Coding changes and reimbursement challenges: Can we pass the buck?

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Disclosures:
- No conflicts of interest
- No discussion of off-label device use

Outline

- Coding
  - 2014 changes
- Valuation/payment
  - Review of the process
  - 2014 changes
  - The future?

Does it do any good to be involved?

Stent Placement

- Previous
  - 37205 (venous stent placement)
  - 75960 (RS&I of venous stent placement)
- 2014
  - 37238 (venous stent placement bundled code)
    - Includes stent, angioplasty and RS&I
      - 37239 (venous stent, additional vessel)
      - 37236, 37237 (arterial stent, initial and additional vessel)

Typical case

- Angioplasty at venous anastomosis with stent placed for elastic recoil, vessel rupture, or any other reason
- 2013
  - 36147, 35476, 75978, 37205, 75960
- 2014
  - 36147, 37238
    - Approximately 40% reduction in RVU’s compared to 2013

What if another venous or arterial angioplasty is done?

- Forearm loop graft with stenosis in cannulation sites (PTA) and basilic outflow (stent)
- Radiocephalic fistula with juxta-anastomotic stenosis (PTA) and stenosis in subclavian vein (stent)
- Brachiocephalic fistula with cephalic arch stenosis (stent) and arterial anastomosis stenosis (PTA)

Guiding Principle

Only one intervention can be coded in each named vessel – and the dialysis access “vessel” is from the peri-arterial anastomosis through the axillary vein
What if another venous or arterial angioplasty is done?

- Forearm loop graft with stenosis in cannulation sites (PTA) and basilic outflow (stent) – 36147, 37238
- Radiocephalic fistula with juxta-aneostomatic stenosis (PTA) and stenosis in subclavian vein (stent) – 36147, 35476, 37238
- Brachiocephalic fistula with cephalic arch stenosis (stent) and arterial anastomosis stenosis (PTA) – 36147, 37238

Coil Embolization

- Previous
  - 37204 (transcatheter occlusion or embolization)
  - 75894 (RS&I of coil insertion)
  - 75898 (post coil angiogram)
- 2014
  - 37241 (vascular embolization or occlusion, venous)

  * RVU’s increase significantly ($1800 to approx $5000)

Origin of a CPT code

- CMS makes final determination on payment
- RPA represents nephrology working closely with ASDIN for procedure issues
- CPT editorial process (determines whether new code is needed or old revised)
- Procedure needs a CPT code (new or refined)

Payment

<table>
<thead>
<tr>
<th>Total RVUs for procedure or service (identified by CPT code)</th>
<th>Physician work RVU</th>
<th>Practice expense RVU</th>
<th>Malpractice RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average time to perform procedure, cognitive skills, risk/stress</td>
<td>46.3%</td>
<td>47.4%</td>
<td>4.3%</td>
</tr>
<tr>
<td>Physician practice costs, supply costs, overhead</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost of malpractice insurance</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Each RVU is multiplied by the Geographic Practice Cost Index (GPCI) and then the Conversion Factor (CF) to get the actual payment

2013 CF = $34.0230
2014 CF = $35.6446

What prompts code review?

- High volume
- Change in place of service
- Change in dominant provider specialty
- Frequent association with another code
- Change in practice expense
- New procedure or service

What is changed?

- Re-valuation of the existing code
  - Work RVU
  - Practice expense RVU

- Bundling of several existing codes into a single new code

In most instances, both of these lead to a reduction in reimbursement
Why be involved?

- CMS continues to require bundling and revaluation of existing CPT codes
  - And this almost always leads to reduction in value
- Is my specialty society membership really making any difference in reimbursement?

### Angioplasty

<table>
<thead>
<tr>
<th>Year</th>
<th>Work RVU</th>
<th>Practice exp RVU</th>
<th>Total RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>35475 (arterial)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>9.48</td>
<td>57.92</td>
<td>68.92</td>
</tr>
<tr>
<td>2013</td>
<td>5.75</td>
<td>41.47</td>
<td>47.14</td>
</tr>
<tr>
<td>2014</td>
<td>6.6</td>
<td>37.34</td>
<td>44.95</td>
</tr>
<tr>
<td>35476 (venous)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>6.03</td>
<td>45.31</td>
<td>52.17</td>
</tr>
<tr>
<td>2013</td>
<td>4.71</td>
<td>39.06</td>
<td>44.42</td>
</tr>
<tr>
<td>2014</td>
<td>5.10</td>
<td>35.24</td>
<td>41.01</td>
</tr>
</tbody>
</table>

Summary of 2014 impact on reimbursement

**POSITIVE**
- 35476/35475 (angioplasty)
  - 2013 reduction in physician work RVU reversed
- 37241 (coil bundle)
  - Significant increase in RVU
- Conversion factor
  - Significant 2014 increase

**NEGATIVE**
- 37238/37236 (stent bundle)
  - 40% reduction mainly due to pta bundle
- Overall PE reduction for all codes
  - 10% negative impact
  - Partially offset by increase in conversion factor

### Upcoming survey

- 75978 RS&I of venous angioplasty
  - Identified for survey because it is high volume and associated with 35476 which was surveyed in 2012 and revalued in 2013
  - Total non-facility RVUs 79.40 = $2830
- Societies participating
  - ACR, RPA, SIR, SVS

Summary

- Re-valuation and bundling of CPT codes will continue into the foreseeable future
  - Pressure is for reduced reimbursement
- Interventional physicians have a voice through ASDIN and RPA
- We are making a difference – the buck stops here!
- Long term requires a different focus ...