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
  — What is coming?

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

  — Approximate 40% reduction in RVU's compared to 2013

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

Typical case

• Fistula angiogram for failure to mature identifies a large accessory vein that is embolized with several coils

• 2013
  — 36147, 36011, 37204, 75894, 75898

• 2014
  — 36147, 36011, 37241

  — Payment impact: $1800 $5000
Origin of a CPT code

- CMS*
- RUC process (determines relative value for the code)
- CPT editorial process (determines whether new code is needed or old revised)
- Procedure needs a CPT code (new or refined)

Payment

- Total RVUs for a procedure or service (identified by CPT code)
- Average time to perform procedure, cognitive skills, risk/stress
- Physician work RVU (pre, intra, post service)
- Practice expense RVU
- Malpractice RVU
- Cost of malpractice insurance

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

- 2013 CF = $34.0230
- 2014 CF = $35.6446

What prompts code changes?

- Existing code
  - High volume
  - Change in place of service
  - Change in dominant provider specialty
  - Frequent association with another code
  - Change in practice expense
- New Code
  - 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, this leads to a reduction in reimbursement

Origin of a CPT code

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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>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Work RVU</th>
<th>Practice exp RVU</th>
<th>Total RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>35474 (venous)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>6.03</td>
<td>45.31</td>
<td>51.17</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>
Peripheral Arterial Disease

<table>
<thead>
<tr>
<th>Code</th>
<th>2013 Total RVU</th>
<th>2014 Total RVU</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>37220</td>
<td>100.67</td>
<td>90.32</td>
<td>-10%</td>
</tr>
<tr>
<td>37221</td>
<td>147.25</td>
<td>132.60</td>
<td>-9.9%</td>
</tr>
<tr>
<td>37224</td>
<td>121.25</td>
<td>109.40</td>
<td>-9.7%</td>
</tr>
<tr>
<td>37226</td>
<td>286.09</td>
<td>266.48</td>
<td>-7.3%</td>
</tr>
<tr>
<td>37228</td>
<td>172.90</td>
<td>155.46</td>
<td>-10%</td>
</tr>
<tr>
<td>37230</td>
<td>261.34</td>
<td>235.43</td>
<td>-9.9%</td>
</tr>
</tbody>
</table>

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?

Summary of 2014 impact on reimbursement

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

Survey Step 1:
Form multidisciplinary task force

- Develop “typical patient scenario”
- Identify possible comparison codes for survey
- Send survey to each society’s participating members

Survey Step 2:
Specialty societies survey members

- Survey will be sent to all interventional nephrologist members of the RPA
  - Coordinate with ASDIN to ensure all IN’s identified
- Participants will have ~ 2 weeks to complete the survey
- Survey requires 20-30 minutes to complete
- Only complete and accurate surveys will be included
Taking the survey: 6 steps to completion

• STEP 1 – Review code descriptor and vignette (a short description of the “typical” patient)
• STEP 2 – Review introduction & complete contact information
• STEP 3 – Identify a reference procedure
• STEP 4 – Estimate your time
• STEP 5 – Compare the survey procedure to a reference procedure
• STEP 6 – Moderate Sedation
• STEP 7 – Estimate work RVU (relative value unit)

Any mistake, anything incomplete = DISCARDED!

Survey Step 3:
Task force analyze and present results

• Collate all completed surveys
• Assign RVU’s (work and PE) based on survey results
• Present task force recommendation to RUC
  April 2014
• CMS publishes proposed rule for comment in August 2014
• CMS publishes final rule in November 2014

Summary

• Re-valuation and bundling of CPT codes will continue into the foreseeable future
  – Pressure is for reduced reimbursement
• Interventional nephrologists have a voice through ASDIN and RPA
• We are making a difference — the buck stops here!
• Success may require a different focus …