2013 Coding Update: The House of Cardiology Prepares You for Sweeping Changes in Cardiology Coding Coming in 2013

November 28, 2012

Participant Poll

How did you hear about today’s program?

☐ Society for Cardiovascular Angiography and Interventions (SCAI)
☐ American College of Cardiology (ACC)
☐ Heart Rhythm Society (HRS)
☐ Other Source
2013 Coding Update:
The House of Cardiology Prepares You for Sweeping
Changes in Cardiology Coding Coming in 2013

Faculty

- James Blankenship, MD, MACC, FSCAI
- Arthur Lee, MD, FSCAI
- Clifford Kavinsky, MD, PhD, FSCAI
- Robert Piana, MD, FACC
- Amit J. Shanker, MD, FHRS

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Percutaneous Coronary Interventions (PCI) – A New Coding Paradigm

Robert Piana, MD, FACC

Overview

The American Medical Association’s CPT Editorial Panel approved 13 new codes for reporting on percutaneous coronary interventions.

Series of base codes for angioplasty, atherectomy, and stenting and add–on codes used when reporting interventions conducted in additional branches of one of the major coronary artery.

The new code set also includes, specific codes for the percutaneous transluminal revascularization of:

- acute total/subtotal occlusion during acute myocardial infarction (STEMI)
- chronic total occlusion
- bypass graft

These changes represent a major paradigm shift in PCI coding.
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Hierarchy of Interventions

Angioplasty (92920)

Stent (92928) = Bypass (92937)

Atherectomy (92924)

STEMI (92941) = CTO (92943) = Atherectomy with Stent (92933)

Ranked lowest to highest

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Major Coronary Artery – BASE CODE
Additional Branches – ADD–ON CODES

CPT Instruction: “PCI performed during the same session in additional major coronary or in additional coronary artery bypass grafts should be reported using the applicable additional base code(s). PCI performed during the same session in additional coronary artery branches should be reported using the applicable additional add–on code(s).”

CMS Instruction Per the 2013 MPFS Final Rule, “We believe that unbundling the placement of branch–level stents in a fee–for–service system may encourage increased placement of stents. To eliminate that incentive, on an interim final basis for CY 2013, we are rebundling the work associated with the placement of a stent in an arterial branch into the base code for the placement of a stent in an artery.” CMS bundled “the work of each new add–on code into its respective base code”. 
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CPT/CMS Bundling Conundrum

SCAI will be assessing the on-going impact of CMS’ decision not to pay for additional add-on codes, as it continues to work with CPT and CMS on this issue.

Please contact SCAI at Coding@SCAI.org to indicate how private carriers are handling the variation and if any confusion among Medicare Administrative Contractors is experienced.

Major Coronary Arteries

- Right coronary artery
- Left anterior descending
- Ramus intermedius
- Left circumflex
- Left Main
Modifiers – Level II HCPCS

- LC – Left circumflex
- LD – Left anterior descending coronary artery
- RC – Right Coronary artery
- LM – Left main coronary artery
- RI – Ramus Intermedius

CMS released modifiers LM and RI via Pub, 100-20; Transmittal 1136

Non-STEMI, Non-CTO, Non-Bypass Graft Percutaneous Coronary Interventions

<table>
<thead>
<tr>
<th>Base Code</th>
<th>PTA</th>
<th>Atherectomy *</th>
<th>Stent *</th>
<th>Atherectomy with Stent*</th>
</tr>
</thead>
<tbody>
<tr>
<td>92920</td>
<td></td>
<td></td>
<td>92926</td>
<td>92933</td>
</tr>
<tr>
<td>92921</td>
<td></td>
<td>92924</td>
<td>92928</td>
<td></td>
</tr>
<tr>
<td>Additional Branch codes (can be used with STEMI code)</td>
<td>92921</td>
<td>92925</td>
<td>92929</td>
<td>92934</td>
</tr>
</tbody>
</table>

*includes PTA when performed

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Alternate Approaches

Multi Vessel Interventions

- Monitor claims closely
- Report any carriers that do not recognize the alpha vessel modifier to Coding@SCAI.org
- For commercial carriers you may want to try use of the FREQUENCY UNIT FIELD, if a carrier is known to have difficulty handling the alpha vessel modifiers when multiple vessels are treated with similar interventions

Frequency Unit Field

For example, if the Left Main artery and the Left Circumflex are both treated with stent, Carriers should process:
- 92928–LM
- 92928–LC

However, we have received reports that some commercial carrier claims processing systems may have difficulty handling alpha modifiers. You may want to try reporting:
- 92928 with a unit of “2”
Real World Coding Example

› Real World Coding Example 1.docx

Real World Coding Example

› Real World Coding Example 2.docx
2013 Coding Update:
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Questions?

Amit J. Shanker, MD, FHRS

Ablations
# Crosswalk to Five New Codes

<table>
<thead>
<tr>
<th>2012 Code</th>
<th>Description</th>
<th>New 2013 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>93620</td>
<td>Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording</td>
<td>93653</td>
<td>Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording, His recording with intracardiac catheter ablation of arrhythmogenic focus; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathways, accessory atrioventricular connections or other atrial foci, singly or in combination</td>
</tr>
<tr>
<td>93651</td>
<td>Intracardiac catheter ablation of arrhythmogenic focus; for treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathways, accessory atrioventricular connections or other atrial foci, singly or in combination</td>
<td>(DELETED CODE)</td>
<td>(DELETED CODE)</td>
</tr>
<tr>
<td>+93622</td>
<td>with left ventricular pacing and recording (List separately in addition to code for primary procedure)</td>
<td>93654</td>
<td>Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording, His recording with intracardiac catheter ablation of arrhythmogenic focus; with treatment of ventricular tachycardia or focus of ventricular ectopy including intracardiac electrophysiologic 3D mapping, when performed, and left ventricular pacing and recording, when performed</td>
</tr>
<tr>
<td>93652</td>
<td>Intracardiac catheter ablation of arrhythmogenic focus; for treatment of ventricular tachycardia</td>
<td>(DELETED CODE)</td>
<td>(DELETED CODE)</td>
</tr>
<tr>
<td>93613</td>
<td>Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Crosswalk to Five New Codes

<table>
<thead>
<tr>
<th>2012 Code</th>
<th>Description</th>
<th>New 2013 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>93620</td>
<td>Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia, with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording</td>
<td>93656</td>
<td>Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia with right atrial pacing and recording, when possible, right ventricular pacing and recording, His bundle recording with intracardiac catheter ablation of arrhythmogenic focus, with treatment of atrial fibrillation by ablation by pulmonary vein isolation</td>
</tr>
<tr>
<td>+93621</td>
<td>with left atrial pacing and recording from coronary sinus or left atrium (List separately in addition to code for primary procedure)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>93651</td>
<td>(DELETE D CODE) Intradcardiac catheter ablation of arrhythmogenic focus; for treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathways, accessory atrioventricular connections or other atrial foci, singly or in combination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>93462</td>
<td>Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2012 Code</th>
<th>Description</th>
<th>New 2013 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>n/a</td>
<td></td>
<td>93655</td>
<td>Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>n/a</td>
<td></td>
<td>93657</td>
<td>Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation (List separately in addition to code for primary procedure)</td>
</tr>
</tbody>
</table>
Overview of the 2013 CPT Code Cat III Changes for EP Services

10 new codes and introductory language for Subcutaneous Implantable Defibrillator System (S-ICD)

- Codes for system insertion, electrode insertion only, and pulse generator insertion only
- Codes for removal of pulse generator only, bundled removal of pulse generator with insertion, removal of electrode
- Code for repositioning pulse generator and/or electrode
- Code for DFT testing
- Codes for device interrogation and programming evaluations

New S–ICD Category III Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0319T</td>
<td>Insertion or replacement of subcutaneous implantable defibrillator system with subcutaneous electrode</td>
</tr>
<tr>
<td>0320T</td>
<td>Insertion of subcutaneous defibrillator electrode</td>
</tr>
<tr>
<td>0321T</td>
<td>Insertion of subcutaneous implantable defibrillator pulse generator only with existing subcutaneous electrode</td>
</tr>
<tr>
<td>0322T</td>
<td>Removal of subcutaneous implantable defibrillator pulse generator only</td>
</tr>
<tr>
<td>0323T</td>
<td>Removal of subcutaneous implantable defibrillator pulse generator with replacement of subcutaneous implantable defibrillator pulse generator only</td>
</tr>
<tr>
<td>0324T</td>
<td>Removal of subcutaneous defibrillator electrode</td>
</tr>
<tr>
<td>0325T</td>
<td>Repositioning of subcutaneous implantable defibrillator electrode and/or pulse generator</td>
</tr>
</tbody>
</table>

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New S-ICD Category III Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0326T</td>
<td>Electrophysiologic evaluation of subcutaneous implantable defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)</td>
</tr>
<tr>
<td>0327T</td>
<td>Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter; implantable subcutaneous lead defibrillator system</td>
</tr>
<tr>
<td>0328T</td>
<td>Programming device evaluation (in person) with iterative adjustments of the implantable device to test the function of the device and select optimal permanent programmed values with analysis; implantable subcutaneous lead defibrillator system</td>
</tr>
</tbody>
</table>

Other New 2013 Codes of Interest to Cardiology

Arthur Lee, MD, FSCAI
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TAVR Category I Codes

Transcatheter Aortic Valve Replacement (TAVR) endovascular approach codes transitioned from Category III (emerging technology) to Category I codes

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TAVR – Endovascular Approach

33361 – Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach
33362 – open femoral artery approach
33363 – open axillary artery approach
33364 – open iliac artery approach
33365 – transaortic approach (eg, median sternotomy, mediastinotomy)
TAVR Transapical Approach

Category III

0318T – Implantation of catheter-delivered prosthetic aortic heart valve, open thoracic approach, (eg, transapical, other than transaortic)

TAVR Cardiopulmonary Bypass

Cardiopulmonary bypass add–on codes use in conjunction with 33361–33365, 0318T

+33367 – cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels)

+33368 – cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels)

+33369 – cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery)
TAVR Special Billing Requirements

Place of service code = 21 (inpatient hospital)

- 62 co-surgeon modifier
- Q0 modifier (signifying CED participation in a qualified registry or clinical study)
- ICD-9 secondary diagnosis code V70.7 (signifying CED participation in a qualified registry)

Percutaneous Ventricular Assist Device (pVAD)

Implantation Codes–

- 33990 – Insertion of ventricular assist device, percutaneous including radiological supervision and interpretation; arterial access only
- 33991 – both arterial and venous access, with transseptal puncture
pVAD Removal and Repositioning

Removal and repositioning of the pVAD at the same session as insertion is INHERENT and NOT separately reportable. Removal and/or repositioning of a pVAD at a separate and distinct session from insertion is a reportable event. Note: Repositioning necessitates and includes imaging guidance.

- 33992 – Removal of percutaneous ventricular assist device at separate and distinct session from insertion
- 33993 – Repositioning of percutaneous ventricular assist device with imaging guidance at separate and distinct session from insertion

Non-selective Dx Cervicocerebral Angiography

Non-Selective

36221 Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed (Do not report 36221 with 36222–36226)
Selective Dx Cervicocerebral Angiography

Selective

- 36222 Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral extracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed

- 36223 Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed

- 36224 Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed

- 36225 Selective catheter placement, subclavian or innominate artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed

- 36226 Selective catheter placement, vertebral artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed

Add-on Dx Cervicocerebral Angiography

Add-on

- +36227 Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure) (Use 36227 in conjunction with 36222, 36223, or 36224)

- +36228 Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation (eg, middle cerebral artery, posterior inferior cerebellar artery) (List separately in addition to code for primary procedure) (Use 36228 in conjunction with 36224 or 36226) (Do not report 36228 more than twice per side)
Complex Chronic Care Coordination Services

- **99487** Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month.

- **99488** Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with one face-to-face visit, per calendar month.

- **99489** Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with one face-to-face visit, per calendar month; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.

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No Payment for Complex Chronic Care Coordination Services

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>RUC REC Value</th>
<th>CMS Rec Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>99487</td>
<td>Cmplx chron care w/o pt vsit</td>
<td>1.00</td>
<td>Bundled</td>
</tr>
<tr>
<td>99488</td>
<td>Cmplx chron care w/ pt vsit</td>
<td>2.50</td>
<td>Bundled</td>
</tr>
<tr>
<td>99489</td>
<td>Cmplx chron care addt30 min</td>
<td>0.50</td>
<td>Bundled</td>
</tr>
</tbody>
</table>
Transitional Care Management Services

• 99495  Transitional care management services with the following required elements
  - communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge,
  - medical decision making of at least moderate complexity during the service period and
  - a face-to-face visit within 14 calendar days of discharge

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• 99496  Transitional care management services with the following required elements
  - communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge,
  - medical decision making of high complexity during the service period and
  - a face-to-face visit within seven calendar days of discharge
### Transitional Care Management Services

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>RUC REC Value</th>
<th>CMS Rec Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>99495</td>
<td>Trans care mgmt 14 day disch</td>
<td>2.11</td>
<td>2.11</td>
</tr>
<tr>
<td>99496</td>
<td>Trans care mgmt 7 day disch</td>
<td>3.05</td>
<td>3.05</td>
</tr>
</tbody>
</table>

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### Revisions

- +92973 now reads

  Percutaneous transluminal coronary thrombectomy mechanical

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Category III Codes

- **0291T**  Intravascular Optical Coherence Tomography during diagnostic evaluation and/or therapeutic intervention, including imaging supervision, interpretation, and report; initial vessel

- **+0292T**  each additional vessel

- **0293T**  Insertion of left atrial hemodynamic monitor; complete system, includes implanted communication module and pressure sensor lead in left atrium including transseptal access, radiological supervision and interpretation, and associated injection procedures, when performed

- **0294T**  Pressure sensor lead at time of insertion of pacing cardioverter-defibrillator pulse generator including radiological supervision and interpretation and associated injection procedures, when performed
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Coding Controversies/Highlights

Clifford Kavinsky, MD, FSCAI

Ad-hoc PCI

Diagnostic coronary angiography codes (93454–93461) and
injection procedure codes (93563–93564) should not be used
with percutaneous coronary revascularization services (92920–
92944) to report:

1. Contrast injections, angiography, roadmapping, and/or
fluoroscopic guidance for the coronary intervention,

2. Vessel measurement for the coronary intervention, or

3. Post-coronary angioplasty/stent/atherectomy angiography,
as this work is captured in the percutaneous coronary
revascularization services codes (92920–92944).

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Indications Supporting Separate Reporting of Dx Cardiac Cath w/PCI

Diagnostic angiography performed at the time of a coronary interventional procedure may be separately reportable if:

1. No prior catheter-based coronary angiography study is available, and a full diagnostic study is performed, and a decision to intervene is based on the diagnostic angiography, or

2. A prior study is available, but as documented in the medical record:
   a. The patient’s condition with respect to the clinical indication has changed since the prior study, or
   b. There is inadequate visualization of the anatomy and/or pathology, or
   c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention.

Diagnostic coronary angiography performed at a separate session from an interventional procedure is separately reportable.

Modifier –59

Modifier –59 (distinct procedural service) MUST be appended to diagnostic cardiac catheterization codes when criteria is met for separate reporting

FAILURE to append modifier –59 to the applicable diagnostic cardiac catheterization codes will result in DENIAL of claims

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Patent Ductus Arteriosus (PDA) Closure

Many commercial carriers have issued coding guidance for transcatheter PDA closure with most recommending the use of the transcatheter embolization codes, which are still component coded with catheterization and RS&I additionally, separately reported:
- 37204 – Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non–head or neck
- 75894 – Transcatheter therapy, embolization, any method, radiological supervision and interpretation
- Plus applicable catheter placement code (commonly 36013, 36014)
- Plus completion angiography code 75898 – Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion

However, there is inconsistency amongst carriers’ coding guidelines as to what other related components remain separately reportable in conjunction with 37204/75894 (eg, selective catheterization, follow-up angiography). Additionally, we found, one carrier directing use of the unlisted code 93799 (Unlisted cardiovascular service or procedure) when transcatheter PDA closure is performed using a ductal occluder device. Please check with your local carriers to see if they have issued specific coding guidance for PDA closure.

Embo Code 37204 Targeted for Bundling

- Code 37204 has been targeted by CMS for bundling.
- A new Category I code for PDA closure is in the pipeline and is anticipated to be available in 2014.
Alcohol Septal Ablation (ASA)

- To our knowledge, all insurance carriers' coverage policies for alcohol septal ablation support coverage for this procedure with directive to use an unlisted code (93799 – *Unlisted cardiovascular service or procedure*) to report these services.
- A new Category I code for ASA is in the pipeline and is anticipated to be available in 2014.

Using “Unlisted” Codes

Typically, the unlisted procedure codes are found at the end of the anatomic sections of code descriptors in the AMA CPT manual. Numerous procedures, therefore, might be described using the same unlisted code for any anatomic area. For this reason, 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.

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”.

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Real World Coding Example

- Real World Coding Example 3.docx

Questions?
The RUC Process – Building Alliances and Coalitions

James Blankenship, MACC, FSCAI

RBRVS

Resource-Based Relative Value Scale
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January 1, 1992……..

…Resource-Based Relative Value Scale (RBRVS)
was implemented by Medicare...

Today..........

........used to set payments for Medicare and > 74% of private payers

The Value of a Relative Value Unit (RVU)
(AKA Conversion Factor)
Value Typically Changes Yearly

- 1998 $36.6873
- 1999 $34.7315
- 2000 $36.6137
- 2001 $38.2581
- 2002 $36.1992
- 2003 $36.7856
- 2004 $37.3374
- 2005 $37.8975
- 2006 $37.8975
- 2007 $37.8975
- 2008 $38.0870
- 2009 $36.0791
- 1/1/10-5/31/10 $36.0791
- 6/1/10-12/31/10 $36.8729
- 2011 $33.9764
- 2012 $34.0376

2013 $25.0008
Absent Congressional Intercession

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Medicare Payment for a Procedure

Physician Work RVUs

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Medicare Payment for a Procedure

Physician Work RVUs
+ Practice Expense RVUs
+ Liability Insurance RVUs

Medicare Payment

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Example: STEMI Code 92941

Physician Work RVUs 12.56
+ Practice Expense RVUs 4.58
+ Liability Insurance RVUs 2.75
TOTAL In-facility RVUs 19.89

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Example: STEMI Code 92941

Physician Work RVUs 12.56
+ Practice Expense RVUs 4.58
+ Liability Insurance RVUs 2.75
TOTAL In-facility RVUs 19.89
X 2012 Conversion Factor ($34.0376) $677.01
X 2013 Conversion Factor ($25.0008) $497.27

Example: Stent Code 92928

Physician Work RVUs 11.21
+ Practice Expense RVUs 4.08
+ Liability Insurance RVUs 2.45
TOTAL In-facility RVUs 17.74
Example: Stent Code 92928

Physician Work RVUs 11.21
+ Practice Expense RVUs 4.08
+ Liability Insurance RVUs 2.45
TOTAL In-facility RVUs 17.74

X 2012 Conversion Factor ($34.0376) $603.83
X 2013 Conversion Factor ($25.0008) $443.51

How are values assigned to procedures?

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How Procedures are Valued

AMA’s CPT Editorial Panel Establishes a CPT Code
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How Procedures are Valued

AMA’s CPT Editorial Panel Establishes a CPT Code

AMA/Specialty Society RBRVS Update Committee (RUC) recommends a work relative value

Medicare accepts/rejects/REVISES RUC Proposal

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CMS (Medicare) directed the RUC to bundle echo codes...

The RUC dropped the value by 17%
CMS (Medicare) directed the RUC to bundle stress echo codes...

The RUC dropped the value by 7%
CMS (Medicare) directed the RUC to bundle stress nuclear cardiology codes...

The RUC dropped the value by 30%
CMS (Medicare) directed the RUC to bundle stress nuclear cardiology codes...

The RUC recommended a drop in value of 4%. CMS arbitrarily adjusted the RUCs proposed values and drop the value by 10%; sent the codes back through the RUC coupled with an assumption that economies should be in the 20–30%, the RUC reaffirmed their recommendation.

CMS (Medicare) directed the RUC to bundle dx cardiac cath codes...

- The RUC recommended a drop in value believed to be 4%
- CMS, due to changes in utilization trending, claims the RUC recommended values would only be a 1% loss in value
- CMS arbitrarily adjusted the RUCs proposed values and drops the value by 10%; sending the codes back to the RUC for reconsideration coupled with an assumption that economies should be support a 20–30% reduction on value
- The RUC reaffirms their recommendation
- CMS, again, ignores the RUC recommendation and upholds their arbitrary 10% reduction in value
CMS (Medicare) targets PCI codes for revaluation…..

The RUC Covenant
It boils down to how long the service takes (time) and the intensity of the service relative to other physicians services (with a scale that ranges from work intensity = .03 for an office visit to work intensity = .14 for brain surgery or liver transplant surgery.)

There is no allowance for whether the service is lifesaving or not (although of course lifesaving services tend to have higher intensity), how it affects hospital length of stay or other hospital costs, how long it takes to train to do the service, or reductions in complication rates (although complication risk factors into intensity).

This may not seem fair, but it is the rules of the game for the past 2 decades by which all societies have played.
2013 Coding Update:
The House of Cardiology Prepares You for Sweeping Changes in Cardiology Coding Coming in 2013

CMS (Medicare) targets PCI codes for revaluation……

The RUC reduces PCI values by 18%-20%

New reduced PCI reimbursement rates actually do reflect a higher level of intensity, and this is a victory because we effectively made the argument to the RUC that stenting is more intense now than when initially valued in 1994.

The question is not so much why reimbursement is reduced by 18%, but how we were able to get paid for 2 hours skin-to-skin procedure time for the average stenting procedure (not including diagnostic angio), from 1994 – 2012. The 2013 reimbursement numbers reflect a more realistic procedure time, as was provided by practicing interventionists in surveys for the RUC.

CMS Ignores CPT Instruction and Bundles Additional Branch Vessels Add-on Codes

CPT Instruction: "PCI performed during the same session in additional major coronary or in additional coronary artery bypass grafts should be reported using the applicable additional base code(s). PCI performed during the same session in additional coronary artery branches should be reported using the applicable additional add-on code(s)."

CMS Instruction Per the 2013 MPFS Final Rule, "We believe that unbundling the placement of branch-level stents in a fee-for-service system may encourage increased placement of stents. To eliminate that incentive, on an interim final basis for CY 2013, we are rebundling the work associated with the placement of a stent in an arterial branch into the base code for the placement of a stent in an artery." CMS bundled "the work of each new add-on code into its respective base code".

While we were successful in garnering the recognition of five major coronary arteries for payment in 2013 (CMS had previously recognized only three), the 2013 Medicare Fee Schedule Final Rule indicates CMS will not pay separately for the new additional branch codes.
RVU Rates for New Codes of Interest

New Codes 2013 RVU values – National Medicare Rates.xlsx

The CPT and RUC Arenas – the Power of Coalitions and Alliances

ACC, SCAI, HRS have built a strong team of representatives that serve by participating in the CPT and RUC processes

Safety in numbers… makes for strange bed fellows

We align with others, when it is to our benefit

- The ACR on imaging issues
- The STS for TAVR
- The ACR, SVS and SIR for peripheral angiography and interventional procedures

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What can you do?

Get involved...

Always participate in all surveys received from ACC, HRS, SCAI

- RUC survey response rates provide your RUC representatives with a much stronger foundation in advocacy efforts aimed at protecting the valuation for your services and procedures
- Other society survey efforts arm us with data; enabling us educating legislators regarding unintended consequences of policies they’ve enacted
2013 Coding Update:
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Questions?

Resources

ACC
Debra Mariani – Dmariani@ACC.org
Coding Mailbox – Coding@acc.org

HRS
Kimberley Moore – Kmoore@HRSOnline.org
Coding Mailbox – Coding@HRSOnline.org

SCAI
Dawn Hopkins – Dhopkins@SCAI.org
Coding Mailbox – Coding@SCAI.org