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SCAI President's Page

Reimbursement Changes with New PCI Codes in 2013

James C. Blankenship, MD, FSCAI
Secretary and Advocacy Committee Chair,
The Society for Cardiovascular Angiography and Interventions, Department of Cardiology, Geisinger Medical Center, Danville, Pennsylvania

and

J. Jeffrey Marshall, MD, FSCAI
President, The Society for Cardiovascular Angiography and Interventions
Medical Director, Cardiac Catheterization Laboratory
Northeast Georgia Heart Center, Gainesville, Georgia

James C. Blankenship J. Jeffrey Marshall

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the average stenting procedure required 120 min of physician time from first injection of lidocaine to last catheter withdrawn, diagnostic catheterization not included.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 coronary stenting 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.

*Correspondence to: J. Jeffrey Marshall, MD, FSCAI, Northeast Georgia Heart Center, 200 South Enota Drive, Suite 200, Gainesville, GA 30501. E-mail: info@SCAI.org

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James C. Blankenship feels honor 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 "misvalued" 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 coding structure to report PCI procedures with new codes that will support reimbursement for the treatment of side branches and for more complex interventions involving bypass grafts, chronic total occlusions, or STEMI. Then SCAI's Clifford Kavinsky, MD, PhD, FSCAI, championed them through the difficult and often contentious AMA relative value update Process (RUC) valuation process.

This new coding paradigm will provide differentiation and an appropriately higher level of reimbursement for complex stenting scenarios, but we will not know how the specific codes will be valued until November of this year when they are published by CMS. They will go into effect on January 1, 2013.

Many more details will be forthcoming from SCAI, including a webinar hosted by the SCAI and ACC, but in the meantime, there are three key take-aways for every practicing interventional cardiologist.

First, it is in the best interest of your practice for you to become familiar with the new CPT codes and help your coding staff learn them. To obtain appropriate reimbursement for coronary interventions in 2013, you need to master the codes and use them accurately. Ask your office staff for AMA's official CPT codebook, and read the section on Coronary Therapeutic Services and Procedures on pages 500–502.

Second, SCAI and ACC succeeded in obtaining more appropriate reimbursement for complex coronary interventions that will mitigate the overall impact of CMS cuts for interventional procedures. It is your support and engagement in your professional medical societies that makes efforts like these successful. Get involved with SCAI! You too can help to make important changes in how interventional cardiology engages with CMS.

And, third, there are more reimbursement challenges on the horizon. SCAI has been actively working to create pathways for reimbursement for new interventional cardiology procedures, such as TAVR and pVAD. Others in the pipeline include alcohol septal ablation, PDA closure, OCT imaging, and renal denervation. Once new Category I CPT codes are secured for these and other procedures, the new codes must be championed through the RUC process. The best way you can support that process is to complete RUC surveys when they are sent to you.

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