The Society for Cardiovascular Angiography and Interventions presents

2017 Interventional Cardiology Coding & Reimbursement Webinar

Poll Question

How many are attending this program at your location?
• 1
• 2
• 3
• 4
• 5 or more

Faculty

• Osvaldo S. Gigliotti, MD, FSCAI, Chair of SCAI Advocacy Committee
• Clifford J. Kavinsky, MD, PhD, FSCAI, SCAI RUC Advisor
• Dmitriy N. Feldman, MD, FSCAI, Co-chair of SCAI Advocacy Committee
• Arthur C. Lee, MD, FSCAI, SCAI CPT Advisor
• James Blankenship, MD, MSc, MSCAI, SCAI Past-President and Cardiology’s RUC Panel Representative
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Coding@SCAI.org
This program is designed to address the major highlights and areas of potential concern impacting coding and reimbursement for interventional cardiology procedures based on the 2017 Medicare Physician Fee Schedule Final Rule.
If you have coding and reimbursement questions about issues not addressed during the program, SCAI members may submit inquiry to Coding@SCAI.org

Comprehensive Review
Structural Heart Disease (SHD)
Procedures
Clifford J. Kavinsky, MD, PhD, FSCAI,
SCAI RUC Advisor
**TAVR**
Transcatheter Aortic Valve Repair

MOST COMMON FOR INTERVENTIONAL CARDIOLOGY

33361 – Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach

- Total RVUs 39.59
- 2017 Medicare national average payment rate $1,420.89
- Co-surgeon Requirement / Modifier -62
- Place of service 21 - inpatient only
- Modifier Q0 (zero) signifying CED participation (qualified registry or qualified clinical study).
- Subject to TAVR National Coverage Determination

For information regarding TAVR codes from alternative approaches, please contact Coding@scai.org

**TMVR**
Transcatheter Mitral Valve Repair

33418 - Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis

33419 - Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; additional prosthesis(es) during same session (list separately in addition to code for primary procedure)

- Total RVUs/2017 Medicare national average payment rates
  - 33418 – 52.42/$1881.35
  - 33419 – 12.39/$444.48
- Co-surgeon Allowed, Modifier -62/Assistant-at-Surgery Allowed –modifier -80/82/AS
- Place of service 21 - inpatient only
- Modifier Q0 (zero) signifying CED participation (qualified registry or qualified clinical study).
- Subject to TMVR National Coverage Determination

90 Day Global Period - providers in FL, KY, LA, NV, NJ, ND, OH, OR, RI will have to report post procedure care.

**Co-Surgeon Modifier**

**Modifier -62**

Both surgeons need to report the same surgery code with the modifier 62. If one surgeon bills with a modifier “62”, and one surgeon bills with no modifier, the claim with the modifier will suspend for review.
**Definition of Co-Surgeon**

CMS definition: "Under some circumstances, the individual skills of two or more surgeons are required to perform surgery on the same patient during the same operative session. This may be required because of the complex nature of the procedure(s) and/or the patient's condition. In these cases, the additional physicians are not acting as assistants-at-surgery."

- Separate reports are expected to be produced by each operator
- Typically, expected to be from two different specialties
- Approval of TMVR claims for co-surgeons from same specialty are at the carrier medical directors discretion
- Both agree to use modifier -62

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**Definition of Assistant-at-Surgery**

CMS definition: "An assistant at surgery is a physician who actively assists the physician in charge of a case in performing a surgical procedure. (Note that a nurse practitioner, physician assistant or clinical nurse specialist who is authorized to provide such services under State law can also serve as an assistant at surgery). The conditions for coverage of such services in teaching hospitals are more restrictive than those in other settings because of the availability of residents who are qualified to perform this type of service."

- CMS typically assumes when there are two providers from same specialty one is serving as an assistant at surgery
- For TMVR claims, CMS directs carriers to "pend" and review claims, requiring the submission of supporting documentation for same specialty co-operator claims prior to payment. They do not conduct pre-payment review of same specialty assistant-at-surgery claims

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**Assistant-at-Surgery Modifiers**

- Modifier -80
- Modifier -82
- Modifier -AS
Modifier -80

Modifier -80  The assistant at surgery service was provided by a medical doctor (MD)

-For non-teaching hospital

Modifier -82

• Modifier -82 is used when the assistant at surgery service was provided by an MD and there was not a qualified resident available. Documentation must include information relating to the unavailability of a qualified resident in this situation.

Attestation for Modifier -82

I understand that §1842(b)(7)(D) of the Act generally prohibits Medicare physician fee schedule payment for the services of assistants at surgery in teaching hospitals when qualified residents are available to furnish such services. I certify that the services for which payment is claimed were medically necessary and that no qualified resident was available to perform the services. I further understand that these services are subject to post-payment review by the Medicare carrier.

• Required to be included in the patient’s medical record
**Modifier -AS**

- Use the modifier "AS" for assistant at surgery services provided by a Physician Assistant (PA) or Nurse Practitioner (NP). The provider must accept assignment. Medicare allows 85% of the 16% for the assistant at surgery services provided by a PA or NP.
- A MD/DO should not submit the "AS" modifier. This modifier is only valid for use by non-physician practitioners (NPP) when billing under their own provider number.

**Impact on Payment**

- **Co-Surgeon**
  Reimbursement is at 62.5% of the global surgery fee schedule amount for co-surgeons
- **Assistant-at-Surgery**
  Reimbursement equals 16% of the amount otherwise applicable for the global surgery.

**TPVI**

33477 – Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed

- Total RVUs 38.02
- 2017 Medicare national average payment rate $1,364.54
- Not typically Medicare aged population
- Some carriers limiting to inpatient only – members are advised to check with their local carrier regarding place of service limits
- No National Coverage Determination for this procedure
New for 2017
Paravalvular Leak Closure and
Left Atrial Appendage Closure

Procedure Codes

Clifford J. Kavinsky, MD, PhD, FSCAI,
SCAI RUC Advisor

Paravalvular Leak (PVL) Closure

93590 - Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve
93591 - Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve
93592 - Percutaneous transcatheter closure of paravalvular leak, each additional occlusion device (list separately in addition to code for primary service)

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<th>Total RVUs</th>
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<td>12.69</td>
<td>$455.44</td>
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</table>

Total RVUs

2017 Medicare national average payment rate

33340 - Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation

<table>
<thead>
<tr>
<th>Total RVUs</th>
<th>2017 Medicare national average payment rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>23.22</td>
<td>$833.37</td>
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</table>
PFO Closure

PFO is an atrial septal defect. Every insurance carrier we are aware of, direct providers to report code 93580.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
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<tr>
<td>93580</td>
<td>Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant</td>
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<table>
<thead>
<tr>
<th>Total RVUs In-Facility</th>
<th>28.47</th>
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<tr>
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<td>$1,021.79</td>
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</table>

Emerging Valve Technologies

EMVRepair via the coronary sinus (eg, annuloplasty)

0345T - Transcatheter mitral valve repair percutaneous approach via the coronary sinus

Transcatheter Mitral Valve Implantation/Replacement

33999 - Unlisted procedure, cardiac surgery

Evaluation and Management E/M Services Performed on the Same-Day as Interventional Cardiology Procedures

Osvaldo S. Gigliotti, MD, FSCAI, Chair of SCAI Advocacy Committee
Same Day E/M

The 2017 Medicare Physician Fee Schedule proposed rule targeted procedural codes commonly reported with a same day E/M code as being potentially misvalued.

CMS erred in including the STEMI PCI code on the target list. SCAI was successful in getting the code removed from this list.

Global Periods

CMS assigns global periods to all procedure codes. Almost all interventional cardiology procedure codes have a 0-day global period (eg, diagnostic cardiac cath and PCI) with the exception of a few codes for which CMS has assigned a 90-day global period (ie, TMVR, carotid stenting, AA/TA Endo Repair, TMVR and TPVI).

Minor vs Major Surgery

• Codes with a 0-day or 10-day global period are considered “minor” surgery. Codes with 90-day global periods are considered “major” surgery. The global period includes all necessary services normally furnished by a surgeon/interventionalist before, during, and after a procedure.
What’s included....

The global period includes all necessary services normally furnished before, during, and after a procedure.

The physician “work up” associated with the performance of a procedure is inherent to the procedure and is NOT a separately reportable service.

Special Circumstances

There are circumstances when Medicare does permit for the additional, separate billing of an E&M service provided on the same day as a procedure. However, the rules vary depending on whether the base service is reported with a minor surgery, 0-/10-day global code or a major surgery, 90-day global code.

For Major Surgery

If a same day E&M visit were performed in conjunction with a 90-day global procedure and that visit represented the “decision for surgery” and NOT just inherent pre-procedure work up was performed, then modifier -57 would be used to communicate to the carrier that an Evaluation and Management (E/M) service resulted in the initial decision to perform surgery either the day before or the day of the “major surgery”.

Modifier 57 - Decision for Surgery: An evaluation and management service that resulted in the initial decision to perform the [major] surgery may be identified by adding modifier 57 to the appropriate level of E/M
Decision for Minor Surgery

Per CMS National Correct Coding Initiative, Chapter 11, the decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25.

Modifier -25

Per CPT, Modifier 25 - Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service: It may be necessary to indicate that on the day of a procedure or services identified by a CPT code was performed, the patient’s condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported ... The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnosis are not required for report of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery.

So, what exactly is “a significant, separately identifiable evaluation and management service”?

The only example CMS provides is, as follows:

An example of a billable hospital observation service on the same day as a procedure is when a physician repairs a laceration of the scalp in the emergency department for a patient with a head injury and then subsequently orders hospital outpatient observation services for that patient. The physician would bill the observation code with a CPT modifier 25 and the procedure code.

We must assume, this is because the physician is no longer monitoring the patient as a result of the laceration. But, the patient has been sent to observation over other concerns related to the patient’s head injury.
What might be some examples for interventional cardiology of a “significant, separately identifiable evaluation and management service”? 

Example 1

PCI is performed on a patient. The provider becomes aware that the patient is also exhibiting signs of peripheral vascular disease that requires “significant” and “separate” work up.

Example 2

A non-interventional cardiologist performs a diagnostic cardiac catheterization procedure and afterwards consults interventional cardiologist on benefits and risks of PCI/CABG. Interventional cardiologist spends 30 minutes face time with patient and documents services in a note specifying that over half the time was counseling.
Example 3

A non-interventional cardiologist plans to perform a diagnostic cardiac catheterization procedure on patient. Patient requests more sophisticated informed consent than non-invasive cardiologist can provide. Non-invasive cardiologist consults interventional cardiologist to review chart and provide detailed informed consent to the patient. Interventional cardiologist spends 30 minutes face time with patient and documents services in a note specifying that over half the time was counseling.

Expect to Be Audited

Document, document, document

It’s not a matter of if you will be audited, it is more likely a matter of when. Be prepared.

In 2005, the OIG conducted a study of claims involving the -25 modifier finding that "Thirty-five percent of claims using modifier 25 that Medicare allowed in 2002 did not meet program requirements, resulting in $538 million in improper payments." Since that time claims involving modifier 25 are often the focus of contractor monitoring and audit.

POST PROCEDURE CARE

- CMS to gather data on post-procedure care provided for all 10- and 90-day global periods codes. Concerns over overstated follow-up care in values for surgical codes.
- FEW interventional cardiology codes implicated.
- ONLY providers in FL, KY, LA, NV, NJ, ND, OH, OR, RI will have to report post procedure care data.
- SCAI will be providing additional guidance to our impacted members.
New Time-Based Moderate Sedation (MS) CPT Codes

Dmitriy N. Feldman, MD, FSCAI, Co-chair of SCAI Advocacy

CMS Strips Work Value of MS from “Appendix G” Codes

“For all other [including most interventional cardiology] Appendix G procedures that currently include moderate sedation as an inherent part of the procedure, we [CMS] are finalizing a 0.25 work RVU reduction from the current values.”

2017 Medicare Physician Fee Schedule Final Rule

CPT Definition of Moderate Sedation

“Moderate sedation is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain cardiovascular function or patent airway, and spontaneous ventilation is adequate.”
Recapture Value Stripped Out
New Patient-Age Dependent MS
Base Code
for initial 15 minutes
+
Add-on code
for each additional 15 minutes

POLL QUESTION
Does your billing office have access to procedure
time data that will be needed to accurately
report this service?
Yes
No

Coding is Based in Intra-service Time
“Begins with the administration of the sedating
agent(s)”

“Ends when the procedure is completed, the
patient is stable for recovery status, and the
physician or other qualified health care
professional providing the sedation ends
personal continuous face-to-face time with the
patient”
Base Codes for MS Provided by Physician Performing Procedure

- **99151** Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status; initial 15 minutes of intra-service time, patient younger than 5 years of age

- **99152** Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status; initial 15 minutes of intra-service time, patient age 5 years or older

### MS Provided by Physician Performing Procedure

#### Patient 5 years or older – Base Code 99152

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<tr>
<th>Time Range</th>
<th>Code</th>
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<tbody>
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<td>Not reportable</td>
</tr>
<tr>
<td>10-22 minutes</td>
<td>99152</td>
</tr>
<tr>
<td>23-37 minutes</td>
<td>99152 + 99153 X 1</td>
</tr>
<tr>
<td>38-52 minutes</td>
<td>99152 + 99153 X 2</td>
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<tr>
<td>53-67 minutes</td>
<td>99152 + 99153 X 3</td>
</tr>
<tr>
<td>68-82 minutes</td>
<td>99152 + 99153 X 4</td>
</tr>
<tr>
<td>83-97 minutes</td>
<td>99152 + 99153 X 5</td>
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<tr>
<td>98-112 minutes</td>
<td>99152 + 99153 X 6</td>
</tr>
<tr>
<td>113-127 minutes</td>
<td>99152 + 99153 X 7</td>
</tr>
<tr>
<td>128 minutes or longer</td>
<td>99152 + 99153 X *</td>
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*99153 is incrementally increased for each additional 15 minutes

#### Patient less than 5 years old – Base Code 99151

<table>
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<tr>
<th>Time Range</th>
<th>Code</th>
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<td>Not reportable</td>
</tr>
<tr>
<td>10-22 minutes</td>
<td>99151</td>
</tr>
<tr>
<td>23-37 minutes</td>
<td>99151 + 99153 X 1</td>
</tr>
<tr>
<td>38-52 minutes</td>
<td>99151 + 99153 X 2</td>
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<tr>
<td>113-127 minutes</td>
<td>99151 + 99153 X 7</td>
</tr>
<tr>
<td>128 minutes or longer</td>
<td>99151 + 99153 X *</td>
</tr>
</tbody>
</table>

*99153 is incrementally increased for each additional 15 minutes
### Base Codes for MS Provided by Other

- **99155** - Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient younger than 5 years of age

- **99156** - Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient age 5 years or older

- **99157** - Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intra-service time (List separately in addition to code for primary service)

### Example One

65-year old patient, Percutaneous Ventricular Assist Repositioning  
Intra-procedure time: **35 minutes**

- **33993** - Repositioning of percutaneous ventricular assist device with imaging guidance at separate and distinct session from insertion
- **99152** – MS initial 15 minutes
- **99153** – MS additional 15 minutes

### Example Two

55-year old patient, STEMI PCI  
Intra-procedure time: **70 minutes**

- **92941** – STEMI PCI
- **99152** – MS initial 15 minutes
- **99153 X 4** – MS each additional 15 minutes
Potentially recoup more than stripped out minus administration costs

<table>
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<td>99157</td>
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<td>$58.50</td>
</tr>
</tbody>
</table>

Other Coding Changes of Interest and What’s in the Pipeline?

Arthur C. Lee, MD, FSCAI, SCAI
CPT Advisor

Revision to IVUS Codes to Include OCT

• 92978 Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel (List separately in addition to code for primary procedure)
• 92979 each additional vessel
In the pipeline….

- Implantable Wireless Hemodynamic Monitoring System for monitoring pulmonary artery pressure (eg, CardioMems)
- Transcatheter Mitral Valve Implantation/Replacement
- Incompetent vein chemical-based treatments

Reporting an Unlisted Code

CPT instruction, “Select the name of the procedure or service that accurately identifies the service performed. Do not select a CPT code that merely approximates the service provided. If no such specific code exists, then report the service using the appropriate unlisted procedure or service code.”

Most Common Unlisted Codes for Interventional Cardiology

- 33999 - Unlisted procedure, cardiac surgery
- 93799 - Unlisted cardiovascular service or procedure
- 37799 - Unlisted procedure, vascular surgery
Valuation of Unlisted Codes

Unlisted codes do not have a set relative value and thus payment for procedures must be on an individual basis. Carrier Medical Directors (CMD) have considerable latitude in establishing payment rates for these procedures on a case-by-case basis. For this reason, it is crucial that the CMD have access to information about the procedure/procedure(s) being reported using an unlisted procedure code. Supporting documentation including literature, an estimate of physician work, appropriate indications, and if appropriate cost savings associated with the procedure should be submitted to the CMD for consideration.

Use the Freeform Field

Whenever reporting a service using an unlisted code, it is strongly recommended that you use the freeform field of the claim form (61 characters in length) to present a crosswalk to another procedure believed to be fairly equivalent and/or comparison to a code for which there is an existing valuation.

For example, “XXX99 (unlisted code) comparable to XXXXX, payment of $XXX.XX expected”.

Example Crosswalks

TMVI/Replacement Reported using 33999
Possible X-walks to consider
- 33361 – TAVRepair code
  39.59 RVUs, 135 minutes intra-service time
- 33418 – TMVR code
  52.42 RVUs, 180 minutes intra-service time, BUT value includes post procedure follow-up within 90-day global period
Resources Available

For details regarding comparison crosswalk codes in regards to value, time, packaged post-procedure care, contact Coding@SCAI.org

The Value of Independent Specialty Designation for Interventional Cardiology

James Blankenship, MD, MSc, MSCAI, SCAI
Past-President and Cardiology’s RUC Panel Representative

POLL QUESTION?

Have the interventional cardiologists in your practice updated their Medicare profiles to reflect Interventional Cardiology as their primary specialty designation?

Yes
No
Specialty Designation

Per CMS, Your specialty is self-designated

Most interventional cardiologists are registered with CMS as general cardiologists; some are registered as internists.

Registration with CMS as an interventional cardiologist will reduce inappropriate claim suspensions and improves the quality of utilization data.

Primary/Secondary Specialty Designation

Interventional Cardiologists should register their primary specialty as interventional cardiology.

Secondary specialty should be general cardiology.

Cardiology Specialty Code

#06 – [General] Cardiology

In effect since the beginning of time...
Others

Others secured specialty designation over the years –

1993 - #93 - Interventional Radiology
2011 - #21 - Cardiac Electrophysiology
2015 - #C3 – Interventional Cardiology

Historical Concerns

Primarily unwanted scrutiny of utilization and gross expenditures by CMS by specialty

“Best to just lay low in the weeds”

No Longer Applicable – as CMS is able to track and publish, utilization and gross payment by not only specialty, but by INDIVIDUAL PROVIDER

“Weeds have all been hacked away”

SCAI Pursuit of Separate Specialty Designation

Prior to 2013 - Continual assessment and deliberation for many, many years...

Early 2013 - SCAI Executive Committee greenlights pursuit of unique specialty code for Interventional Cardiology as requested by SCAI Advocacy Committee

March 2013 – formal request submitted to CMS

May 2014 – informal notice from CMS provided that request was granted

August 2014 – formal notice published by CMS – new specialty code for Interventional Cardiology to be effective 1/1/15; carriers instructed to accept requests 1/5/15

1/1/15 – NEW INTERVENTIONAL CARDIOLOGY CODE EFFECTIVE

1/5/15 – Medicare Carriers Administrators starting accepting requests for reassignment/assignment to new Interventional Cardiology specialty code
Benefits of Separate Specialty Designation

Less Claims Denials

The most immediate impact will be that interventional cardiologists will no longer have consultation claims denied for referrals from general cardiologists within the same physician group.

Example

You and general cardiologist Dr X are in same group.

Dr X does diagnostic cath and refers patient to you for consideration for PCI.

Before 1/1/15, your consultation was coded as an established patient visit or if seen on same day, not a billable service.

After 1/1/15, if you are CMS-designated as an IC, it is now a billable new patient service.

Apples-to-Apples Comparison

Interventional Cardiology comparisons with general cardiology on quality metrics and resource consumption are skewed.

Under MACRA, these metrics will determine payments.

ICs need to be compared to other Interventional cardiologists, not general cardiologists.
Enhanced Recognition of SCAI Advocacy Efforts

Strong UNIQUE identity – with CMS, with legislators and HILL staff, with reporters, press, colleagues, and patients

Google search “CMS form 855i”


MEDICARE ENROLLMENT APPLICATION
PHYSICIANS AND NON-PHYSICIAN PRACTITIONERS

CMS-855

Help is Available

For guidance on how to update your specialty designation under the Medicare PECOS system, see http://www.scai.org/ICDesignation

and/or contact dgray@scai.org
Join the AMA - Please

- SCAI's Membership in the AMA is in jeopardy (we need more of our members in the AMA to stay in)
- Staying in gives Cardiology an extra voice and SCAI direct engagement in all CPT and RUC activity
- AMA member benefits include:
  - Unlimited access to the JAMA Network® which brings together JAMA and all 11 specialty journals with CME
  - STEPS Forward™ the AMA’s new effort to help physicians improve the patient experience, better population health and lower overall costs with improved physician satisfaction.
  - Free 18-month trial of DynaMed Plus®, and evidence-based, clinical support tool.
- Please activate your 2017 AMA membership, visit ama-assn.org or call Member Relations at (800) 262 3211, if you are currently a member. Thank you!