SHOCKWAVE | IVL

SHOCKWAVE CORONARY IVL

PHYSICIAN CODING GUIDE

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Effective July 1, 2022, Category III add-on CPT®[1] code +0715T *(Percutaneous transluminal coronary lithotripsy) (List separately in addition to code for primary procedure)* has been established for Shockwave Coronary Intravascular Lithotripsy. This document is intended to provide coding support to physicians and staff for use of this new code.

SHOCKWAVE IVL INDICATIONS

Shockwave Medical received PMA approval from the US Food and Drug Administration (FDA) for its Coronary Intravascular Lithotripsy technology February 12, 2021. The Shockwave Intravascular Lithotripsy (IVL) System with Shockwave C[2] Coronary IVL Catheter is indicated for lithotripsy-enabled, low-pressure balloon dilatation of severely calcified, stenotic de novo coronary arteries when used prior to stenting.

CATEGORY III CPT CODE

The American Medical Association (AMA) guidelines for Category III CPT codes include the following: *"Category III codes allow data collection for [emerging technologies, services, procedures, and service paradigms]. Use of unlisted codes does not offer the opportunity for the collection of specific data. If a Category III code is available, this code must be reported instead of a Category I unlisted code."*[2] **Physicians are required to use the most appropriate code to describe the service provided.**

To facilitate payment associated with the Category III code, additional documentation is often required as CMS does not establish relative value units (RVUs) for Category III CPT codes. **Category III CPT codes are very common for new procedures and technologies.**

Category III CPT codes may be payable when medically necessary and reported with appropriate documentation. Payers and local contractors may cover procedures they believe are medically necessary and offer a safe and long-term alternative.

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2. https://www.ama-assn.org/system/files/cpt-category3-codes-long-descriptors.pdf

SHOCKWAVE CORONARY IVL CATEGORY III CPT CODE +0715T

In order to allow tracking of Coronary IVL procedures, the AMA has assigned a Category III CPT code. This Category III code is an add-on code (+0715T), which identifies coronary lithotripsy as its own defined therapy.

Effective July 1, 2022, physicians are required to report the Shockwave Coronary Intravascular Lithotripsy (IVL) procedure using Category III CPT Code: +0715T *(Percutaneous transluminal coronary lithotripsy) (List separately in addition to code for primary procedure)*

TABLE 1. CATEGORY III CPT CODE: CORONARY IVL

CPT Code	Description	Work RVUs	Physician Payment (Facility)
+0715T	Percutaneous transluminal coronary lithotripsy (List separately in addition to code for primary procedure)	NA	Payer Determined

TABLE 2. PRIMARY CODES FOR CORONARY IVL (+0715T)

Category III CPT code +0715T is an add-on code and should be used only in conjunction with the following primary procedure codes:

CPT Code	Description	Work RVUs[3]	2022 Payment[3]
92920	Perc transluminal coronary angioplasty; single major coronary artery or branch	9.85	$537
92924	Perc transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch	11.74	$641
92928	Perc transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	10.96	$598
92933	Perc transluminal coronary atherectomy, with intracoronary stent, with coronary angio when performed; single major coronary artery or branch	12.29	$671
92937	Perc transluminal revasc of or through coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including distal protection; single vessel	10.95	$597
92941	Perc transluminal revasc of acute total/subtotal occlusion during acute MI, coronary artery or CABG, any comb of intracoronary stent, atherectomy and angio, inc aspiration thrombectomy when performed, single vessel	12.31	$672
92943	Perc transluminal revasc of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any comb of intracoronary stent, atherectomy and angio; single vessel	12.31	$672
92975	Thrombolysis, coronary; by intracoronary infusion, including selective coronary angiography	6.99	$382

3. Medicare 2022 Physician Facility Payment and RVUs, 2022 Medicare Physician Fee Schedule, Addendum B.

REPORTING CATEGORY III CPT CODES

Category III codes are not nationally valued and therefore payers use different payment methodologies to determine physician reimbursement associated with the code. For Medicare claims, associated RVUs and payment rates for Category III codes are established by the Medicare Administrative Contractors (MACs). Each MAC establishes their own payment rates and coverage policies for Category III CPT codes. **It is recommended that providers check with their specific MAC for additional information related to the payment levels for CPT code +0715T.**

Private payors determine coverage and payment for procedures described by Category III CPT codes individually and may pay based on a percentage of physician charges, a percentage of Medicare fee schedule amounts, or by some other methodology. **We recommend checking with your payer contracts to determine if they have specific guidelines for pricing and billing of Category III codes.**

In the absence of established RVUs, payers rely on the use of a comparator code to set an RVU rate for codes without established payment. Payers will require supporting documentation to assign payment. It will be important to document the services provided regarding resources and time for appropriate payment valuation. Physicians should be prepared to submit information to assist in coverage and payment decisions.

Recommended items to support your Category III claims submissions include:

- Copy of operative or procedure report
- Letter of medical necessity
- Clinical notes (severity of calcification)
- Relevant crosswalk CPT code with anticipated payment indicated
- Copy of relevant published clinical literature or Shockwave Coronary IVL bibliography
- Copy of the FDA approval letter

CATEGORY III CROSSWALK CODE

Physicians should provide a coding crosswalk to an existing Category I code procedure, similar in complexity and time, to help guide the payer/claims processor in setting a fair and accurate reimbursement level. Coronary IVL code +0715T is deemed an add-on code to a primary coronary intervention. The crosswalk code should be a comparable add-on code in terms of complexity and time.

To select a coding crosswalk:

- Select a comparable procedure with an established payment level that involves similar physician time, medical decision making and practice expense as the Coronary IVL procedure;
- Include a comparison statement of similarities and differences in time, training and resources;
- Indicate that the payment for the Coronary IVL code should be at the similar rate as the referenced procedure since the procedures both require similar physician time, effort, and complexity;
    - Document any differences in work for the service associated with the +0715T CPT code as a percentage increase or decrease of the work for the comparison service;
- Include a statement on freeform field 19 of the claim form indicating “Code +0715T is comparable to crosswalk code XXX, payment of $$$ is expected”;
- Include a brief cover letter explaining the crosswalk code and anticipated payment for Coronary IVL.

CROSSWALK EXAMPLES

The following CPT add-on codes are examples of potential crosswalk codes that may be comparable to Coronary IVL. It is ultimately the physician's responsibility to choose the most appropriate add-on CPT code comparator that is best representative of the work and complexity associated with the Category III Coronary IVL code.

Reminder: It is critical for the physician to document the services provided regarding time and resource utilization. Physicians report CPT code 0715T on their claims submission forms and document the crosswalk or comparable CPT I code in their documentation and cover letter to ensure payment is commensurate with comparable cardiovascular procedures they currently perform. Note: Do not report/bill the CPT crosswalk code on the claim form.

EXAMPLE: POTENTIAL CPT CODE CROSSWALKS FOR CPT CODE +0715T

Category I Add-on CPT Code	Brief Description	Physician Work RVUs[3]	Total Physician RVUs (Facility)[3]	Medicare 2022 Payment Physician (Facility)[3]	Physician Intraoperative Service Time[4]
+92973	Percutaneous transluminal coronary thrombectomy mechanical	3.28	5.18	$179	40 minutes
+36908	Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit	4.25	6.03	$209	40 minutes
+36909	Dialysis circuit permanent vascular embolization or occlusion (including main circuit or any accessory veins), endovascular	4.12	5.87	$203	30 minutes
+37185	Primary percutaneous transluminal mechanical thrombectomy, noncoronary, non-intracranial, arterial or arterial bypass graft	3.28	4.74	$164	40 minutes
+37186	Secondary percutaneous transluminal thrombectomy noncoronary, non-intracranial, arterial or arterial bypass graft	4.92	7.11	$246	60 minutes

Physician Work Relative Value Units (RVUs) = Work RVUs account for the provider's work when performing a procedure or service. Variables factored into this value include technical skills, physical effort, mental effort and judgement, stress related to patient risk, and the amount of time required to perform the service or procedure.

Total RVUs = The Total RVUs are a combination of Physician Work, Practice Expense and Malpractice RVUs.

Intraoperative Service time is limited to intraoperative work only and does not include time for pre-evaluation, pre-positioning, pre-service scrub time or immediate post service time.

3. Medicare 2022 Physician Facility Payment and RVUs, 2022 Medicare Physician Fee Schedule, Addendum B.
4. CMS CY2022 PFS Final Rule Physician Time File; Available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items.

FREQUENTLY ASKED QUESTIONS – CATEGORY III CODES (PART 1)

Can we bill only the CPT codes that describes coronary intervention, or even an unlisted code, instead of the new Category III CPT code?

Per CPT guidance from the AMA, if an appropriate Category III CPT code exists, it must be utilized *in lieu* of an unlisted procedure code. Category III CPT code +0715T must be used when reporting coronary IVL procedures when performed in conjunction with a listed primary procedure for services performed on or after July 1, 2022.

Is the new Category III CPT code covered by payers?

Category III codes may be reimbursed by payers on a case-by-case basis. Coverage and payment will be based on physician documentation of medical necessity for the procedure. Coronary IVL is indicated for severely calcified lesions, which should be documented during the preauthorization process.

How can we identify an appropriate CPT code crosswalk?

A comparable CPT code crosswalk should be similar in work, intensity, time, complexity, etc. to that of Coronary IVL. The comparable code should be an add-on code to compare equitably with Coronary IVL. We have provided some potential crosswalk CPT codes based on time and complexity. However, the provider is ultimately responsible for selecting the most appropriate comparator code and pricing.

Do we need to preauthorize the Category III code?

The prior authorization process does not change when using CPT Category III codes. We encourage providers to seek prior authorization for private payers. Prior authorization is recommended to help the payer understand what is being requested and the benefits of the procedure. Please note that traditional Medicare does not perform prior authorizations.

FREQUENTLY ASKED QUESTIONS – CATEGORY III CODES (PART 2)

The preauthorization request was moved to a peer-to-peer review. Now what?

It is common for coronary procedures to require prior authorization and even a peer-to-peer review. The same is true with Coronary IVL. A peer-to-peer review provides the physician the opportunity to discuss the patient's clinical need for IVL treatment as well as a chance to educate the insurance company on the benefits of IVL therapy. Consider collecting the following information for your physician prior to the peer-to-peer review:

- Name and title of physician reviewer performing peer-to-peer as well as credentials and specialty of reviewer
- Patient clinical information / medical chart
- Overview of IVL therapy
- FDA clearance / approval date
- Request a peer-to-peer specialty match to ensure that the review is performed by a physician with experience in coronary interventions

The peer-to-peer review was denied. Now what do we do?

If the peer-to-peer review is unsuccessful, it is important that the next steps for payer appeal be determined. Second or third level appeals involving either a written appeal or an elevated peer-to-peer discussion are typically available. This information is usually sent with the payer denial letter. Shockwave Medical can assist with appeals at any level.

If needed, please contact the Reimbursement Hotline at (877) 273-4628 for appeal assistance.

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