2019 CMS Reimbursement and Your Ambulatory Strategy

As trends in health care continue to move toward ambulatory surgery centers, will you be ready to take advantage of the benefits they can offer?

WITH TONY LAFATA; MARC TOTH, CMAA; AND JACOB TURMELL, DNP, RN, NP-C, ACNS-BC, CCRN-CMC

Changes in health care are occurring at an incredibly fast rate, and cardiology is no exception to this phenomenon. We are all affected by these changes, whether it is in the migration of services to the ambulatory space, evidence-based practices, new medications, best practice guidelines, technology changes, or reimbursement rules. Many programs utilize multiple sources of information, including journals, newsfeeds, and blogs, to keep up with the constant changes. One area that can be both challenging and incredibly confusing to keep up with is the rules surrounding reimbursement rates from the Centers for Medicare & Medicaid Services (CMS). Recently, CMS published reimbursement guidelines for 2019. This article is a conversation among Tony Lafata, Chief Development Officer of National Cardiovascular Partners; Marc Toth, Chief Executive Officer of ACA Cardiovascular; and Jacob Turmell, Vice President of MedAxiom Consulting, about the changes included in the guidelines and the expected impact they will have on ambulatory strategies in cardiology.

IMPLICATIONS OF THE CMS RULING

Mr. Lafata: In October 2018, CMS issued the final rule governing Medicare reimbursement in an ambulatory surgery center (ASC) for the 2019 calendar year, updating some important rules related to allowable payments in an outpatient setting, ASC, and office-based lab (OBL). In the ruling, CMS revised the definition of *surgery* to include "surgery-like" procedures that are assigned codes outside the CPT surgical range. CMS also finalized its proposal to include 17 cardiac-specific diagnostic codes that were not eligible for coverage in surgery centers under the previous definition of surgery. As of January 2019, physicians who were performing these procedures in the hospital outpatient setting can begin to perform them in the ASC setting. Keep in mind, however, that this is subject to individual state laws and regulations. The complete list of the new codes, with their descriptors and payment indicators, are included in Table 1. This is a critical step for the addition of percutaneous coronary intervention (PCI) procedures to be covered by CMS in the ASC setting.

WHAT DO THE RECENT CMS RULINGS MEAN FOR YOUR PRACTICE?

Mr. Toth: If you're basing your group's overall ASC strategy solely on the rates and covered services for 2019, then you might be missing the bigger picture. The outpatient migration that we have seen in gastrointestinal, orthopedic, spinal, and pain procedures over the past 40 years has paved the way for the cardiovascular outpatient migration wave. First, it was vascular access, then peripheral artery procedures, then electrophysiology device implants; now, coronary diagnostic catheterizations are migrating to the ambulatory setting. The movement is here, and the bigger picture looks beyond the 2019 ASC final rule and into 2020, when many expect that PCI will be added to this list. That is the big picture that will reshape the ambulatory strategy for many cardiovascular programs and patients. Technologic advancements, such as those in radial access and closure devices, as well as trends toward increased adoption of same-day discharge strategies have made OBLs and ASCs (or a hybrid of the two) efficacious site-of-service options in the cardiovascular outpatient migration. OBLs are limited in their scope of service but are traditionally easier and less expensive to open and operate. ASCs offer a broader scope of service—CMS has approved more than 3,600 CPT codes in ASCs and will continue to add new codes each year. Combining the two sites of service into one facility to open a "hybrid" lab seems to be a model that is here to stay. Having two different sites of service in the same building (licensing it as a different type of facility on preassigned days of the week) is a great way to mitigate the risk of CMS dramatically lowering the rates in one setting, as happened in 2017 for fistula work.

Partnering with the hospital, the practice, and an ASC company in a joint venture is another good way

TABLE 1. NEW CARDIOLOGY CODES FOR 2019 ACCORDING TO MR. LAFATA		
CPT Code	**Descriptor**	**CY 2019 ASC Payment Indicator**
93451	Right heart catheterization, including measurement(s) of oxygen saturation and cardiac output, when performed	G2
93452	Left heart catheterization, including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed	G2
93453	Combined right and left heart catheterization, including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed	G2
93454	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation	G2
93455	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography	G2
93456	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization	G2
93457	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization	G2
93458	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	G2
93459	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	G2
93460	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	G2
93461	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	G2
93462	Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (list separately in addition to code for primary procedure)	N1
93566	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective right ventricular or right atrial angiography (list separately in addition to code for primary procedure)	N1
93567	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for supravalvular aortography (list separately in addition to code for primary procedure)	N1
93568	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for pulmonary angiography (list separately in addition to code for primary procedure)	N1
93571	Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel (list separately in addition to code for primary procedure)	N1
93572	Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; each additional vessel (list separately in addition to code for primary procedure)	N1
Abbreviations: ASC, ambulatory surgery center; CPT, Current Procedural Terminology; CY, calendar year.		

to potentially mitigate risk. This is the "good neighbor" approach, and it has worked very well with multispecialty ASCs. As more cardiovascular procedures shift to the ambulatory setting, hospitals may be more amenable to partnering with physician groups in an ASC model. This allows you to maintain your referral base and have a partner with access to capital and real estate options for an ASC. Additionally, there are experts in the field of ASCs that are always seeking high-quality partners for a joint venture, either solely with a physician group or with physicians and hospital partners combined.

A LOOK BACK

Mr. Turmell: Although some might be concerned with safety in this setting, we should reflect on the days in cardiac catheterization before we had the ability to perform elective PCI in the hospital without surgical backup. These patients were loaded into the ambulance and transferred to a facility that could intervene, often with the sheaths still left in place. Patient care may not have been efficient, but it was a necessary step in moving toward allowing PCI without surgical backup.

Another concern that we expect will soon be alleviated is that a practice would have two separate standards of care for those with Medicare/Medicaid and those with commercial payors. Some select commercial payors have been reimbursing for diagnostic catheterizations and interventional procedures in the ASC and OBL settings. So, although a practice could keep the private payor patient on the table and intervene on a blockage in the ASC setting, the same blockage and in a patient with Medicare coverage would have to be transferred. This difference in care and lack of standardization does not drive efficient care models, and we look forward to this discrepancy being eliminated, as well as the adoption of payment by more private payors that would ultimately follow the lead of CMS. I anticipate that we will see this movement to outpatient PCI as we continue to see the safety and efficacy of catheterizations and coronary interventions in the ASC setting. The advantages for the patient and the interventionalist should continue to drive this migration until the day comes when we could possibly see the hospital-based labs become more focused on urgent procedures and myocardial ischemia patients. This would allow the ASCs to play a much greater role in diagnostic and elective coronary intervention cases.

WHAT'S NEXT?

Mr. Toth: Who would have thought 10 years ago that level 3 spinal fusions and total joint replacements would be performed in an ASC? Probably not many of us. So, what are the possibilities for future procedures to be performed in the ambulatory setting? Could we see the following procedures being performed in an ASC setting within the next 5 to 10 years?

- PCI: Same-day discharge; PCI in hospitals without surgical backup
- Transcatheter aortic valve replacement: 30-minute procedures for nonsymptomatic low-risk patients
- Endovascular aneurysm repair (EVAR): A vascular center in the Southeast has successfully performed a series of EVAR cases in an outpatient setting
- Left atrial appendage occlusion: Watchman device (Boston Scientific Corporation) implantation procedures

This shift from inpatient to outpatient to ambulatory is one that is being felt throughout health care. If we think about what is best for the patient, many would argue that the ambulatory space is ideal for patients to undergo elective PCI. The centers are accredited and report to the same registries as the hospital outpatient departments. Furthermore, the patient can access the ambulatory center more easily than a large hospital. The risk of an urgent procedure delaying the elective procedure is unlikely to nonexistent, and the physicians and staff may feel more ownership toward the care the patient receives. I think these driving forces will continue to have health care providers and payors evaluating which procedures can safely move to the ambulatory space to provide better and lower-cost care. If not you, then your market will certainly experience the effects of this outpatient strategy for coronary diagnostics and interventions. Where will you be standing when it happens? ■

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