Priority Health	BILLING POLICY No. 063

ENDOMYOCARDIAL BIOPSY WITH RIGHT HEART CATHETERIZATION

Date of origin: Dec. 26, 2024	Review dates: 2/2025

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise stated
- Medicaid follows MDHHS unless otherwise stated

DEFINITION

- **Endomyocardial biopsy** – Removal of a small piece of the heart for examination which is done through a catheter that is threaded into the heart.
- **Cardiac catheterization** – An introduction and positioning of a catheter in the heart to assess cardiac function and structure, for diagnosis, treatment planning or to assess therapy. This assessment may include measurement of intracardiac and intravascular pressures and determination of cardiac output.

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get additional details on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Coding specifics

93505 – Endomyocardial biopsy

93451 - Right heart catheterization (RHC) including measurement(s) of oxygen saturation and cardiac output, when performed

- RHC bundles with Endomyocardial biopsies; code selection should be based on the main purpose of the procedure.
- Modifiers should **only** be applied if documentation supports bundled service is separately distinct.
- RHC or selective catheterization shouldn't be reported for intravascular placement of catheters into the right ventricle as this is required to perform the endomyocardial biopsy.
- Some services are considered integral to defined procedures based on standards of medical/surgical practice. These integral services shouldn't be reported separately.

Place of service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information.

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the provider. In addition, the provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

Documentation requirements may include:

- Notation of medical necessity to fully support the procedure(s) performed
- A report of procedure and interpretation of each procedure performed
- Documentation of medical decision making if procedures aren't performed
- Signatures. Unsigned documentation is considered incomplete and will be denied.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. Get more information on modifier use in our Provider Manual.

- 59 – Distinct procedural service
- XE – Separate encounter
- XS – Separate Practitioner
- XU – Unusual non-overlapping service
- 26 – Professional component
- TC – Technical component

Note: See specific criteria from CMS that must be met in order to properly use modifier 59, XE, XS or XU.

DEFINITIONS

Standards of medical/surgical practice
The component service is:

- An accepted standard of care when performing the comprehensive service
- Usually necessary to complete the comprehensive service
- Not a separately distinguishable procedure when performed with the comprehensive service

Distinct procedural service
An independent service from another service performed the same day:

- Different session
- Different site or organ system
- Separate lesion or injury
- Separate incision

RESOURCES

- OIG report: Hospitals nationwide generally did not comply with Medicare requirements for billing outpatient right heart catheterizations with heart biopsies (OIG)
- Cardiac Catheterization and Coronary Angiography – L33557 (CMS)
- Medicare NCCI 2023 Coding Policy Manual – Chapter 11 (CMS)
- Medicare NCCI 2023 Coding Policy Manual – Chapter 1 (CMS)

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and

Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 14, 2025	Added "Disclaimer" section