### Yearly Potential SGR Cut To The CF Averted By Legislation (x12)

- 2004 The Medicare Modernization Act (P.L. 108-173) updated 1.5 percent in 2004 and 2005
- 2006 The Deficit Reduction Act (P.L. 109-362) froze payment rates at the 2005 level for 2006
- 2007 The Tax Relief and Health Care Act (P.L. 109-432) froze at a 2006 level
- 2008 The Medicare, Medicaid, and SCHIP Extension Act (P.L. 110-173) increased by 0.5 percent for January-June 2008
- 2009 The Medicare Improvements for Patients and Providers Act (P.L. 110-275) increased by 0.5 percent for July-December of 2009 and by 1.1 percent for 2010
- 2010 PL 111-118, PL 111-144, and PL 111-152 froze at the 2009 level through June 2010; PL 111-192 and PL 111-266 increased payment rates by 2.2 percent through December of 2010
- 2011 Temporary Payroll Tax Cut Continuation Act of 2011 (P.L. 112-78) froze through Feb 29, 2012 at the 2011 level
- 2012 Middle Class Tax Relief and Jobs Creation Act of 2012 (P.L. 112-96) froze through December of 2012
- 2013 American Taxpayer Relief Act (P.L. 113-240) froze through December 2013
- 2014 SGR Reform Act (P.L. 113-167) increased by 0.5 percent through March 2014
- 2014 Promoting Access to Medicare Act (P.L. 113-95) froze through March 2015

### Medicare Conversion Factor

- **2015 (June-December)** $35.9335
  
  *Promised 0.5% ↑ per year by MACRA*

- **2016** is actually lowered to $35.8279

  *Need to pay back the 2014 SGR patch through PAMA and ABLE statutes*

<table>
<thead>
<tr>
<th>MACRA</th>
<th>ABLE</th>
<th>Budget neutrality</th>
</tr>
</thead>
<tbody>
<tr>
<td>↑ 0.5%</td>
<td>↓ 0.77%</td>
<td>↓ 0.02%</td>
</tr>
</tbody>
</table>

  *NET CHANGE is ↓ 0.29%*

### Sequestration

- The global 2% cut to Medicare payments was supposed to end on April 1, 2016

- Extended “across the board” to FY 2025 in the 2015 budget deal
**Vascular Lab Payments**

- **Deficit Reduction Act “DRA” of 2005**
  - The DRA caps office-based technical payment for ultrasound since 2007 at the lesser of:
    - Hospital Outpatient Payment versus Medicare Physicians Fee Schedule
    - No change in the professional fee from the MPFS
    - Physiologic studies are exempt from the DRA
- The APCs for vascular lab payments were completely overhauled for 2016 by CMS

**Hospital Vascular Lab Technical APCs in 2015**

1. APC 97  Level 1 Physiologic Studies
2. APC 266  Level 2 Ultrasound Studies
3. APC 267  Level 3 Ultrasound Studies

**Hospital Vascular Lab Technical APCs in 2016**

1. APC 5734  Level 4 Minor Procedures
2. APC 5721  Level 1 Diagnostic Tests and Related Services
3. APC 5531  Level 1 Ultrasound and Related Services
4. APC 5532  Level 2 Ultrasound and Related Services

**2016 Vascular Lab Payments**

- Professional fee reimbursement saw no significant change across the board
- Technical payments in the office:
  - Physiologic studies are stable
  - Seven codes will have a significant drop
  - Remaining codes will have minimal change

<table>
<thead>
<tr>
<th>CPT</th>
<th>2015 TC</th>
<th>2016 TC</th>
<th>% drop</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>93880</td>
<td>$165</td>
<td>$154</td>
<td>7%</td>
<td>Bilateral carotid</td>
</tr>
<tr>
<td>93970</td>
<td>$165</td>
<td>$154</td>
<td>7%</td>
<td>Bilat venous extremity</td>
</tr>
<tr>
<td>93925</td>
<td>$190</td>
<td>$154</td>
<td>19%</td>
<td>Bilateral LE arterial</td>
</tr>
<tr>
<td>93930</td>
<td>$172</td>
<td>$154</td>
<td>10%</td>
<td>Bilateral UE arterial</td>
</tr>
<tr>
<td>93975</td>
<td>$190</td>
<td>$154</td>
<td>19%</td>
<td>Complete abdominal</td>
</tr>
<tr>
<td>93990</td>
<td>$135</td>
<td>$99</td>
<td>27%</td>
<td>AV Access</td>
</tr>
<tr>
<td>G0365</td>
<td>$189</td>
<td>$154</td>
<td>19%</td>
<td>1st AV access vein map</td>
</tr>
</tbody>
</table>

**2016 CPT Changes**

- IVUS code bundling
  - Codes 37250/75945 and 37251/75946 deleted
  - New bundled add-on codes created
    - +37252 Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial noncoronary vessel
    - +37253 each additional noncoronary vessel
  - Removed restrictive parentheticals for billing
    - Diagnostic and/or therapeutic angiography
    - EVAR, TEVAR, lower extremity arterial/venous Rx
  - Valued in both the hospital and outpatient setting
2016 IVUS Coding

<table>
<thead>
<tr>
<th>CPT</th>
<th>wRVU</th>
<th>tRVU facility</th>
<th>tRVU non-facility</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>37252</td>
<td>1.80</td>
<td>2.70</td>
<td>39.70</td>
<td>IVUS, first vessel</td>
</tr>
<tr>
<td>37253</td>
<td>1.44</td>
<td>2.16</td>
<td>6.17</td>
<td>IVUS, subsequent vessel</td>
</tr>
</tbody>
</table>

CPT and RUC 2017

• New Category 1 AAA screening CPT code to replace the HCPCS G0389 code
• New mechano-chemical ablation CPT code
  – E.g., the “Clarivein procedure”

CPT and RUC 2017

• Hemodialysis access diagnostic angiography and endovascular intervention
  – CPT codes 36870, 36147, 36148, 35476 were flagged as reported together >75% in specific combinations by a RUC screen
  – Referred to the CPT Panel for creation of new bundled endovascular coding for 2017
  – Nine new bundled codes were created
  – Actively surveying these new codes now

CPT and RUC 2017

• Angioplasty outside the lower extremity
  – CPT codes 35475, 35476, 75962, and 75968 were flagged as reported together >75% in specific combinations by a RUC screen
  – Aortic, upper extremity arterial, visceral artery, and venous
  – Referred to the CPT Panel for creation of new bundled endovascular coding for 2017
  – Four new bundled codes were created
  – Actively surveying these new codes now

CPT and RUC 2018

• Infrarenal EVAR
  – 34802, 34812, 34825 identified as having “high pre-service” time by a RUC screen
  – Referred to the CPT Panel for creation of new bundled EVAR coding
  – New code structure is currently being designed by the SVS coding committee

CMS Attempts at Quality / Value

• CMS has attempted to create an atmosphere of quality and value through multiple initiatives:
  - Physician Quality Reporting System
  - Meaningful Use EHR
  - Value-based modifier
  - Shared Savings Models
**Merit-Based Incentive Payment System**
Created By MACRA

- MIPS goes into effect 2019
  - Integrate/simplify CMS quality programs
  - Up to 9% of pay at risk when this matures
- SVS needs to identify and help create appropriate quality measures for MIPS
- SVS BOD has made this a priority
  - Focus for the next BOD meeting (this Saturday)

**With SGR Gone, What Determines Medicare Payments?**

- 2016-18: 0.5% increase each year
  - Adjusted by PQRS, MUE, & VBM
  - Subject to the ABLE bill cuts (max of 0.5%/yr)
- 2019: 0.5% increase & MIPS kicks in
  - Current PQRS, MUE, & VBM disappear
  - Personal CF “MIPSed” +/- 4%
- 2020-25: Medicare payments will be altered by each physician’s personal MIPS score
  - Budget neutral: mandated winners & Losers
  - In 2022: Personal CF “MIPSed” +/- 9%

**What Are The Options?**

1. Hire support staff, buy a registry, and identify quality metrics to submit
2. Ignore the entire program, keep working hard, and accept a procedural reimbursement cut up to 9%
3. Participate in an Alternative Payment Method to avoid MIPS altogether

**Alternative Payment Mechanism = Big Winner**

- If you derive substantial portion of income from an APM you’re not subject to “MIPS”
  - 5% bonus each year from 2019-2024
- Starting in 2026
  - APM participants get 0.75% ↑ per year
  - MIPS participants get 0.25% ↑ per year

**Conclusions**

- Medicare CF will decrease by 0.3%
- Several vascular lab technical payments will drop due to the HOPPS APC changes
- IVUS coding has changed for 2016
- MIPS will begin in 2019
- Consider participation in an APM
- SVS needs to help shape the quality metrics that effect reimbursement