

### 3. Create G Codes for Monitoring Heart Rhythms

Technological advances have made cardiac telemetry equipment, typically used in hospitals, available in the home setting. It is now possible to discharge patients with arrhythmias to a home setting and have them monitored at home in a manner similar to hospital monitoring. This monitoring can be used to diagnose arrhythmias or to monitor patients with known arrhythmias to determine, on a real-time basis, whether the patient is having ongoing arrhythmias. The equipment consists of patient leads and a home telemetry station that is connected to a distant monitoring station via the telephone. The monitoring station is attended twenty-four hours a day, seven days a week by a technician. Upon receipt of rhythm strips, the technician records and formats the strips and faxes them to the treating physician.

This equipment automatically records the patient's heart rhythm and is not triggered by the patient (for example, his response to symptoms). The equipment is pre-set with parameters (for example, heart rate of over 120) that trigger it to transmit the patient's cardiac rhythm to monitoring station. Additionally, the technician at the monitoring station can interrogate the home station and have it transmit rhythm strips upon request even when no arrhythmia has triggered an automatic transmission. These latter transmissions are at the discretion of the technician and may or may not be faxed to the treating physician based on previous orders.

Depending on the clinical need, patients may be monitored by this equipment for varying lengths of time. Furthermore, the frequency of transmission of cardiac rhythms varies, as does the amount of material that must be reviewed by the physician. For example, a patient may have no cardiac rhythms transmitted for one or more days while on other days the patient may have several minutes of arrhythmias transmitted for physician review.

To ensure this technology is available to Medicare beneficiaries for covered indications (coverage is currently at the discretion of the local Medicare contractors because there is no national coverage determination for this service) we are creating several HCPCS G codes to describe this service and are establishing national payment amounts for these services. Currently Medicare contractors are requiring both the PC and TC of this service to be billed under CPT code 93799, *Unlisted cardiovascular procedure or service*.

This service is covered under the diagnostic test benefit category at section 1861(s)(3) of the Act.

Medicare is establishing the following HCPCS codes to describe this service:

**GXXX1**—*Electrocardiographic monitoring for diagnosis of arrhythmias, utilizing a home computerized telemetry station and trans-telephonic transmission, with automatic activation and real time notification of monitoring station, 24-hour attended monitoring, per 30-day period of time; includes recording, monitoring, receipt of transmissions, analysis, and physician review and interpretation.* (global)

**GXXX2**—*Electrocardiographic monitoring for diagnosis of arrhythmias, utilizing a home computerized telemetry station and trans-telephonic transmission, with automatic activation and real time notification of monitoring station, 24-hour attended monitoring, per 30-day period of time; recording (includes hook-up, recording and disconnection)*

**GXXX3**—*Electrocardiographic monitoring for diagnosis of arrhythmias, utilizing a home computerized telemetry station and trans-telephonic transmission, with automatic activation and real time notification of monitoring station, 24-hour attended monitoring, per 30-day period of time; monitoring, receipt of transmissions, and analysis*

**GXXX4**—*Electrocardiographic monitoring for diagnosis of arrhythmias, utilizing a home computerized telemetry station and trans-telephonic transmission, with automatic activation and real time notification of monitoring station, 24-hour attended monitoring, per 30-day period of time; physician review and interpretation.*

We are establishing the following payment amounts for these codes:

**GXXX1**—We are assigning 0.52 physician work RVUs and 0.24 malpractice RVUs which is equivalent to *CPT Code, 93268 Patient demand single or multiple event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; includes transmission physician review and interpretation.*

We are also crosswalking the practice expense inputs from CPT Code 93268. **GXXX2**—We are assigning 0.07 malpractice RVUs which is equivalent to *CPT Code 93270, Patient demand single or multiple event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; recording (includes*

*hook-up, recording, and disconnection)* and crosswalking the practice expense inputs from CPT Code 93270.

**GXXX3**—We are assigning 0.15 malpractice RVUs which is equivalent to *CPT Code 93271, Patient demand single or multiple event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; monitoring, receipt of transmission, and analysis* and also are crosswalking the practice expense inputs from CPT Code 93271.

**GXXX4**—We are assigning 0.52 physician work RVUs and 0.02 malpractice RVUs which is equivalent to *CPT Code 93272 Patient demand single or multiple event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; physician review and interpretation only.* We are also crosswalking the practice expense inputs, from CPT Code 93272.

We believe these proposed RVUs and crosswalks are appropriate as the services provided in the new codes are very similar in terms of physician work, resource use, and malpractice risk to the existing CPT Codes.

### 4. CPT Code 88180 (Flow Cytometry; Each Cell Surface, Cytoplasmic or Nuclear Marker)

Flow cytometry is a technique to analyze single cell suspensions from blood, bone marrow, body fluids, lymph nodes, and other tissues. The technique, currently coded as CPT code 88180, *Flow cytometry, each cell surface, cytoplasmic or nuclear marker*, quantifies cell surface, cytoplasmic, and nuclear antigens. The results are frequently used to diagnose lymphomas and leukemias. They are also used to monitor lymphocyte subpopulations in patients with HIV infection or solid organ transplantation. For example, in patients with HIV infection, physicians evaluate CD4+ lymphocytes as a measure of the severity of the infection (some physicians also measure other markers although their clinical relevance is not as well established). In patients with solid organ transplantation, physicians measure various lymphocyte subpopulations to help assess early rejection, identify bone marrow toxicity during immunosuppressive therapy, and differentiate infections from transplant rejection. In these cases the treating physician, not the pathologist, makes the diagnosis. It is inappropriate for the pathologist to report the professional component (PC) of this service. In general, flow cytometry results must be utilized along with clinical data to make