Reimbursement Changes with New PCI Codes in 2013

The Centers for Medicare and Medicaid Services (CMS) will reduce payment for coronary stenting on January 1, 2013. That is the bad news. More on that later.

Is there any good news? Yes. First, CMS could have cut payments for coronary stenting 10 or more years ago, but it did not.

Second, coronary stenting has been reimbursed for the past 17 years at a rate that was set in 1994. To appreciate that, one has to remember that 1994 was the year the STRESS [1] and BENESTENT [2] studies compared elective stenting to balloon angioplasty, and a randomized trial published in *Catheterization and Cardiovascular Interventions* compared then the state-of-the-art Palmaz-Schatz and Gianturco-Roubin II stents [3]. Elective stenting was just starting; most stents were placed to bail out failed balloon angioplasty.

1994 was also the year that CMS determined how much it would pay physicians to perform coronary stenting. The expert panel that advised CMS on reimbursement estimated that the average stenting procedure required 120 min of physician time from first injection of lidocaine to last catheter withdrawn, diagnostic catheterization not included. The expert panel also estimated that the average stenting procedure required 45 min of preparation time before the procedure and 60 min of physician work after the procedure, for a total physician work time of 225 min per coronary stenting case. Interventionalists have been paid at a rate based on about 4 hr per procedure for the past 17 years.

Conflict of interest: Nothing to report.

James C. Blankenship feels honored to share the byline with Dr. J. Jeffrey Marshall on this President’s Page.

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WHY CORONARY STENTING CODES CAME UNDER SCRUTINY

CMS is responsible for identifying potentially “mis-valued” services. More recently, CMS had increased its efforts to identify such services by using several “screens.” For example, procedures whose work has decreased over the years might be overvalued. CMS’s efforts to identify potentially misvalued services are in response to pressure from the Medicare Payment Advisory Commission, the independent Congressional entity that advises the United State Congress on issues affecting Medicare. Also, CMS hopes to increase funding for primary care’s “cognitive” Evaluation and Management services by shifting reimbursement away from procedures. If potentially overpriced services are revalued downward, then CMS saves money.

These economic and political forces have resulted in many cardiology procedures being revalued. In 2008, the diagnostic cardiac catheterization values were targeted. SCAI, in partnership with the American College of Cardiology (ACC), fought the reduction in the values for diagnostic catheterization services, ultimately limiting the reduction to 10 percent. Other subspecialties suffered steeper decreases: 10–40 percent for nuclear cardiology and echocardiography, and 27–56 percent for lower extremity revascularization.

In 2011, just as the new diagnostic cardiac catheterization codes and values took effect, CMS targeted coronary stenting for revaluation.

A direct resurvey of the existing stent codes might have revealed a drop in time for physician work compared to the times on which the existing values were based. If so, then a decrease in physician work times would result in lower values for coronary intervention procedures.

SCAI RESPONSE

Complex coronary stenting procedures have been reimbursed at the level of simple stenting procedures since 1994 because the CPT® codes for coronary intervention included only two codes for stenting: 92980 for stenting of the first artery and 92981 for stenting of an additional artery. There was no reimbursement code for stenting of side branches in addition to the parent vessel, and no recognition of the increased work of stenting bypass grafts, chronic total occlusions, or culprit lesions causing ST-elevation myocardial infarction. Recognizing that reimbursement for routine coronary stenting might decrease, SCAI and the ACC decided to develop a new coding paradigm for PCI procedures that more accurately captured the increased work of complex coronary procedures.

SCAI’s Arthur C. Lee, MD, FSCAI, and the ACC’s Robert Piana, MD, developed a completely new CPT cod-
