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CMS cardiac procedure changes could cost hospital cardiac programs $700 million

Jun 01, 2019

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A new final rule clears the way for some cardiac procedures to be performed in ambulatory surgery centers, creating financial uncertainty for hospitals regarding Medicare payment for the cardiology service line.

U.S. Hospitals collectively breathed a great sigh of relief in late 2018 when they learned that the Centers for Medicare & Medicaid Services (CMS) had decided not to add total hip or knee arthroplasty to the list of surgeries allowed in ambulatory surgery centers (ASCs).1 But they had little time to celebrate this reprieve. The very next day, CMS was to adopt a change with potentially profound financial implications for hospitals.

In the 2019 Outpatient Prospective Payment System Rule (OPPS), issued on Nov. 2, 2018, CMS added 17 cardiac procedures to the list of ASC-approved procedures. These procedures, represented by CPT codes

93451-93462 and 93566-93572, include left and right heart catheterization and cardiac angiography. In 2016, according to data in the Medicare Provider Access and Review (MEDPAR) file, Medicare beneficiaries underwent more than 523,000 cardiac catheterizations with those CPT codes on outpatient basis in hospitals, resulting in an estimated $682 million in payments.

Emergent coronary angiography and percutaneous cardiac intervention with stenting are common life-saving treatments performed in hospitals for heart attacks. Yet every day in thousands of hospitals around the country, patients undergo elective coronary angiography, often accompanied by an intervention such as a stent placement for chest pain or other symptoms. These procedures can be performed electively because they are not deemed to be emergent.2

Under previous Medicare regulations, such testing had to be performed in a hospital, usually on an outpatient basis with a hospital stay lasting several hours to overnight. The financial implications of CMS's new ruling for both hospitals and the Medicare program bear close consideration. Clearly, hospitals would take a major financial hit if such testing were to shift from hospitals to predominantly ASCs.

Cardiovascular use of ASCs has been limited

In 2018, the only cardiovascular procedures allowed at ASCs were peripheral vascular interventions, such as lower-extremity angioplasty and placement of pacemakers and defibrillators. Few ACSs perform these cardiovascular procedures. According to the 2016 MEDPAR data, only 31 ASCs nationwide were billed by Medicare for performing these procedures. This is likely because specialized equipment is required and potential volume typically is insufficient to cover those fixed costs.

Furthermore, because a large percentage of cardiologists' patients are of Medicare age and much of the invasive cardiac testing Medicare patients require were not permitted at ASCs, there was little reason for cardiologists to have privileges to work in ASCs, much less to have an ownership interest in these organizations.

However, the newly acquired ability to perform cardiac catherization and angiography may provide enough additional volume to prompt more ASCs to consider offering cardiac procedures and more cardiologists to consider applying for privileges or even investing in ASCs.

Large cardiology groups may see a benefit in having one or more physicians at an ASC performing elective procedures on specific weekdays. They would be able to enjoy greater convenience while avoiding the interruptions for emergent procedures that commonly occur in a hospital's catheterization lab. And, patients would enjoy a significantly lower coinsurance. Although the facility's payment for an angiogram, for instance, varies depending on the site of service, the physician's professional fee does not, so from a payment perspective, it would make no difference to a physician if the angiogram were performed at the hospital or an ASC.

CMS's change also creates a perverse incentive for physicians: For example, if a patient has an elective coronary angiography at an ASC and it is determined that a stent is indicated, the second procedure would need to be scheduled at a later date at the hospital, resulting in a second professional fee payment to the physician. Of course, fees associated with a procedure should never be a consideration in choosing the site of service or determining whether to perform a procedure. But this point is raised to address the full ramifications of the proposed change.

Effect on Medicare costs

Although cost is not a primary consideration for CMS in adding procedures to ASCs, such a change does have complex cost implications for the Medicare program. The effects could be positive or negative depending on the circumstances. Consider elective angiogram, for example.

Elective angiogram with no intervention. If a patient has an elective coronary angiogram at a hospital as outpatient and no intervention is performed, the facility fee payment to the hospital, under CMS's Comprehensive Ambulatory Payment Classification (C-APC) rate, is about $2,810 (C-APC 5191), with adjustments made for wage index and other factors. If the same procedure is performed at an ASC, the facility

fee payment to the ASC is about $1,360. In this case, every angiogram performed at an ASC as opposed to a hospital saves Medicare $1,450.

Elective angiogram with intervention. If a patient has an angiogram at a hospital and the physician performs stenting at the same time with a drug-eluting stent, the hospital facility fee payment is about $9,669 (C-APC 5193). But if the patient's angiogram is performed at an ASC, and it is discovered that stenting is needed, the patient must be scheduled at the hospital for that procedure at a later date, as noted previously. In that case, the ASC gets a facility fee of $1,360 and the hospital gets $9,669, for a total expenditure of $11,029, thus costing the Medicare program an additional $1,360.

Cost impact regarding patients who present with chest pain

An even more complex scenario also is possible. Hospitals now can stratify patients presenting to the emergency department (ED) with chest pain for risk to determine which patients require hospital care and urgent testing. For patients not considered high risk, some tests could potentially be scheduled semi-electively, thereby providing safe care for these patients while reserving beds for patients requiring hospital care.

When patients experiencing chest pain come to the ED, they routinely undergo testing to determine if the problem is a myocardial infarction, and a period of monitoring is necessary. The patients are placed under observation services on an outpatient basis, and testing for unstable angina, including a stress test, is performed to ascertain whether urgent intervention is indicated. The costs to Medicare vary based on what happens next.

No urgent intervention required. Following the observation period, if testing is normal and an immediate angiography is not required, a patient will be discharged home on medications and scheduled for an angiogram at an ASC. If that angiogram is abnormal and a stent is indicated, the patient will then be scheduled at the hospital for their intervention. Assuming it is successful, the result is a complex scenario involving the following facility fees:

- Observation stay with stress test, $2,387 to hospital (C-APC 8011)
- Cardiac angiography at ASC, $1,360
- Coronary intervention with stenting at hospital, $9,669

Total cost: $13,416.

Urgent intervention required. If following the outpatient observation period, a patient were kept in the hospital to undergo cardiac angiography with stenting, with discharge occurring prior to the second midnight, the hospital would receive $9,669, thus costing the Medicare program $3,747 less than the total cost in the previously described scenario.

But if the patient had the angiogram and stenting at the same time and the medically necessary stay extended past the second midnight, the facility would likely be paid by DRG 247 (Percutaneous cardiovascular procedures with drug-eluting stent without major complication or comorbidity), with a facility base payment (without any inpatient fee adjustments, such as for wage index, teaching status or DSH payments) of $13,000, saving the Medicare program $416.

On the other hand, if the patient didn't require intervention, and following outpatient observation services, an angiogram were performed at the hospital, the Medicare program would pay $2,810 (C-APC 5191). That amount is $937 less than the $3,747 the program would pay if the patient had simply an outpatient observation stay at the hospital for $2,387 (C-APC 801) and then an angiogram at an ASC for $1,360.

Comprehensive APC rules often fiscally painful

These numbers include some adverse Medicare payment effects with respect to hospital payment for angiograms performed on patients presenting with chest pain. Consider that the hospital payment for a patient with chest pain who has simply a period of observation is $2,387, whereas if that same patient has an angiogram without stenting, the payment goes up to $2,810. The difference between these payments is $423, which suggests Medicare is paying only this small amount for the angiogram.

This payment policy is a reflection of CMS's thinking when it developed the comprehensive APC system. The agency believed paying for each service as a line item did not encourage thoughtful use of medical services by providers. When CMS introduced the concept, the agency used the example of a patient coming to hospital for a pacemaker placement. CMS reasoned if the patient was coming to the hospital for such a procedure, the hospital should receive only one single payment for the stay, regardless of what was done in addition to placing the pacemaker.

Although this payment policy seemed to have been designed for elective outpatient procedures, under billing rules, it also has been applied to patients who present emergently and then need a procedure. For example, Medicare pays the same amount for a patient who presents to the ED with syncope and is found to have heart block, where a pacemaker is placed the same day, as it pays for a patient who has an electively scheduled pacemaker placement, without regard for the former patient's significant use of ED resources. Now, with CMS's new comprehensive APC rules, the same policy applies to a patient under observation in the ED who subsequently has a procedure. The costs for such a patient will include not only use of ED resources but also room and board and nursing care during the observation period, with no additional revenue for the hospital.

Implications for hospitals

CMS approved 17 cardiac procedures to move to the ASC-approved list as of Jan. 1, 2019. Whether more ASCs equip themselves to perform these cardiac procedures and recruit cardiologists to join their medical staffs remains uncertain. If they do, cardiologists may shift not only Medicare patients but also commercially insured patients to the ASCs. Hospitals will need to look closely at the financial implications of this loss of volume from their facilities and act accordingly.

CMS has also been asked to approve total joint arthroplasty in ASCs, but it has so far resisted that move. The potential loss of both cardiac and orthopedic volumes should create even deeper concerns for hospitals, prompting them to begin developing a response strategy sooner rather than later.

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This document provides a detailed summary of the February 24, 2020, proposed rule published by CMS that would revise certain aspects of the Comprehensive Care for Joint Replacement model.

MARCH 03, 2020