

Medicare payment for non-hospital cardiac catheterization services

In June 2006, CMS proposed a new method for determining the practice expense (clinical staff time, medical supplies, and medical equipment) portion of Medicare physician payments – that is, the practice expense relative value units (RVUs). This new method is being phased in over four years, beginning in 2007. Two key elements of the new method are the replacement of the “top-down” methodology with the “bottom-up” approach and the elimination of the non-physician work pool. The result of these changes was significant cuts to many procedures with technical components, for example, nuclear imaging, echocardiography and in-office catheterization.

CMS’s June 2006 proposed practice expense RVUs for cardiac catheterization services performed in the non-hospital setting would have cut practice expense RVUs for one of the most commonly provided set of cardiac catheterization services by 67 percent by the time the new RVUs were fully implemented in 2010 (see Attachment 1). The cardiology community, including ACC and cardiology practices with their own cath labs, persuaded CMS to allow local Medicare carriers to set prices in 2007 while the agency re-evaluated the data used to calculate the proposed values. CMS usually looks to the AMA/Specialty Society RVS Update Committee (RUC) for recommendations on the direct practice expense inputs for Medicare’s RBRVS. The RUC uses very specific and rigid requirements that derive from CMS’s methodology to determine what can be counted as direct practice expenses. A specialty society’s recommendations must be based on “typical patient” scenarios, defined as what occurs 51% or more of the time. Only equipment with a purchase price higher than \$500 that is used for the typical patient can be counted as direct expense. Similarly, only medical supplies consumed in caring for the typical patient and only clinical staff activities specific to the individual typical patient can be counted. All other expenses – administrative staff, equipment and supplies on hand but not typically used, building space, etc. – are considered indirect expenses.

From November 2006 – March 2007, the ACC and the Society for Cardiovascular Angiography and Interventions (SCAI) worked with the Cardiovascular Outpatient Center Alliance (COCA) to assess the direct practice expense inputs for non-hospital cardiac catheterization services and make recommendations to the RUC. This presentation was made in April 2007. The RUC approved the ACC/SCAI/COCA direct practice expense recommendations with very few modifications. CMS proposed in a July 2007 notice of proposed rulemaking (NPRM) to implement practice expense RVUs based on the RUC’s recommendations new direct practice expense inputs for 2008. As a result of the collaborative RUC presentation, practice expense RVUs for the set of non-hospital cardiac cath procedures described above increased 20 RVU’s compared to CMS’s original proposal. However, the revised RVUs still result in a substantial payment cut for this set of services: 18% in 2008 and nearly 30% by 2010, independent of the projected 10.1% decrease in the Medicare conversion factor in 2008.

The non-hospital cardiac cath lab community, led by COCA, protested the RVUs proposed in the July 2007 NPRM, asserting in written comments to CMS that values proposed failed to reflect all practice expenses for non-hospital cardiac cath labs. Consequently, in the 2008 Physician Fee Schedule Final Rule, CMS asked that the RUC review this issue again.

The ACC Cardiovascular Relative Value Update Committee (CV RUC) discussed the COCA comments and CMS’ response at great length and concluded that since COCA’s concerns relate primarily to methodological issues – for example, the definition of direct expenses, methods for calculating indirect expenses -- the AMA RUC is not the most effective forum for addressing them. ACC, therefore, has advised that CMS work directly with the non-hospital cath lab community to evaluate these outstanding issues.

Attachment 1

Payment Impact of New Practice Expense RVUs for Non-Hospital Cardiac Catheterization Services

Diagnostic cardiac catheterization procedures consist of a set of services – catheter placement, injections, and imaging – that is reported with multiple CPT codes. For example, a practice performing a diagnostic left heart catheterization would report the following CPT codes:

- 93510 - Left heart catheterization
- 93543 – Injection; selective left ventricular or left atrial angiography
- 93545 - Injection; for selective coronary angiography
- 93555 - Imaging S&I and report for injection procedure(s); ventricular and/or atrial angiography
- 93556 - Imaging S&I and report for injection procedure(s); pulmonary angiography, aortography, and/or selective coronary angiography

The following table shows the impact of the revised practice expense methodology on this illustrative set of services.

Medicare Practice Expense Payments for Non-Hospital Cardiac Catheterization

	2006 Practice Expense RVUs	Proposed 2010 Practice Expense RVUs (June 2006 NPRM)	2010 Practice Expense RVUs (November 2007 Final Rule)	2008 Practice Expense RVUs
93510 TC	37.06	16.55	28.12	31.39
93543	0.11	0.16	2.62	1.37
93545	0.16	0.18	5.86	3.01
93555 TC	6.63	0.66	0.59	3.22
93556 TC	9.92	0.49	0.88	5.16
Total				
Practice Expense RVUs	53.88	18.04	38.07	44.15
Payment *	2,042	684	1,443	1,673
Percent Change from 2006		-67%	-29%	-18%

* Payment calculated using 2006 Medicare conversion factor

The bottom line is that Medicare payments for many non-hospital cardiac catheterization services will be cut over the next three years – in the example shown here, by nearly 30 percent. The example shown above is independent of the 10 percent cut to the Medicare Conversion Factor that is scheduled to go into effect on January 1. However, by working together through the established regulatory process, the cardiology community was able to significantly reduce the magnitude of the payment cuts. Note the proposed cut would have been 67% in 2010 based on CMS’s original proposal– not the 29% projected now.

