

**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).**

We proposed 0.07 malpractice RVUs and crosswalked the practice expense inputs from 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).*

**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**

We proposed 0.15 malpractice RVUs and crosswalked the practice expense inputs from 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.*

**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 proposed 0.52 physician work RVUs and 0.02 malpractice RVUs and also crosswalked the practice expense inputs, from 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.*

**Comment:** Commenters representing cardiac arrhythmia specialists and cardiologists recommended that we withdraw the proposal to create new G codes for monitoring heart rhythms. The commenters stated that this request was not made by the medical community nor from the manufacturers of these heart rhythm monitoring systems. The commenters contended that the proposal appears to address specifically one manufacturer and specifies a particular mode of transmission and patient location, even though there are

other new systems of this type that are not captured by this proposal.

The commenters recommended that we allow this technology to be utilized on a local level before implementing a national coding solution. The commenters further supported that when this new technology warrants a national coding solution, a CPT coding application should be initiated and then the code should be sent to the RUC for review. The commenting specialties stated their willingness to provide medical input into the evaluation, coding and reimbursement for this new technology. Two commenters also stated that the descriptors and the proposed reimbursement do not reflect the monitoring systems that have been developed. Other commenters also requested that we withdraw or reconsider our proposal, as it did not follow the established process for creating and valuing new codes. One specialty society representing clinical endocrinologists supported the establishment of these HCPCS codes, while another commenter, a cardiac monitoring company, provided a general outline of how the various cardiac monitoring technologies can best be used for maximum quality and value. Another commenter suggested that until efficiency of the new technology is demonstrated this proposal should be postponed.

**Response:** Our intention in proposing these G codes was to recognize and nationally price all currently available real time cardiac telemetry monitoring technology. It was not intended to address only one system currently in use. Based on the concerns raised by commenters, we will not proceed with these proposed HCPCS codes because we want to ensure that any HCPCS codes developed encompass the various technologies that are being utilized for such monitoring.

#### 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 August 15, 2003 proposed rule discussed our concerns that the current coding scheme (payment on a per marker basis) may encourage the performance of more markers than may be medically necessary because the pathologist determines what markers to perform

and when to perform them. We indicated that we understood the laboratory community would be reviewing this issue and considering whether to recommend changes to the current coding for the procedure. We also requested recommendations on appropriate values for the procedure should we wish to develop a future proposal.

**Comments:** Commenters, both individuals and organizations, asked that we not put forth a proposal for payment of flow cytometry. The College of American Pathologists (CAP) has proposed coding revisions to both the immunology and anatomic pathology section of CPT and is working with other groups to establish practice guidelines for flow cytometry. CAP asked that we not establish new “G” codes for 2004, but work with CAP and allow the CPT and RUC evaluation process to be used to determine appropriate coding and relative value units for flow cytometry.

**Decision:** We agree with the commenters. We will work with CAP, the CPT and the RUC to develop appropriate coding and payment policies for flow cytometry.

#### 5. Change in Payments to Physicians Managing Patients on Dialysis

In the August 15, 2003 rule, we proposed to make CPT codes 90918, 90919, 90920, and 90921 for the monthly capitation payments (MCP) invalid for Medicare. We also proposed to create 3 new G codes in place of each CPT code with payments varying with the number of visits provided within each month to an end stage renal disease (ESRD) patient. Under our proposal, there would be separate codes when the physician provides 1 visit per month, 2–3 visits per month and 4 or more visits per month. The code for 1 visit per month would have the lowest payment while a higher payment will be provided for 2 to 3 visits per month and the highest payment for 4 or more visits per month. These new codes would be reported once per month for services performed in an outpatient setting that are related to the patient’s ESRD. These physician services would continue to include the establishment of a dialyzing cycle, outpatient evaluation and management of the dialysis visits, telephone calls, and patient management provided during a full month. These codes would not be used if a hospitalization occurred during the month.

The proposed codes are as follows:

**GXXX5—End Stage Renal Disease (ESRD) related services per full month, for patients under 2 years of age to**