the next optimization cycle and a further claim under 76999. This approach may be used for patients in surgery or ICU.
The number of optimization cycles is determined by the length and complexity of the surgical procedure and can have a wide range. Similarly, a patient in ICU may require multiple interventions throughout their stay.

- **How much is the Medicare payment for use of EDM?**

  Medicare typically values physician services using relative values and these are published annually as the Physician Fee Schedule. Since an EDM-specific CPT code does not yet exist, CMS instructs the Medicare carriers to “carrier price” miscellaneous codes. This means that the carrier determines the reimbursement. When submitting the miscellaneous code it is likely that the Medicare Contractor will ask for further information in order to set a payment. Deltex Medical has prepared a descriptive informational packet that you may find helpful if asked to help value the service. This is available by contacting Deltex Medical at USreimbursement@deltexmedical.com.

- **Why isn't EDM considered to be part of already reimbursed anesthesia or critical care service (that is “bundled”)?**

  Monitoring and aspects of care such as fluid administration are typically considered an inherent component of anesthesia and critical care. As such they are “bundled” or included in the codes used to report those services. Use of EDM has never been included or bundled in existing codes since it has previously been a non-covered Medicare Service. Medicare’s recent reversal of this policy was based on review of the published clinical evidence supporting the value of CardioQ and a technology assessment undertaken by the Agency for Healthcare Research and Quality (AHRQ). As a matter of policy, Medicare has chosen to make EDM a separately billable and separately payable service to encourage uptake and recognize the additional effort involved in providing this service.

- **Who is able to submit claims and be paid for use of EDM?**

  In the case of hospitalized patients, Medicare has made it clear that the material cost ("technical component") of the service is included in the hospitals payment. For services in an Ambulatory Surgical Center (probably a rare occurrence) the facility can bill for the technical component. In all cases the using physician can bill and be paid for the work ("professional component") of the service. This can be the anesthesiologist, critical care specialist or other physician using EDM, irrespective of other services they provide.

- **Can the operating surgeon bill for the use of EDM?**

  Although billing by the operating surgeon is not expressly prohibited, Medicare policies do not allow the surgeon to bill for anesthesia and monitoring separately and it is unlikely that Medicare would alter the existing policies to allow for this form of billing.

- **How will claims for the use of EDM be processed?**

  The use of a miscellaneous code such as 76999 requires that the claim be manually processed. This will probably require a response to requests for supplemental information the first claims submitted.

- **Will claims processing become more efficient over time even though a miscellaneous code is being used?**

  Yes, as contractors become familiar with EDM and the billing situations that occur they will develop facilitated claims processing.
- **When will EDM have a specific CPT code?**

  A specific CPT code will be developed in due course. Until that time 76999 is the proper code to use when using EDM.

- **How can I get answers to questions about claims submission and billing?**

  Deltex Medical has engaged the services of Princeton Reimbursement Group to assist our customers with reimbursement and coding advice for esophageal Doppler monitoring. PRG can be contacted, toll free on 877 725 9767. Alternatively, you can email Deltex Medical on usreimbursement@deltexmedical.com.