

Percutaneous Coronary Intervention in the Outpatient Setting

WHITE PAPER

I recently attended a webinar presented by a national healthcare service and product provider that discussed progress taking place in cardiovascular medicine and coding. There is a large movement to introduce advanced endovascular interventional procedures to the outpatient market; a market which has enjoyed substantial growth in recent years driven by technology-based solutions.

This activity follows closely on the heels of the orthopedic specialties who experienced a tremendous amount of success transferring inpatient-only procedures such as total hip and knee arthroplasty to ambulatory surgery centers (ASCs). In the past, these procedures required both a hospital setting to perform and a hospital setting to claim reimbursement. Cardiovascular specialties are now following suit with Percutaneous Coronary Intervention (PCI) procedures being transitioned to outpatient ASCs.

In 2019, CMS reviewed clinical safety data and approved billing of PCI codes in freestanding ambulatory surgery centers in the CY 2020 OPPI final rule. Fueled by recent advancements in technology and with patient safety in mind, it was deemed that new advances now allow for a safe transfer. Enabling technologies include improved arterial access and closure devices along with reductions in the outer diameter of equipment used to facilitate PCI. The shift is also linked to recently developed CMS strategies of rethinking rural health and unleashing innovation.

Six approved code/procedures

At the present time, only six (6) codes/procedures are approved for PCI in the ASC. Please note this list does not include the CPT 92933-92973 range for percutaneous revascularizations during acute myocardial infarction, chronic/total occlusions, atherectomy, mechanical thrombectomy, or bypass graft work. Such interventions are currently reserved for the hospital setting (for now).

- **92920** Percutaneous transluminal coronary angioplasty; single major coronary artery or branch
 - **92921** each additional branch of a major coronary artery
- **92928** Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch
 - **92929** each additional branch of a major coronary artery
- **C9600** Percutaneous transcatheter placement of drug eluting intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch
 - **C9601** each additional branch of a major coronary artery

Changing communities, growing healthcare demands

Changes prompted me to reflect upon my own local community and its growing demands from healthcare. Like similar rural locales in the USA, it will experience significant population growth over the next decade as displayed in the numbers of new retirees exiting large urban centers. Current healthcare offerings within a one-hour drive do not include a catheterization lab or a facility capable of providing percutaneous interventions.

With that being said, the establishment of PCI treatment centers is entirely dependent upon attracting skilled cardiologists and endovascular specialists to new territories. Recently, a leading regional healthcare system built a DaVinci robotic suite in my community. This is an indicator that regional systems are preparing for growth to occur in remote sectors. Such growth might heavily rely upon advanced same day outpatient procedures and draw more skilled specialists to outlying areas.

Specific incentives do exist for providers to migrate their services and expertise to freestanding ASC's. Sites can be group owned and physicians may handpick staff members without being



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limited to the existing vendor partnerships of a larger system. Scheduling is more flexible than in a hospital setting, along with cutting much of the red tape associated with hospital administrations. In addition, practice groups can be more invested in the overall economy and reputational success of their facility.

Savings and advantages

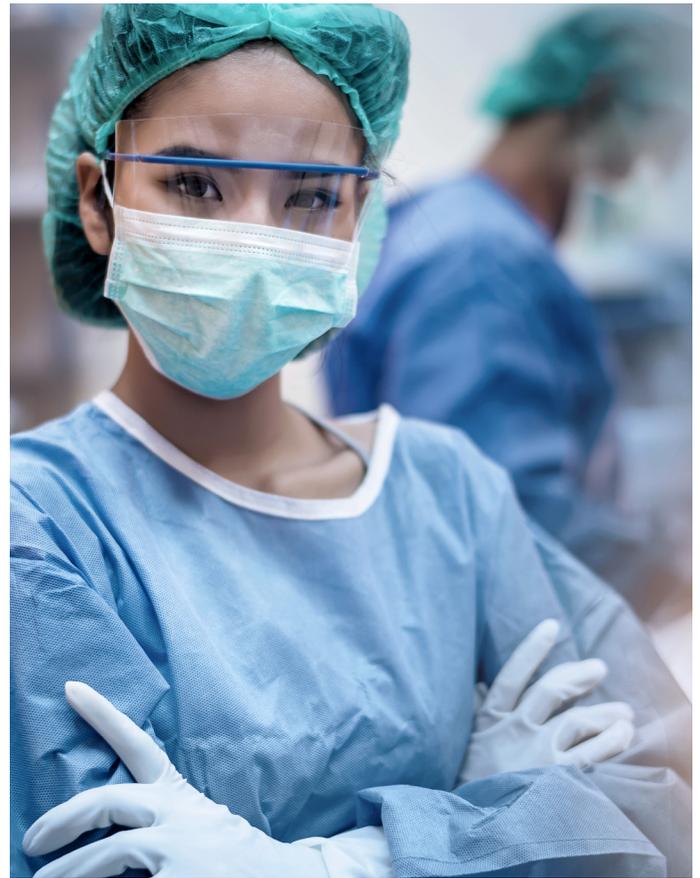
In terms of savings:

- Average cost for PCI in the hospital: \$12,000
- Average cost for PCI in the ASC: \$6,000
- Moving 5% of cases to ASC: \$15,000,000 annual savings for Medicare alone
- Moving 20% of cases to ASC: \$800,000,000+ annual savings nationwide

There are also distinct patient advantages to the initiative beyond reduced out-of-pocket expenses. It is difficult to express thoughts about healthcare without mention of the immediate context of Covid-19. Patients are simply less willing to be exposed to acute care patients in the same setting. This sentiment was present pre-pandemic and will carry on into a post-pandemic world. Overall, patients are more comfortable in the ASC with added parking, convenience options and comfortable waiting areas. What does this mean for medical coding? It sets the stage for smaller specialized vendors to experience growth as the market shifts more volumes towards ASCs - placing skilled subject matter experts and quality oversight roles where they are most needed on the ground. Demand is also expected to increase for interventional coding specialists holding credentials such as the Certified Cardiology Coder (CCC) and Certified Interventional Radiology Cardiovascular Coder (CIRCC).

Communication is critical

Communication plays an incredible role during new project startups; maintaining strong communication throughout the life of a project is essential. When provisioning services to provider-run practices and treatment centers, specialized firms can operate more nimbly. Turnover rates generally decrease as vendor coding staff is more invested in the organizational success of a client. Direct communication with providers is more readily achieved for cultivating long-term coding compliance and lasting partnerships.



In time, we hope to see CMS expand the list of approved codes for use in ambulatory settings including 92941; percutaneous revascularization during acute myocardial infarction (due to acute coronary occlusion). Conceivably, cardiovascular ASCs could incorporate a separate critical access functionality to extend emergent life-saving services to remote locations. As the scope of transition broadens in coming years, expect more interest in outpatient interventional and cardiovascular coding to follow.

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SOURCE:

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