THERE IS NOTHING PERMANENT EXCEPT CHANGE.
From Lives of the Philosophers by Diogenes Laertius

Changes in coding which will be updated for 2011:
• 1. Add On codes for 36148 and 37186
• 2. 35475 has been made a component of a column 1 code and
• 3. All 70000 level codes now require a-59 modifier when coupled with a 30000 level code

Changes in reimbursement for 2011:
• For the positive: add-on codes defined
• For the positive: increases in most 30000 level codes of about 10%
• For the positive: the SGR has at least temporarily been fixed
• For the negative: the application of the 59 modifier for 70000 level codes

Changes in reimbursement for 2011:
• For the negative: decrease to the conversion factor of about 8 %
• For the negative: the definition of an access is the same for a fistula as well as a graft
• For the negative: only one angioplasty code is allowed from the arterial anastomosis up to the central veins

Changes in reimbursement for 2011:
• For the negative: an arterial and venous angioplasty (35475 and 35476) may not be coded within the body of the access for the same procedure
• For the negative: only one angioplasty code may be used within the central vessels
CODING CHANGES

Coding changes:
- Add-on codes: what are they?
  - When multiple procedures are performed in the same setting they are reduced by 50% with only the highest value code getting full value.

Coding changes:
- However, when the CPT committee constructs certain codes the multiple procedure modifier is built into the body of the code.
- Therefore, the value of these codes should not be reduced further even though they are an additional procedure.
- They are identified with the symbol (+).

Coding changes:
- I would try to avoid using the 59 modifier as it may cause confusion
  - However, your intermediary (MAC) may require it
  - Appeal if they mistakenly drop the value when they issue payment

Coding changes:
- The National Correct Coding Initiative (NCCI) is an organization solely owned by CMS
  - It establishes edits to screen all coding submissions to make sure inappropriate combinations of codes are not reimbursed by the MACs

Coding changes:
- Codes will be listed in columns 1 and 2 of an edit with the highest value code in column 1
  - If two codes are felt to be incompatible, the second code will be designated (0) in the sixth column of the edit
Coding changes:

- If two codes are felt to be compatible, the lower value code will be designated with a (1) in column 6
- This indicates that it should be reduced in value by 50%

Coding changes:

- However, if the column 2 code is an add-on code, column 6 will designate a (+) indicating that its value should not be reduced in value further
  - Codes that we use that fall into this category are 36148, 37186, 36218, 36248

Coding changes:

- NCCI released an edit with 35476 in column 1 and 35475 in column 2
  - Although we pointed out to them that this would result in 35475 (the higher value code) being reduced in value

they disagreed

"I said SIT!, You Idiot!"

Coding changes:

- As soon as members started receiving reductions in 35475 we went back to NCCI
  - CMS finally agreed to change the edit and now 35475 is a column 1 code 35476 is a column 2 code

Coding changes:

- Some years ago, CPT/RUC decided that since 30000 level codes are susceptible to a multiple procedure reduction, associated 70000 level codes when USED WITH a 30000 level code should also be reduced
Coding changes:

• NCCI is now releasing edits that will force this reduction in the 70000 level codes when they are used with a 30000 level code

• Percutaneous placement of PD catheter had been coded: 49421

• However, the entire area of surgical and percutaneous placement of PD catheters was found to be problematic by the RUC

Coding changes:

• Existing codes were wiped out and new ones created

• ASDIN and RPA worked closely with SIR/ACR to create the CPT description of 49418 based around the insertion of a PD catheter

• Working with the RPA we were instrumental in the obtaining adequate value for the procedure

• 2011 RVUs released and there is an approximate 4 fold increase in value in POS 11

Purely reimbursement changes:

• VALUATION OF CPT CODES IS A COMPLEX PROCESS.

• THE RVU’S ARE ASSIGNED BY THE RUC.

• CMS adds in factors for overhead, or what are called GPCI’S (geographic practice cost index)

  These are for malpractice and cost-of-living differences

  • These vary by place of service
Coding changes:

• People who understand the variables that go into these calculations often have PhD’s in statistics, public policy or related fields

So I would just concentrate upon the results

Coding changes:

• This year, CMS decided to correct inequities in the practice overhead expense in place of service 11
  – This resulted in increases in most of our 30000 level codes of about 10%

Coding changes: we celebrated,

BUT

Coding changes:

• But then we thought it through and remembered that if something appears to be too good to be true it probably is………

The SGR

• MMA (Medicare Modernization Act) is a statutory change that was mandated by Congress some years ago with the intent to help make Medicare solvent in the long run
The SGR

- Its methodology was faulty and resulted in inordinate decreases in physician reimbursement
  - As physicians started to drop out of the Medicare program Congress started passing a series of temporary fixes to the SGR

- Because the SGR was statutory and because the Bush administration and Congress never attempted a permanent fix, the physician reimbursement changes kept adding up

- This year, physicians were faced with a 21% decrease
  - A longer but still temporary fix was passed by Congress
  - Part of this resulted in the reassessment of the overhead practice expense

- However, “Medicare is a zero sum game”
  - For anything which goes up, something must go down

- To convert CPT codes to dollar values the RVUs associated with each are multiplied by a conversion factor
  - The conversion factor for 2010 was $36.87
  - To maintain budget neutrality the physician conversion factor was reduced to $33.97 in 2011
The SGR

- This is an 8% decrease when applied to all of our codes
- When this is combined with the 10% increase to the 30000 level codes it is pretty much a wash

Changes in coding practices:

- As our field has evolved we have gone from 90% grafts to approximately 50% fistulas

Changes in coding practices:

- It is apparent to any of us who do these procedures daily that working in fistulas is significantly harder than working on grafts

Changes in coding practices:

- However, the data it is not there to sustain this assertion scientifically
- CMS, lacking this data, is unwilling to differentiate for coding purposes between fistulas and grafts

Changes in coding practices:

- By defining the access the same for both fistulas or grafts, CMS maintains the following principles which have been communicated to the intermediaries:
  - The access, AVG or AVF, extends from the arterial anastomosis up to but not including the subclavian vein
  - In this circuit only one angioplasty code is allowed for any single procedure
Changes in coding practices:
• A second angioplasty code is allowed for the central vessels that may be used only once and therefore
• A maximum of two angioplasty codes will be allowed any single procedure

Changes in coding practices:
• However, we have been in discussions over the last several years with SIR to resolve differences in approach towards coding

Changes in coding practices:
We have all agreed, including the vascular surgeons, on the definition of an arterial angioplasty

Changes in coding practices:
• If the balloon must cross the anastomosis into the artery in order to perform the angioplasty, it should be coded as an arterial angioplasty (35475)

Changes in coding practices:
• That also means that if an angioplasty is done at the arterial anastomosis and within the fistula, only one angioplasty code is allowed but it should be 35475 and not 35476
Changes in coding practices:

• This definition will be added to the CPT manual this year

• Prior to that, you may have problems with intermediaries but should definitely appeal any denials

Questions?

My name is Gerry Beathard