

2008 Medicare Physician Fee Schedule Final Rule: Impact on Payment for Cardiovascular Imaging Services

Medicare payments for many key cardiovascular imaging services will continue to decline in 2008. Payment restrictions result from a CMS regulatory initiative -- the revised method for calculating practice expense RVUs -- and a statutory mandate -- the Deficit Reduction (DRA) cap on Medicare payments for the technical component of in-office imaging services. In addition, the Final Rule addressed coding policies and announced payment and coverage related to new codes that are relevant to cardiovascular imaging.

Practice expense RVUs

2008 is the second year of the transition to a revised method for calculating the practice expense portion of Medicare physician payments. A key element of the revised method was elimination of a separate practice expense methodology for services without physician work RVUs. When the resource based practice expense methodology was first implemented in 1999, data were insufficient to establish reasonable values for many services without physician work RVUs. These services included both procedures performed by non-physicians (e.g., audiology, medical nutrition services) and physician procedures split into a professional component and technical component (e.g., imaging procedures). CMS therefore developed an alternative methodology for these “non-physician work pool” services. The alternative methodology relied on pre-1999 charged-based practice expense values to calculate practice expense RVUs for such services. As a result, practice expense RVUs for the nonphysician work pool services remained fairly close to their pre-1999 levels, instead of being cut significantly, as they would have been under the standard methodology.

Between 1999 and 2006, CMS worked with the AMA/Specialty Society Practice Expense Advisory Committee (PEAC) to refine the direct practice expense data. Several specialties, including cardiology and radiology, which performed the largest share of services in the non-physician work pool, conducted supplemental surveys of overall practice expenses. In a 2006 proposal, CMS determined that data for the non-physician work pool services was sufficiently improved so that the non-physician work pool method was no longer justified. The move to a single methodology results in significantly reduced practice expense RVUs for nearly all services that were in the non-physician work pool.

The new formula is being phased in over four years from 2007 to 2010. In 2008, practice expense RVUs reflect a 50/50 average of the RVUs from the previous formula and the RVUs from the new formula. As a result, payments for many, though not all, cardiovascular imaging services provided in the physician office will decline in 2008 and will continue to decline in 2009 and 2010. Table 1 shows the impact on payment for several representative cardiovascular imaging services.

Table 1

Trends in National Average Medicare Payments for Selected Cardiovascular Imaging Services

Payment to Physician When Performed in Physician Office

CPT Code	Modifier	Short Descriptor	2006	2007	2008	2010
71275		Ct angiography, chest	\$ 586	\$ 390	\$ 386	\$ 386
78465		Heart image (3d), multiple	\$ 548	\$ 473	\$ 471	\$ 457
78478		Heart wall motion add-on	\$ 96	\$ 80	\$ 63	\$ 46
78480		Heart function add-on	\$ 96	\$ 72	\$ 55	\$ 37
93307		Echo exam of heart	\$ 205	\$ 197	\$ 172	\$ 164
93320		Doppler echo exam, heart	\$ 90	\$ 87	\$ 76	\$ 73
93325		Doppler color flow add-on	\$ 122	\$ 100	\$ 71	\$ 32
93350		Echo transthoracic	\$ 152	\$ 172	\$ 177	\$ 224
93556		Imaging, cardiac cath	\$ 440	carrier	\$ 232	\$ 73
93880		Extracranial study	\$ 249	\$ 181	\$ 170	\$ 170
93924		Extremity study	\$ 212	\$ 220	\$ 208	\$ 227

Deficit Reduction Act

The Deficit Reduction Act (DRA) required that, beginning in 2007, Medicare payments for the technical component of in-office imaging services be limited to the lesser of the amount determined by the Medicare Physician Fee Schedule or the amount paid under the Medicare Hospital Outpatient Prospective Payment System (HOPPS). For 2007, the DRA payment cap has had a large impact on cardiovascular imaging, costing cardiology more than \$150 million in Medicare payments. Nearly half of the impact resulted from the cap on payment for a single procedure – the SPECT myocardial perfusion imaging study (CPT 78465).

In 2008 the impact of the DRA cap on cardiology is less severe – ACC analysis projects an impact of less than \$50 million based on current information, due in large part to policy changes adopted under HOPPS. The 2008 HOPPS includes new policies on packaging and bundling that raised HOPPS payment rates for some key cardiovascular imaging services to levels higher than corresponding payment amounts under the physician fee schedule. Therefore, the physician fee schedule payment amount will prevail. The bundling and package policies do not apply to physician services, just to hospital outpatient departments facility fees, so the payment amounts may not be directly comparable. However, the DRA statutory requirements and implementing regulations do not compel CMS to take such questions of comparability into account in determining whether the DRA cap applies. So, for example, the HOPPS payment rate for the technical component of CPT 78465 (SPECT MPI) is higher than the physician fee schedule payment, so physician practices performing this service will receive the full physician fee schedule payment amount.

Payments for many imaging services performed by cardiovascular specialists will be limited by the DRA, though. Vascular imaging studies such as a duplex scan of extracranial arteries (CPT 93880), as well as cardiac CTA (CPT 0144T – 0151T) and cardiac MR procedures (CPT 75557 – 75564) are affected by the cap.

Echocardiography coding

One bright spot in the Final Rule was CMS's decision not to implement a proposal to eliminate separate payment for color flow Doppler echocardiography (CPT 93325) into all other echocardiography services. ACC worked very closely with the American Society of Echocardiography in the weeks following the release of the bundling proposal to convince CMS to rescind this ill-advised and harmful policy. The ACC/ASE efforts were back up by broad-based support from the AMA/Specialty Society RVS Update Committee (RUC), the Medical Group Management Association, the American Academy of Pediatrics, and individual cardiologists.

It is important to note that payment for CPT 93325 will be cut in 2008, 2009, and 2010 as a result of the revised practice expense formula described above. Cardiology practices will be able to plan for this transition in reimbursement rather than abrupt elimination of payment for a very frequently performed service.

For additional information please contact Rebecca Kelly at rkelly@acc.org or Denise Garris at dgarris@acc.org.