

Letters

I'm not sure what is more disappointing about the article entitled "The New 2013 Coronary Intervention Codes" in the March/April 2013 issue of *Cardiac Interventions*

Today: the fact that it tries to rationalize the reimbursement cut to coronary interventions or the fact that it was written by our American College of Cardiology/Society for Angiography and Interventions (ACC/SCAI) representatives to the Relative Value Update Committee.

This article, along with another recent article in SCAI's *Catheterization and Cardiovascular Interventions*,¹ states that the impetus for the reimbursement cut was the response given by cardiologists on a 2012 survey. "Practicing cardiologists estimated the skin-to-skin time required for coronary stenting to be much less than the 1994 estimate of 2 hours; 45 minutes to be exact." In other words, we cardiologists are to blame because of the answers given on a random survey. Not only does the article fail to mention any challenge to this random survey, or its inherent flaws, but it also goes on to explain that "without the new codes, reimbursement would have been reduced proportionately by 50%." Interventionists should all take solace in knowing that things "could be worse."

The article goes on to explain the "logic" behind the relative value unit (RVU) reimbursement system. It gives a brief background; however, it only discusses the "work RVU" in the total RVU formula. In fact, the work RVU, in most cases, accounts for approximately 50% of the total RVU. The article fails to mention the "practice RVU" or the "malpractice RVU" components of the formula, which account for the other half of the total RVU. Although the procedure time for a percutaneous coronary intervention (PCI) in 2013 may have gone down, the amount of stress, malpractice liability, and overhead (also factored into the total RVU) have undeniably increased proportionally, if not more. No other procedure in medicine is as time-sensitive (in terms of patient outcome and quality-of-care reporting) as coronary interventions (ie, door-to-balloon times). Although the authors' example of emergency tracheostomy gets a high-intensity rating, I am unaware of any core quality measure reporting on such procedure times.

The article's cheerleading for the new CPT codes culminates with the assertion that, "The new codes solve several long-standing problems." I almost choked on my coffee. It claims that interventionists are now reimbursed for the intensity of ST-elevation myocardial infarction (STEMI), saphenous vein graft, and chronic total occlusion interventions. The article fails to mention the absurdity that PCI in a crash-and-burn anterior STEMI in cardiogenic shock reim-

burses the same as PCI in a stable, asymptomatic non-STEMI case—or why the difference between a straightforward 1-hour PCI and a challenging 3-hour PCI is only a "modifier." I challenge the authors to find a single interventional cardiologist in clinical practice who agrees that this new coding system "solves" anything.

Contrary to the facile optimism of the article, I think the new CPT codes solve absolutely nothing. Trying to rationalize them, or claiming that they "solve" anything, is insulting to interventionists. One of the responsibilities of the ACC/SCAI is to represent the interests of cardiologists. By taking such a moderate stance on this issue, our ACC/SCAI representatives weaken any ground they have for counterargument to CMS. The new codes are simply old wine in a new bottle—a completely irrational and broken system that was contrived by panels of "experts," many of whom are obviously detached from any clinical reality in the practice of medicine. It takes willful ignorance not to see this.

Payam Fallahi, MD, FACC, FSCAI
Hagerstown, Maryland

1. Blankenship JC, Marshall JJ. Reimbursement for coronary intervention. *Cathet Cardiovasc Interv*. 2103;81:745-747.

RESPONSE

We appreciate Dr. Fallahi's letter regarding our article on the new PCI codes and their values, which average 20% less than the old PCI codes.¹ He has articulated what many interventionists are thinking—that the interventional cardiology community should be taking more radical actions to fight these reductions.

First, consider what actions have already been taken. We knew long ago that these cuts would someday occur, and we were able to keep them off of the CMS chopping block for the past 10 years. Although that offers little solace now, a generation of interventionists has enjoyed reimbursement rates for PCIs that made interventional cardiology one of the highest-paid of all specialties.

Anticipating these cuts, representatives of the ACC and SCAI wrote new codes that would allow at least some of the codes (eg, for STEMI) to retain relatively higher value—as opposed to having all PCI procedures radically devalued. That process further delayed the cuts by a couple of years.

When the new codes were valued, these same representatives convinced the American Medical Association's Relative Value Update Committee and CMS that the intensity of work for PCI was three to six times that of cognitive services—much higher than was assumed for the old PCI codes.

Remember that for the past 20 years, reimbursements for PCI codes have been based on the assumption that the average PCI took 2 hours skin-to-skin. So, although the 20% reduction in PCI code values now is terrible, it is quite true that the devaluation could easily have occurred 10 years ago and could have been much worse.

Dr. Fallahi suggests that the survey methodology that estimated the average time for a PCI (excluding diagnostic angiography) of 45 minutes is flawed. There is widespread agreement on this point, and CMS has hired contractors (Rand Corporation and Urban Institute) to produce alternative estimates of procedural times and alternative valuation methodologies. Our personal experience, as well as those in published articles,²⁻⁵ suggest that average PCI times may be even less than 45 minutes. If the CMS contractors confirm that, CMS will further reduce reimbursement for PCI.

Dr. Fallahi notes correctly that our article discussed only work RVUs and that “the work RVU, in most cases, accounts for approximately 50% of the total RVU.” For the PCI codes, work RVUs are approximately two-thirds of the total RVU. For the base stenting codes, 92928, the work RVU is 11.21, RVUs to pay for malpractice insurance are 2.45, and RVUs to pay for practice expenses (eg, running your office while you are doing the PCI) are 4.1. If this seems inadequate, compare it to the values for a level-5 outpatient visit, for which malpractice RVUs are 94% less (0.14 RVUs), and practice expense is 50% less (1.95 RVUs). Part of the practice expense RVUs are for indirect expenses (overhead), which CMS estimates based on a survey of medical practices done several years ago. Both the ACC and SCAI have vociferously and repeatedly (as recently as June 2013) lobbied CMS to update this survey, but to date, CMS has refused to do so. We urge readers to write to CMS on this issue.

Dr Fallahi states that “STEMI in cardiogenic shock reimburses the same as PCI in a stable, asymptomatic non-STEMI case.” This reflects some confusion between 92928 (the basic stenting code, 11.21 RVUs) and 92941 (percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, 12.56 RVUs). As written, the 92941 code could be used for the 80% of STEMI patients and the 20% of NSTEMI patients with “total/subtotal occlusion.”^{6,7} The 92941 code was *intended* only for patients taken to the catheterization laboratory emergently for STEMI or STEMI equivalents (new left bundle branch block or posterior MI). The AMA will clarify this in its coding publications, and operators should be careful to document the emergent nature of procedures using this code. Finally, most shock patients also receive a balloon pump (code 33967, 4.84 RVUs) or a percutaneous left ventricular assist device (code 33990, 8.15 RVUs).

The larger issue is that for any given procedure, cases that are stressful or prolonged do not have a special code. They can be designated “modifier -22,” which some pay-

ers will reward with a 25% to 50% additional payment.^{8,9}

Remember that procedures are valued based on the *average* procedure. If you are not paid extra for a difficult case, you are not paid *less* for the easier-than-average PCI of a slam-dunk type A lesion. CMS and indeed the entire health reform movement is actively moving away from paying for the particular service you provided in favor of payments for large bundles of care. We were fortunate that CMS agreed with breaking the one old coronary stenting code into codes for basic PCI, STEMI PCI, graft PCI, and chronic total occlusion PCI. There is just no chance that CMS would agree to separate codes based *only* on the length or difficulty of the procedure.

Dr. Fallahi is discouraged that representatives of the ACC and SCAI did not take a more militant stance with respect to the PCI reimbursement cuts. SCAI did object to these cuts in letters and a face-to-face meeting with CMS officials. SCAI surveyed members for suggestions about additional possible actions. Few members even responded, and only a handful agreed to participate in strikes, work slowdowns, or a demonstration on the Capitol steps in Washington, DC. SCAI emailed templates of letters that members could personalize and send to CMS, their legislators, and local newspapers. To date, it appears few members have taken even those simple actions. Both ACC and SCAI have political action committees that allow interventionists to translate their outrage into action. We urge members of ACC and SCAI to get involved. In fact, Dr. Fallahi was offered membership on the SCAI Advocacy Committee and has agreed to participate. We look forward to his input on future actions and suggest others get similarly involved by contacting the authors at jblankenship@geisinger.edu or clifford_j_kavinsky@rush.edu. ■

*Jim Blankenship, MD
Danville, Pennsylvania*

*Cliff Kavinsky, MD
Chicago, Illinois*

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