Interventional Nephrology: Coding Changes, Bundling, Reimbursement Trends

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Goals

• Review the new changes in coding for 2015
• Discuss some changes in interpretation of old recommendations
• Brief overview of Interventional Nephrology
  • Changes that have occurred in who is performing dialysis access procedures
• Changes in reimbursement that have occurred with time
• Raise some issues concerning expected future coding changes
Coding Changes for 2015
59 Modifier

• Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances.
  • A different session
  • Different procedure or surgery
  • Different site or organ system
  • Separate incision/excision
  • Separate lesion
According to CMS, modifier 59 has been grossly misused.
X{EPSU} Modifiers to Replace Modifier 59
<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Example</th>
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<tbody>
<tr>
<td>XE</td>
<td><strong>Separate encounter:</strong> A service that is distinct because it occurred during a separate encounter. This modifier should only be used to describe separate encounters on the same date of service.</td>
<td>For example: If a patient had a thrombectomy and later that same date the patient re-clotted and returned to have a repeat thrombectomy, the XE modifier could be the appropriate modifier to use to indicate that a second service occurred at a separate distinct encounter.</td>
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<tr>
<td>XP</td>
<td><strong>Separate Practitioner:</strong> A service that is distinct because it was performed by a different practitioner.</td>
<td>For example: If two of the same services were performed on the same day, but the services were performed by different practitioners at different encounters, the second service could be reported with the XP modifier.</td>
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<tr>
<td>XS</td>
<td><strong>Separate Structure:</strong> A service that is distinct because it was performed on a separate organ/structure.</td>
<td>For example: If an angioplasty is performed in the dialysis access (either venous or arterial portion) and a second angioplasty is performed in the central vessels during the same session the second CPT code (e.g., 35476) could be reported with an XS modifier to indicate that the second angioplasty was performed in a separate structure. The radiologic and supervision and interpretation code for the second angioplasty (e.g., 75978) could also be reported with an XS modifier.</td>
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<tr>
<td>XU</td>
<td><strong>Unusual Non-Overlapping Service:</strong> The use of a service that is distinct because it does not overlap usual components of the main service.</td>
<td>For example: If a therapeutic intervention performed in a patient’s dialysis access requires a third cannulation, the XU modifier could be used to indicate the third cannulation.</td>
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The RPA/ASDIN Coding Committee publishes a new coding manual every year. In addition to new changes, the committee tries to clarify issues and update recommendations to reflect CMS guidelines and what other societies are doing.
Selective Catheterization
Selective Catheterization

- Selective catheterization involves the use of a catheter which is moved, manipulated or guided into a branch of the vessel, either an artery or a vein, which was entered as defined for nonselective cannulation.

- This is generally done under fluoroscopic guidance and most often using a guidewire.

- This involves more physician work and effort and increases the complication risk to the target vessel.

- It is important to recognize that this definition refers to the location of the catheter and not the guidewire.
• The key element here is the **branching anatomy**, selective catheterization is advancing the catheter from one vessel into a chosen branch

• **These codes are not attached to an anatomically named vessel.** The same vessel could be a first or second order branch depending on the vessel which was the primary site of the nonselective cannulation.
• Within the **dialysis vascular access** as defined for an angiogram
  • If the catheter is passed into a **contiguous (continuous), nonbranching** vessel, either vein or artery, rather than a branch, a selective catheterization code is not warranted

• The **feeding artery** is not part of the vascular access as defined
  • It is considered a branch of the dialysis vascular access
  • If the catheter is **advanced into the feeding artery**, it is a branch and warrants the selective catheterization code
In the past, the **work component** has been emphasized, this is no longer the case.

In the past, it was recommended that the work component – catheter manipulation – **be documented**.

If no work occurred, the recommendation was that selective catheterization not be coded, **this is no longer the case**.

The **only requirement is passage of the catheter** into a branch.
• The performance of a selective catheterization requires a double indication

• First, there is a requirement for a medical indication for the procedure that is to be performed (such as an angiogram or the placement of a coil)

• Second, there is an absolute need for a medical indication for the selective catheterization
Selective Catheterization Disqualifications

• If done for angioplasty balloon positioning
• If done to visualize access (as defined for diagnostic procedures)
• If done for superior or inferior vena cava
• If done to visualize arterial anastomosis
• If done for the purposes of performing a post-angioplasty angiogram
Lower Extremity

• With a lower extremity arterial procedure on a dialysis access, the Lower Extremity Revascularization codes must be used
• Selective catheterization is bundled with the Lower Extremity Revascularization codes

• The code 37224 would generally be appropriate for an arterial PTA in lower extremity
• The descriptor for this code is - revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal angioplasty.
Tunneled Catheters
Catheter Exchange

• TDC replaced - same venous access site
  • +77001 – Fluoroscopy
  • 36581 – Catheter exchange

• Non-tunneled catheter replaced with TDC
  • +77001 – Fluoroscopy
  • 36558 – Catheter insertion

• TDC – placed at new venous access site
  • +76937 - Ultrasound guidance
  • +77001- Fluoroscopy guidance
  • 36558 – Catheter insertion
  • 36589 - Catheter removal
Interventional Nephrology
What is happening and what can we expect
History

• IN began in the mid-1980s in the private sector
• Although academic programs have been developed, growth has continued to be primarily in private sector

• Most IN practiced in freestanding dialysis access centers
  • POS 11 – extension of doctor’s office

• Growth has almost been exponential
Dialysis Access Center (DAC)

• Volume: DACs treat over 250,000 cases per year

• Most are voluntarily accredited
  • Joint Commission
  • Accreditation Association for Ambulatory Health Care (AAAHC)
  • American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF)
Freestanding Dialysis Access Centers (DAC)

Number of Centers


- 2005: 58
- 2006: 86
- 2007: 126
- 2008: 180
- 2009: 185
- 2010: 190
- 2011: 196
- 2012: 203
- 2013: 210
Size Distribution

- 27% of centers have 250-500 size
- 11% of centers have 500-750 size
- 9% of centers have 750-1,000 size
- 32% of centers have 1,000-1,500 size
- 11% of centers have 1,500-2,000 size
- 9% of centers have 2,000-3,000 size
- 2% of centers have 3000+ size
2013 Statistic

• 48% for nephrology practices have access centers
• 59% have at least 1.0 FTE Interventional nephrologist

Nephrology News and Issues
Controlling Costs in Healthcare

• Reduce price (reimbursement)

• Create value incentives

• Transfer risks
Moving Target

• CMS continues to make changes
  • New codes
  • Redefined codes
  • Revalued codes
  • Bundled codes
Past Changes

• Revaluation
  • Angioplasty (35476, 35475)

• Bundling
  • Cannulation/angiogram (36147)
  • Stent/angioplasty (37236, 37238)
Anticipated future coding changes
More Bundling

• CMS has indicated that any two individual codes are used together 75% of the time or more they are to be bundled

• All dialysis access management codes will be bundled
Dialysis Access Management Codes

- Bundled code will be all inclusive
  - Cannulation and selective catheterization
  - All imaging
  - Radiological supervision and interpretation
  - Angioplasty
  - Thrombectomy
  - Stenting
Coding of procedures in feeding arteries (> 2cm from anastomosis) will not change

Central vein procedures would be coded as an add-on
Impact on Payment???

• CPT and RUC process (2015)
  • Final bundles and coding rules
  • Reassessment of practice expense
  • Survey for physician work

• CMS acceptance and inclusion in PFS
  • Likely 2017
It seems that For CMS an opportunity to change is also regarded as an opportunity to short change.
The typical patient scenario will change from a graft to a **fistula**

The typical stent will be a **covered stent**
Summary

• Interventional Nephrology is doing well
• We are currently the major specialty offering dialysis access management
• We continue to have significant challenges
• With most of our work being done in a freestanding DAC, declining reimbursement rates represent a major challenge
Public and Private Leaders Moving to “Value-Based” Care

Sylvia Burwell, HHS Secretary
January 2015

Since my very first days as Secretary, you’ve heard me talk about improving our nation’s health delivery system to better meet the needs and expectations of the people of America.

Our first goal is for 30% of all Medicare provider payments to be in alternative payment models that are tied to how well providers care for their patients, instead of how much care they provide – and to do it by 2016. Our goal would then be to get to 50% by 2018.

Healthcare Transformation Task Force:
30 Industry Leaders

Value-based service delivery and payment systems must be designed to deliver the triple aim of better health, better care and reduced total cost of care.

Health care costs should not continue to crowd-out other vital national investments in education, infrastructure, and research. As such, growth in total health costs, both public and private, should be at or below the overall rate of GDP growth.

We commit to have 75% of our respective businesses operating under triple aim focused contracts that address the total cost of care by January 2020. We will advocate for policies by all payers to meet this goal.
National presence of organizations pursuing value-based care: 2010

Sources: News releases, company websites, Dartmouth Atlas PCSAs, Claritas, Oliver Wyman analysis

1. ACOs defined as providers participating in Pioneer ACO, Medicare Shared Savings, a Medicaid ACO, PGP Transition, or in a shared savings/risk arrangement with a commercial payer; Prep activity defined as participation in a learning collaborative or providers preparing to become an ACO
National presence of organizations pursuing value-based care: 2011

Legend
- Public
- Private
- Both
- Prep activity only

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Two-thirds of patients live near organizations pursuing “value-based” care

Sources: News releases, company websites, Dartmouth Atlas PCSAs, Claritas, Oliver Wyman analysis

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Spectrum of Public Value-Based Care

- ESCO
- MSSP ACO
- Pioneer ACO
- Next Generation ACO Model
- ????

Axes:
- Shared Savings
- Capitation
- Specialty
- Primary Care
Opportunity: High Needs Patients Require Specialized Networks

Medicare Spending – Dialysis Patients

Collectively, we are best positioned to deliver on the promise of value-based care for one of the most complex and costly Medicare cohorts.
The future of reimbursement
Episode based payment model

Centers for Medicare and Medicaid
Innovation Concept
Rich Nee, GM
Lifeline Vascular Access
The future of reimbursement

• CMS is interested in new payment models

• Moving away from pay for volume to pay for value

• CMMI Issued Request For Information on Episode of Care based payments from medical specialties last year
Why CMMI is interested in Episode of Care Based Payments

- According to the Medicare Payment Advisory Commission (MedPAC), bundling Medicare payments to cover all services associated with an episode of care has the potential to improve incentives for providers to deliver the right mix of services at the right time.

- Bundling services also aims are reducing costs.
How the industry is responding

• The Coalition for Vascular Care responded to the Request for information

• Placed vascular access care under the category of a Complex Medical Management Model

• Outlined how to appropriately think of vascular access care in terms of episodes of care
What we proposed

Complex Medical Management Model:
Episode-Based Payment Structure

- Episode Start: Incident and prevalent Medicare ESRD beneficiaries
- Episode End: Patient death or transplant
- Payment: Separate variable length episode payment for each trigger

**Trigger 1:** Initial Vascular Access Placement
- Phase Start: Vessel mapping; Fistula/graft creation; Catheter placement; PD access placement
- Phase End: Interventional care to achieve access maturity
- Other Included Services: Access site maturity (first successful dialysis treatment)

**Trigger 2:** On-Going Maintenance
- Phase Start: Vascular access surveillance, repair, and maintenance
- Phase End: Angiogram, angioplasties, thrombectomies, coil embolization, and stents

**Trigger 3:** Access Failure/New Access
- Phase Start: Access failure (placement of catheter or creation of new fistula/graft)
- Phase End: Interventional care to achieve access maturity

Bundle Payment:
- Standardized rate * X%
- Standardized rate * Y%
- Standardized rate * Z%
What we are now working on

• The Coalition is looking to proactively provide CMMI with detailed information on how the model could be structured and paid
• Commissioned a bundling study with the Dobson DaVanzo group
• Investigating the feasibility of developing a bundled payment for vascular access maintenance in ESRD patient care under an Episode of Care framework
• Goal is to present a developed concept this year to CMMI for agency review and comment, engage MedPac with our findings, and share our results with CMS