



The Society for Cardiovascular Angiography and Interventions

SCAI President's Page

Reimbursement for Coronary Intervention

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How we care for patients did not change on January 1, 2013, but how Medicare describes and reimburses our services certainly did. Most interventional cardiologists are wondering what happened, why, and what to do about it.

Since 1994, interventionists have been reimbursed for almost 4 h of work for every coronary stenting procedure, even as coronary stenting procedure times have decreased as technology and expertise evolved. In 2010, the Centers for Medicare and Medicaid Services (CMS) required that the coronary stenting Current Procedure Terminology (CPT) code be revalued. SCAI took this opportunity to introduce new codes to describe complex coronary interventions that could be reimbursed at appropriately higher rates than routine stenting.

Physicians who were surveyed in 2012 estimated the time required for coronary stenting at 45 min, down from the 2 h estimated by cardiologists in 1994. If Medicare had decided to decrease reimbursement for coronary procedures in proportion to the decreased time required for the procedure, then payments for percutaneous coronary intervention (PCI) would have dropped by 50%. However, because the new codes for

complex PCI reflected higher intensity of work, they were valued higher, so that the average decrease for the entire family of PCI codes was about 18%.

While it could have been worse, an 18% reduction in reimbursement is catastrophic to many SCAI members and the medical professionals and office staff who work with them. Is there any chance that we could convince CMS to erase the reduction? No, because SCAI and the American College of Cardiology called in all of their political bargaining chips just to limit the loss to 18%. CMS bases reimbursement for physician services mostly on time, and since practicing interventionalists (including some of you reading this)

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Conflict of interest: Nothing to report.

DOI: 10.1002/ccd.24903

Published online 21 March 2013 in Wiley Online Library (wileyonlinelibrary.com).

TABLE I. Survey Respondents Suggestions for Action

| Potential SCAI action | Respondents who support SCAI action (%) | Potential Individual action | Respondents willing to take action (%) |
|---|---|---|--|
| Meet with CMS officials to object to reimbursement cuts | 87 | Meet with CMS officials to object to reimbursement cuts | 49 |
| Write to CMS to object to reimbursement cuts | 56 | Sign letter to CMS objecting to the cuts | 80 |
| Take out ads in major newspapers objecting to cuts | 38 | Help pay for ads in major newspapers | 31 |
| Submit letter to local newspaper | 21 | Write letter to local newspaper | 24 |
| “Strike” for a day by postponing elective PCIs | 25 | “Strike” for a day by postponing elective PCIs | 26 |
| “Walk on Washington” with doctors and their patients demonstrating on the Capitol steps | 27 | Come and bring patients to an SCAI-sponsored “walk on Washington” | 21 |
| Disenroll from Medicare | 23 | Disenroll from Medicare | 10 |
| Lobby members of Congress | 77 | Meet with members of Congress | 61 |
| None of the above | 2 | Contribute to the SCAI PAC | 44 |
| | | None of the above | 5 |

estimated that coronary stenting procedure times decreased by more than 50% since 1994, there is no basis for appeal unless we challenge the entire basis for valuation that has spanned decades and encompasses all fields of patient care.

Interventionalists argue that reimbursement does not compensate for the intensity of our work. In fact, CMS values procedures in part on their intensity. SCAI and ACC argued that as technology and operator experience improved, and stent procedure times decreased, their intensity increased. This argument was successful: the new coronary PCI code values reflect intensity ratings that are 30–80% higher than the old stent codes. RVUs are appropriately higher for coronary stenting, minute-for-minute, than for cerebral aneurysm surgery, coronary bypass surgery, or aortic surgery.

How will cuts in PCI reimbursement affect SCAI members and their patients? SCAI surveyed members to find out. Here is a summary of what respondents said:

- 32% found it “likely or very likely” that they will quit or reduce their practice of interventional cardiology in the next 3 years due to changes in reimbursement or employment status.
- 31% planned to reduce or stop taking call for ST elevation myocardial infarction.
- 65% reported reductions in staffing or services in their own or colleagues’ practices.
- 47% expected that Medicare cuts will lead to rationing of care.
- 52% reported that patients complain of the facility fees charged under the Hospital Outpatient Prospective Payment System when cardiologists work as hospital employees in hospital-based facilities.

SCAI members suggested various strategies for responding to the cuts in reimbursement (Table I). Individual responses were emotional, ranging from de-

spair to anger to cynicism. Many respondents knew colleagues who had dropped or limited their interventional practice. Many knew of layoffs of staff in their practices or cath labs. Opinions about “strikes” or work slowdowns were mixed with some advocating them and others opposing them as being unprofessional.

SCAI’s Advocacy Committee and leadership have developed several principles to guide SCAI’s response:

1. For reasons mentioned above, it is unlikely SCAI can convince CMS to reverse its cuts for PCI. However, CMS bundled payment for side-branch PCI codes into the base codes against all recommendations from ACC, SCAI, and the AMA. Furthermore, CMS’s 10% reduction of payments for catheterization procedures in 2011 was arbitrary and without quantitative justification. SCAI is vigorously opposing these two decisions by CMS.
2. SCAI members should not limit their patient care if doing so denies patients necessary services (e.g., do not stop ST elevation myocardial infarction coverage at a hospital simply because of reimbursement issues).
3. Coronary intervention has been under attack by critics who suggest that it is (1) no better than medical therapy for stable patients, (2) overutilized, occasionally to an illegal extent, and (3) over-reimbursed, as suggested by CMS and the Medicare Physician Advisory Commission. SCAI is vigorously rebutting these criticisms.

SCAI plans the following actions in response to the cuts in reimbursement:

1. Continue current efforts and plan future efforts to promote and publicize high-quality patient-centered interventional practice (e.g., SCAI Quality Improvement Toolkit); reverse the misunderstandings

resulting from allegations of stent overuse in Maryland, Florida, and elsewhere; and promote the benefits of PCI, including improvements in quality of life, angina, and reduced time off from work.

2. Meet with CMS officials to object to CMS's repeated targeting of coronary procedures for payment reductions; emphasize that PCI and cath procedures have decreased by 33% since 2006 [1]; educate about SCAI/ACC quality efforts, including guidelines, appropriate use criteria, and consensus statements; provide data about the economic impact of reimbursement cuts on physicians' practices, office staff, and trends toward hospital employment; emphasize how driving cardiologists into employment has increased CMS' costs, and how >50% of patients complain of the increased fees that are associated with Hospital Outpatient Prospective Payment System.
3. Distribute sample letters to SCAI members that they can submit to local newspapers, congressional representatives, and CMS. The letters will emphasize that interventional cardiology procedures save lives, improve quality of life, and yet have decreased in frequency by 33% since 2006 and have decreased in reimbursement by 50% in the past 20 years (including the 18% reduction on January 1, 2013). Interventional cardiologists have contributed more than their share to improve quality and decrease costs for Medicare. Further cost reductions and reimbursements to interventional cardiology are likely to lead to decreased availability of services to Medicare patients (i.e., underuse of medically necessary procedures) [2].
4. Aggressively pursue reimbursement for new technologies. For example, transcatheter aortic valve replacement and peripheral left ventricular assist device procedures are reimbursed as of January 1, 2013, and next year reimbursement will be obtained

for alcohol septal ablation for hypertrophic cardiomyopathy and patent ductus arteriosus closure.

5. Work with the AMA to reevaluate the heavy reliance on time as opposed to intensity when valuing procedures, and look at other ways to value procedures appropriately in the current era.

In summary, reimbursements for interventional procedures have been revalued, based on physician surveys that document shorter procedural times for stenting in 2012 compared to 18 years ago. New PCI codes for complex PCI mitigated what otherwise would have been 50% reductions in PCI reimbursement. If SCAI members choose to reduce their interventional practices, in doing so they should not leave patients untreated. SCAI efforts will be concentrated at improving the public's and health care providers' perceptions of coronary intervention; convincing CMS to reverse recent cuts in catheterization procedures and unbundle the side-branch codes; and empowering SCAI members at a grassroots level to write letters to editors of local papers, congressional representatives, and CMS with the message of the value of coronary intervention and how interventional cardiology has done more than its share to reduce health care costs, and how further cuts in interventional reimbursement threaten availability of interventional services to patients.

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