Society for Maternal•Fetal Medicine

Coding Committee

April 2022

Coding Tip – Guidance for Performance of a PR Interval

In response to recent questions, this month's Coding Tip is focused upon updating coding guidance for when a PR interval is performed. This Coding Tip is an update from prior guidance on this topic published in July 2017.

The PR interval is often performed in attempt to identify early forms of fetal congenital heart block. The Coding Committee does not provide clinical guidance, so we defer to the appropriate imaging society guidelines or published peer review articles as to whether sufficient literature exists to support the performance of a PR interval. Regardless of the codes submitted, some payers may feel that that this service is 'investigational' or 'experimental' as per their own review of the literature and guidelines. At the current time major National payers (Aetna, CIGNA, UHC) do NOT have policies on this issue.

Clinical Scenarios

(1) The PR interval is assessed for the first time at the same time a fetal echocardiogram is performed.

- The PR interval is coded with the CPT code 76827 similar to the other PW Doppler measurements performed during the fetal echocardiogram study.
- If follow-up PR intervals are obtained, the correct CPT code for this is 76828.

(2) PR intervals are assessed prior to performing a full fetal echocardiogram. This presents a quandary as there is not clear guidance or opinion on the best billing option in this scenario.

Example: A 40-year-old G1P0 with known SLE on Plaquenil and SSA/SSB positive status presents to your office. Focusing only on the ultrasound coding of the PR interval the following may occur:

- 16-week PR interval: There is no separate CPT code just for PR intervals (prior to a complete fetal echocardiogram being performed). The 76815 or 76999 are potential CPT codes that may be used (see below). If other study components are assessed at the time of the visit, other codes may be more appropriate.
- 18-week Detailed fetal anatomy study + PR interval: 76811 only.
- 20-week PR interval: 76815, 76816, or 76999. This will again depend upon whether additional components are assessed (Ex. if follow-up views are required from the fetal anatomic study, 76816 would be most appropriate).
- 22-week Fetal Echocardiogram + PR interval: 76825+76827+93325
- 24-week PR interval: 76828

Herein lies the problem. Potential CPT coding options for the 16-, 20-, and 24-weeks PR interval studies are problematic. Focusing on the verbiage/positioning of the codes in the CPT handbook, it does not appear possible to bill a 76828 in isolation BEFORE the full 76827 is performed given the CPT definition of 76828 is 'follow-up or repeat study' AND this code is in a 'parent-child relationship' with the 76827. Drawing from senior coding experts who were present when this code was created, it seems clear NOW that the verbiage should have stated "follow-up *or limited*". This would have aligned this with similar code sets for adult medicine such as:

- CPT code 93321 Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; follow-up *or limited study*.

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This medicine echocardiography CPT allows a limited Doppler assessment without requiring that a CPT 93320 Doppler echocardiography, pulsed wave and/or continuous wave with spectral display be performed prior to its use. This would have allowed for a 'cleaner' claims process. As this code is utilized by other subspecialities besides MFM – pediatric cardiologists – in order to appeal for a verbiage change to the CPT, we would need to be aligned with other societies that this warrants a change. This code has been in existence for a long time and the SMFM Coding Committee has not heard of any interest from other specialty societies to make a change. In addition, further clinical guidance is needed from our Societies that performance of a PR interval at 16 weeks prior to an anatomy ultrasound and prior to optimal timing for a full fetal echo is indicated and/or necessary and well supported by medical literature before the Coding Committee or ACOG Coding can apply for a change.

Using the 76815 CPT is an alternative solution. The concern, however, is that while the 'work RVUs' for 76815 and 76828 are relatively comparable (0.65 vs. 0.56, respectively), the total RVUs are not (2.44 vs. 1.48, respectively). Payers may reject this due to an unwillingness to pay 65% more for the same service when billed as a 76828.

Lastly, using the 76999 CPT Unlisted ultrasound procedure (e.g., diagnostic, interventional) is another potential option as it addresses the concern noted with the first 2 options but, of course, there remains the inherent problems associated with using an unlisted code.

At this time, if this service is routinely performed in your office, the SMFM Coding committee would suggest you contact your payers and determine how best to code for this service to optimize reimbursement and to discuss if reimbursement will be provided in clinical scenario 2 noted above.