

Coding and Reimbursement for CAS

What you need to know about the hottest issue in reimbursement today.

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In an effort to keep readers informed of pertinent issues related to coding and billing, Endovascular Today provides this semiregular forum in which experts discuss perennially difficult components of the current system and updates that emerge in the future. If there is a specific topic that you would like one of the authors to cover, please contact us at evteditorial@bmctoday.com.



There are two issues that determine reimbursement for any procedure: payment policy and coverage policy. Payment policy determines how a procedure is to be coded, with the amount of payment based on the assigned values for those codes.

CPT codes that have gone through the CPT and RUC (Relative Value Update Committee of the AMA) process and have been published in the Federal Register determine how a procedure is to be coded and how it will be reimbursed. If Level I CPT codes are available, they constitute a national payment policy, and one must use the appropriate CPT codes to receive payment. Payment for Medicare patients will be based on the assigned RVUs (Relative Value Units) for these codes and cannot be more or less than the published values.

Coverage policy refers to a carrier's official position regarding whether they will or will not pay for a specific procedure or service. The coverage policy typically includes indications for which that procedure will be reimbursed if the service is covered. Coverage policy is frequently determined locally, and often is not addressed at the national level.

CURRENT POLICY FOR CAS

As of June 2004, there are no Level I CPT codes that describe carotid artery stenting (CAS). Thus, there is no payment policy at a national level. There is, however, a coverage policy for Medicare, and the policy is that CAS is not reimbursed except when done as part of FDA-approved investigational protocols.

CURRENT OPTIONS FOR CODING CAS

There are currently three options for coding CAS (Table 1). For both options 1 and 2, there are similar issues that the provider and carrier will need to discuss. These codes are not clearly defined at a national level, so it is not clear which work is included in the code and which is not. For instance, it is not clear if 0005T includes diagnostic angiography, and it is not clear whether the selective catheter placement is included in the code. The Level III CPT codes and the unlisted procedure code do not have assigned valuations, and will likely be reimbursed with \$0.00 if one does not discuss their use and the proposed procedure with the carrier directly. Some carriers may choose to consider these codes as "bundled," including all aspects of the work of the procedure, while others may consider them "components," including only the portion of the procedure directly involving placement of the stent, with or without the work of the distal protection device. All of these interpretations of the codes are legitimate, but it is critical for the provider and for the carrier to understand how they are using the codes to achieve appropriate reimbursement. This variation is typical when there is no national payment policy in place.

Although the codes in option 1 (Level III CPT codes) are the most accurate and specific for CAS, they are not recognized by some carriers, including some local Medicare carriers. Most carriers do recognize unlisted procedure codes such as 37799 (option 2).

For option 3, use of existing CPT codes may be deemed fraudulent by some carriers. The existing vascular stent codes (37205, 37206, 75960) were not intended for use with CAS, and were not valued to cover CAS. Use of these codes is suggested *only* when this approach has been previously agreed upon by the provider and carrier.

How one should code a CAS procedure in 2004 depends directly on the preference of the carrier. One should not assume that they know which is correct without first checking with the individual carrier—this is true for procedures done as part of approved clinical trials, as

well as for those procedures that are not part of an approved clinical trial. One also should not assume that payment for the procedure indicates that their choice of coding is correct. Carriers may do audits looking for errors, and may require repayment of large sums of money if they determine that payment was incorrect.

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RESEARCH PROTOCOL PROCEDURES

One should check with the carrier prior to doing any procedure as part of a clinical trial. The carrier should grant permission to proceed with the protocol. The carrier is not required to pay for procedures done as part of a trial that they did not prospectively approve. The carrier also should communicate how they want the procedures coded. They should provide instructions that allow identification of study patients for the carrier, and should instruct the provider on how to code and bill for the procedure. Medicare Part A and Part B should both be contacted, and approval from both is necessary to ensure that payment for both the professional and facility sides will be granted. This should be accomplished prior to enrolling any patient in the trial. The communication from the carrier should be in writing, and should be saved for future referral and documentation.

NONRESEARCH PROTOCOL PROCEDURES

As of May 2004, Medicare will not pay for CAS procedures that are performed outside of a research protocol. This noncoverage policy includes both professional and facility charges. In order to be paid for a noncovered procedure, one must talk with the patient before the procedure, and have the patient sign an Advanced Beneficiary Notice (ABN), which documents that the patient has been told that Medicare will not pay for the procedure and that the patient agrees to pay for the procedure personally. Separate ABNs are needed for the physician and for the facility if they are separate entities. If the patient does not sign the ABN prior to the procedure, one cannot legally bill the patient directly for the noncovered charges.

For non-Medicare patients, one must know each carrier's policy regarding CAS. Some non-Medicare insurers do cover CAS at this time. Precertification with each carrier may help

TABLE 1. OPTIONS FOR CODING CAS

<p>Level III CPT Codes*</p> <p>0005T—placement of stent in extracranial cerebrovascular vessel, initial vessel</p> <p>0006T—placement of stent in extracranial cerebrovascular vessel, each additional vessel</p> <p>0007T—placement of stent in extracranial cerebrovascular vessel, each vessel, radiologic supervision and interpretation</p> <p>Unlisted Procedure CPT Code(s)†</p> <p>37799—unlisted vascular procedure</p> <p>Existing Level I CPT Codes That Do Not Necessarily Accurately Describe the Procedure</p> <p>37205—noncoronary vascular stent, initial vessel</p> <p>37215, 36216, 36217, 36218—selective catheterization codes for brachiocephalic vessels</p> <p>75960—noncoronary vascular stent, radiologic supervision and interpretation</p> <p>35475—PTA, brachiocephalic vessel</p> <p>76942—PTA, noncoronary vessel, radiologic supervision and interpretation</p> <p><i>*Level III CPT codes are temporary codes used for emerging technology. CPT uses these codes for promising new procedures that have not yet met the required level of documentation of clinical efficacy to achieve Level I CPT codes. These codes allow tracking and coding of new technology, but the Level III codes do not go through the same rigorous procedure to define what is included in the code and what the work is worth that Level I codes go through.</i></p> <p><i>†Unlisted procedure codes are present throughout CPT. They are used to allow billing of procedures that are not otherwise described in CPT. If procedures develop that do not have codes, unlisted procedure codes sometimes may be used while application for other CPT codes is in process. Sometimes these codes are used when CPT changes the description of an existing code such that it excludes a previously described procedure. The same unlisted procedure code could be used for several different procedures. The carrier and the provider must be clear on which procedure the unlisted code refers to with each claim submission.</i></p>
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CODING & REIMBURSEMENT

ensure smoother negotiations for coverage and payment.

FUTURE PAYMENT POLICY

Level I CPT Codes for CAS are anticipated for 2005. Codes were accepted by the CPT Panel in February 2004, and have progressed through the valuation process. It is expected that they will be activated January 1, 2005, and will constitute a new national payment policy, making the coding and level of reimbursement for CAS uniform throughout the country.

FUTURE COVERAGE POLICY

It is anticipated that when the FDA approves a stent/protection device system for use in the carotid artery, CMS (Centers for Medicare and Medicaid Services, the national body directing Medicare policy) will reconsider its noncoverage policy for CAS. Although it is not possible to know or predict when and how the noncoverage policy will be changed, it is expected that CMS will carefully consider data from the ongoing research studies to determine any change in their policy. Efforts will be made by multiple professional societies, individual physicians, Medicare patients and their families, and industry to encourage CMS to provide cover-

age for the population(s) of patients that data show would benefit from CAS. As larger studies and trials conclude in the coming years, it is expected that the coverage policy will continue to change and expand to encompass the findings of those trials.

INTERIM INSTRUCTIONS AND SUPPORT

Once FDA approval is given for marketing devices specific for CAS, there may be an interim period before the new national payment policy is activated (January 2005). Depending on when CMS reconsiders its coverage of CAS, there may be a short time when there is a national coverage policy allowing payment for CAS but not a national payment policy. If this occurs, the multiple specialty societies that have worked closely to attain CPT codes and code valuations will again work together to publish a model policy that can be used by individual providers or by local carriers to establish guidelines for coding and reimbursement until January 2005. ■

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