Cath Lab Digest

A product, news & clinical update for the cardiac catheterization laboratory specialist

CCL BASED PROCEDURES:		FY23	FY24	FY25	2YRDIFF
Diagnostic Catherization:					
286	CIRC DIS EXC AMI, W CATH W MCC	$14,549	$15,093	$15,752	4.4%
287	CIRC DIS EXC AMI, W CATH W/O MCC	$7,547	$7,573	$7,755	2.4%
Coronary Intervention:					
321	PCI W/ INTRALUMINAL DEVICE W/MCC OR 4+ ARTERIES	-	$20,127	$20,260	0.7%
322	PCI W/ INTRALUMINAL DEVICE W/O MCC	-	$12,767	$12,875	0.9%
323	CORONARY INTRAVASCULAR LITHOTRIPSY W/ INTRALUMINAL DEVICE W/	-	$28,987	$30,313	4.6%
324	CORONARY INTRAVASCULAR LITHOTRIPSY W/O INTRALUMINAL DEVICE	-	$20,785	$22,739	9.4%
325	CORONARY INTRAVASCULAR LITHOTRIPSY W/ INTRALUMINAL DEVICE W/O	-	$18,514	$20,369	10.0%
250	PCI W/O STENT W MCC	$16,598	$16,459	$16,460	0.0%
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252	OTHER VASC PROCEDURES W MCC	$22,933	$23,482	$24,413	4.0%
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278	ULTRASOUND ACCELERATED AND OTHER THROMBOLYSIS OF PERIPHERAL	-	$31,230	$35,606	14.0%
279	ULTRASOUND ACCELERATED AND OTHER THROMBOLYSIS OF PERIPHERAL	-	$22,409	$22,804	1.8%

REIMBURSEMENT UPDATE

CMS 2025 Updates – Inpatient and Outpatient

Jackie Shepard, Business Consultant, Corazon

The Centers for Medicare & Medicaid Services (CMS) recently released its 2025 updates, introducing significant changes to the Medicare payment systems that will impact healthcare providers nationwide. These updates, which include adjustments to the Inpatient Prospective Payment System (IPPS), Outpatient Prospective Payment System (OPPS), Ambulatory Surgery Centers (ASCs), and Physician Fee Schedule (PFS), are designed to address current challenges and trends within the healthcare landscape. As providers navigate these updates, understanding the detailed revisions and their implications will be essential for strategic planning and operational efficiency in the year ahead.

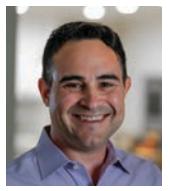
continued on page 13

In This Issue

STRUCTURAL HEART & EP

Lead Management in Patients With Cardiac Implantable Devices and Tricuspid Regurgitation

CLD talks with Electrophysiologist Mark D. Metzl, MD, and Structural Interventionalist Mark J. Ricciardi, MD.



How often do cardiac implantable electronic device (CIED) leads cause significant tricuspid regurgitation (TR) and what are the causes?

Dr. Ricciardi (Structural Interventionalist): While there are cases where the lead can impinge on the valve leaflets and cause tricuspid valve dysfunction, it is not very common. We see many patients in valve clinic with significant TR and a lead in place, where the leads themselves are not causal; they just happen to be present. A review summarizing the frequency of occurrence or worsening of TR following CIED implantation found that its occurrence ranged from 7% to 45% of studied patients.[1]

continued on page 10

MEETING UPDATE

Fall Meeting Roundup: Highlighted Research From the Latest Interventional Symposia

From the 2024 European Society of Cardiology (ESC), Transcatheter Cardiovascular Therapeutics (TCT), and Vascular InterVentional Advances (VIVA) meetings

continued on page 16

Continued from cover

CMS 2025 Updates – Inpatient and Outpatient

Jackie Shepard, Business Consultant, Corazon

Continued from cover

To frame these updates, Medicare's payment systems function under distinct reimbursement models:

- IPPS for inpatient services uses Diagnosis-Related Groups (DRGs);
- OPPS and ASCs operate with Ambulatory Payment Classifications (APCs); and
- PFS relies on Current Procedural Terminology (CPT) codes.

Updates to the Inpatient Prospective Payment System (IPPS)

The IPPS for acute care hospitals has undergone notable changes. Starting with the market basket update, for fiscal year 2025, acute care hospitals that report quality data and meet electronic health record meaningful use standards will see a 2.9% increase in Medicare operating rates. This figure accounts for a projected market basket update of 3.4%, offset by a 0.5% productivity adjustment.[1]

Additional factors affect each hospital's specific Medicare base payment rate. CMS continues applying a permanent 5% cap on wage index decreases from the prior year. There were changes to the Disproportionate Share Hospital (DSH) payments in FY 2025, while the Indirect Medical Education (IME) formula remains the same.[1] CMS has also introduced a 10% cap on annual decreases in DRG relative weights, and made key DRG additions and deletions, particularly within Major Diagnostic Categories (MDCs) 5 and 8. This year also brings 252 new ICD-10 codes, along with 13 deletions and 36 revisions, shaping reimbursement rates for many procedures.[1]

Quality Standards and Performance-Based Programs

CMS maintains its budget-neutral structure for the Value-Based Purchasing (VBP) program, reducing hospitals' DRG payments by 2% each fiscal year and redistributing the total as incentive payments.[1] CMS has also added seven new quality measures, removed five, and made two modifications for fiscal year 2025, setting the stage for updates to the HCAHPS Survey (Hospital Consumer Assessment of Healthcare Providers and Systems), anticipated in fiscal year 2030. For hospital-acquired conditions, the 1% payment reduction for hospitals in the worst-performing quartile remains unchanged, as does the structure for the Hospital Readmissions Reduction Program.[1]

New Technology Add-On Payment (NTAP) and Transforming Episode Accountability Model (TEAM) Updates

The NTAP program encourages the adoption of advanced medical technologies by providing extra payments for high-cost, innovative treatments that meet specific criteria. For 2025, CMS has increased the NTAP reimbursement rate from 65% to 75% for certain gene therapies, particularly for sickle cell disease, helping offset high treatment costs.[1] CMS has also refined the "newness" period for NTAP eligibility, which will now align with the fiscal year starting October 1, 2026, for added predictability.[1] Technologies placed on "hold" status will remain eligible for NTAP, though withdrawn applications will still be ineligible. For 2025, CMS approved NTAPs for 5 new technologies, with additional support for 11 breakthrough devices, underscoring its commitment to promoting clinically valuable innovations.[1]

Launching in January 2026, TEAM is a mandatory episode-based payment model targeting specific high-cost surgical procedures, including coronary artery bypass grafts. The model introduces bundled payments with target prices for all services within a surgical episode, incentivizing hospitals to manage total costs efficiently. Hospitals in selected geographic regions will participate, with three risk/reward tracks designed to balance incentives and financial responsibility.[1] Providers who keep costs below target may receive bonuses, while those who exceed target costs could owe repayments. TEAM promotes coordinated, value-based care for complex surgeries, aiming to enhance both quality and cost-effectiveness in Medicare's approach to reimbursement.

CMS approved a 2% increase for thrombectomy and craniotomy procedures, while diagnostic catheterizations rose by 4.4% and 2.4%. Percutaneous coronary interventions (PCI) procedures also saw reimbursement increases, as did peripheral vascular procedures, with some inpatient reimbursement rates increasing up to 14%.[1]

Table 1. Surgical Reimbursement Changes.

NEUROSURGERY & INTERVENTIONS:		FY23	FY24	FY25	2YRDIFF
Intracranial with Hemorrhage					
020	INTRACRANIAL W MCC	$63,816	$59,180	$57,367	-3.1%
021	INTRACRANIAL W CC	$46,571	$43,000	$38,008	-11.6%
022	INTRACRANIAL WO CC/MCC	$29,897	$27,465	$19,656	-28.4%

OPEN HEART SURGERY (OHS):		FY23	FY24	FY25	2YRDIFF
Valve Procedures:					
212	CONOMITANT AORTIC AND MITRAL VALVE PROC	-	$75,412	$77,526	2.8%
216	VALVE W CARD CATH W MCC	$66,825	$67,953	$68,682	1.1%
217	VALVE W CARD CATH W CC	$43,550	$44,567	$45,957	3.1%
218	VALVE W CARD CATH W/O CC/MCC	$40,737	$39,886	$42,340	6.2%
219	VALVE W/O CARD CATH W MCC	$55,756	$53,991	$55,064	2.0%
220	VALVE W/O CARD CATH W CC	$37,282	$36,721	$37,694	2.7%
221	VALVE W/O CARD CATH W/O CC/MCC	$32,456	$32,548	$32,683	0.4%
266	ENDOVASCULAR VALVE REPLACE & SUPPLEMENT PROCEDURES W MCC	$45,278	$43,733	$42,634	-2.5%
267	ENDOVASCULAR VALVE REPLACE & SUPPLEMENT PROCEDURES W/O MCC	$35,399	$34,169	$33,481	-2.0%

MCC = mechanical chest compression

Key DRG Changes in Major Diagnostic Categories 5 and 8

In the 2025 updates, CMS introduced a new Diagnosis-Related Group, DRG 317, specifically designed for cases involving the combined procedures of left atrial appendage closure (LAAC) and cardiac ablation. This new DRG addresses the unique clinical and resource needs associated with performing these two procedures together, as they require specialized equipment, highly skilled staff, and extended procedural time.[1] CMS also modified the DRG 276 description to account for neuromodulation devices for heart failure.

Surgical and Interventional Reimbursement Changes

Neurosurgery (Table 1) has seen reimbursement reductions ranging from 3% to 28% for procedures involving intracranial hemorrhage. Open heart

surgery DRGs mostly increased slightly, though transcatheter aortic valve replacement (TAVR) saw a decrease of 2%.[1]

For interventional procedures (Table 2), CMS approved a 2% increase for thrombectomy and craniotomy procedures, while diagnostic catheterizations rose by 4.4% and 2.4%. Percutaneous coronary interventions (PCI) procedures also saw reimbursement increases, as did peripheral vascular procedures, with some inpatient reimbursement rates increasing up to 14%.[1]

Outpatient Prospective Payment System (OPPS) Updates

The calendar year 2025 OPPS updates include a market basket increase of 2.9%, bringing the conversion factor to $89.169. This is 0.3% higher than last year's update, reflecting a projected increase of 3.4% offset by a 0.5% productivity adjustment. APC assignments will influence outpatient procedure reimbursement rates.[2]

CMS also finalized a separate reimbursement for diagnostic radiopharmaceuticals with a per-day cost exceeding $630, a move intended to account for high costs.

Quality Reporting and Equity Measures

For 2025, CMS introduced several important changes to the Outpatient Prospective Payment System (OPPS) and Ambulatory Surgery Center (ASC) Quality Reporting Programs, with a strong focus on advancing health equity and improving data transparency.

In alignment with its broader commitment to health equity, CMS has added new measures related to social determinants of health (SDOH). These measures allow facilities to report on key factors such as patient demographics, access to care, and social challenges that might impact health outcomes.[2] For 2025, reporting on these measures will be voluntary, giving providers time to adjust and collect data, with mandatory reporting set to begin in 2028. Additionally, CMS is implementing the Screen Positive Rate for SDOH measure, initially voluntary in 2025, but becoming mandatory in 2026 to guide future health policy.[2]

CMS is introducing a Patient-Reported Outcome-Based Performance Measure for the Outpatient Quality Reporting (OQR) program. This measure, focused on collecting direct patient feedback on outcomes, will begin as voluntary in 2026, transitioning to mandatory in 2027. By including patient-reported data, CMS aims to gain deeper insights into quality and satisfaction, helping hospitals and ASCs better address patient needs and experiences.[2,3]

CMS has modified its policy for measure removal, shifting to a "measure suspension" policy in the OQR and ASC Quality Reporting (ASCQR) programs. This change is designed to improve transparency in the process of removing or modifying quality measures, allowing hospitals and ASCs greater insight into decision-making around quality metrics.[2,3]

CMS continues to enforce payment reductions for facilities that do not meet quality reporting requirements, applying a 2% reduction to payments for those who fall short. This policy underscores CMS's emphasis on quality compliance, encouraging facilities to maintain reporting standards and work towards continuous improvement.[2,3]

These quality reporting updates mark a step toward more comprehensive and equitable patient care, with a particular focus on health equity, patient-centered outcomes, and transparency in quality measurement across outpatient and ASC settings.

Table 2. Interventional Reimbursement Changes.

NEUROSURGERY & INTERVENTIONS:		FY23	FY24	FY25	2YRDIFF
Craniotomies w Device (includes thrombectomy)					
023	CRANIO W DEVICE OR CHEMO IMPLANT OR EPILEPSY STIM W MCC	$39,315	$39,691	$40,600	2.3%
024	CRANIO W DEVICE WO MCC	$27,087	$26,528	$27,055	2.0%
CCL BASED PROCEDURES:		**FY23**	**FY24**	**FY25**	**2YRDIFF**
Diagnostic Catherization:					
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325	CORONARY INTRAVASCULAR LITHOTRIPSY W/ INTRALUMINAL DEVICE W/(	-	$18,514	$20,369	10.0%
250	PCI W/O STENT W MCC	$16,598	$16,459	$16,460	0.0%
251	PCI W/O STENT W/O MCC	$11,149	$11,111	$11,120	0.1%
Peripheral Vascular:					
252	OTHER VASC PROCEDURES W MCC	$22,933	$23,482	$24,413	4.0%
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279	ULTRASOUND ACCELERATED AND OTHER THROMBOLYSIS OF PERIPHERAL	-	$22,409	$22,804	1.8%

CCL = cardiac catheterization laboratory; MCC = mechanical chest compression; PCI = percutaneous coronary intervention

Table 3. Outpatient Procedures.

CCL BASED PROCEDURES:		FY23	FY24	FY25	2YRDIFF
Diagnostic Catherization:					
OP	Level 1 ENDOVASCULAR PROC (C-APC 5191)	$2,958	$3,108	$3,216	3.5%
Coronary Intervention:					
OP	LEVEL 2 ENDOVASCULAR PROC (C-APC 5192)	$5,215	$5,452	$5,702	4.6%
OP	LEVEL 3 ENDOVASCULAR PROC (C-APC 5193)	$10,615	$10,493	$11,341	8.1%
OP	LEVEL 4 ENDOVASCULAR PROC (C-APC 5194)	$17,178	$16,725	$17,957	7.4%
Peripheral Vascular:					
OP	LEVEL 2 ENDOVASCULAR PROC (C-APC 5192)	$5,215	$5,452	$5,702	4.6%
OP	LEVEL 3 ENDOVASCULAR PROC (C-APC 5193)	$10,615	$10,493	$11,341	8.1%
OP	LEVEL 4 ENDOVASCULAR PROC (C-APC 5194)	$17,178	$16,725	$17,957	7.4%
OP	LEVEL 1 VASCULAR PROC (APC 5181)	$579	$599	$618	3.2%
OP	LEVEL 2 VASCULAR PROC (C-APC 5182)	$1,488	$1,528	$1,553	1.7%
OP	LEVEL 3 VASCULAR PROC (C-APC 5183)	$2,979	$3,040	$3,148	3.5%
OP	LEVEL 4 VASCULAR PROC (C-APC 5184)	$5,140	$5,241	$5,406	3.1%
ELECTROPHYSIOLOGY:		**FY23**	**FY24**	**FY25**	**2YRDIFF**
Defibrillator:					
OP	LEVEL 1 ICD AND SIMILAR PROCEDURES (C-APC 5231)	$22,818	$22,482	$22,446	-0.2%
OP	LEVEL 2 ICD AND SIMILAR PROCEDURES (C-APC 5232)	$32,076	$31,379	$32,062	2.2%
Pacemaker Procedures:					
OP	LEVEL 1 PACEMAKER AND SIMILAR PROC (APC 5221)	$3,351	$3,746	$3,639	-2.8%
OP	LEVEL 2 PACEMAKER AND SIMILAR PROC (C-APC 5222)	$8,163	$8,103	$8,276	2.1%
OP	LEVEL 3 PACEMAKER AND SIMILAR PROC (C-APC 5223)	$10,329	$10,185	$10,465	2.8%
OP	LEVEL 4 PACEMAKER AND SIMILAR PROC (C-APC 5224)	$18,672	$18,585	$19,071	2.6%
Electrophysiologic Procedures					
OP	LEVEL 1 ELECTROPHYSIOLOGIC PROC (C-APC 5211)	$1,117	$1,135	$1,214	6.9%
OP	LEVEL 2 ELECTROPHYSIOLOGIC PROC (C-APC 5212)	$6,733	$7,123	$7,588	6.5%
OP	LEVEL 3 ELECTROPHYSIOLOGIC PROC (C-APC 5213)	$23,481	$22,653	$24,532	8.3%

CCL = cardiac catheterization laboratory; ICD = implantable cardioverter defibrillator

CMS continues to enforce payment reductions for facilities that do not meet quality reporting requirements, applying a 2% reduction to payments for those who fall short.

Table 4. Ambulatory Surgery Center Payment System Updates.

CPT Code	CPT Description	Procedure Category	APC	HOPD	ASC	Diff
92920	Prq cardiac angioplast 1 art	PCI	5192	$5,701.52	$3,628.13	-36%
93458	L hrt artery/ventricle angio	Dx Cath	5191	$3,216.41	$1,655.71	-49%
33206	Insert heart pm atrial	Devices	5223	$10,465.33	$7,408.11	-29%
33240	Insrt pulse gen w/singl lead	Devices	5231	$22,446.19	$18,593.09	-17%
37221	Iliac revasc w/stent	Peripheral Vascular	5193	$11,340.57	$7,176.05	-37%
37224	Fem/popl revas w/tla	Peripheral Vascular	5192	$5,701.52	$3,639.70	-36%
36902	Intro cath dialysis circuit	Dialysis	5192	$5,701.52	$2,629.62	-54%
36906	Thrmbc/nfs dialysis circuit	Dialysis	5194	$17,956.72	$11,783.21	-34%

CPT = Current Procedural Terminology; APC = Ambulatory Payment Classifications; HOPD = hospital outpatient department; ASC = ambulatory surgery center

Reimbursement rates for categories like cath/PCI, devices, and vascular procedures are lower in the ASC setting compared to the hospital outpatient setting.[3] However, this comparison does not account for the typically lower expenses associated with performing these procedures in an ASC, where costs can decrease by approximately 30%-40%.[5]

Reimbursement Changes: Outpatient Procedures

Within the outpatient setting, diagnostic catheterizations and PCI procedures both saw increases in APC rates (Table 3). Peripheral vascular procedures showed increases across all categories, while electrophysiology procedures saw nuanced adjustments, including a 2% increase for certain defibrillators and a 3% decrease in pacemakers at Level 1, balanced by slight increases in other levels.[2]

Ambulatory Surgical Center (ASC) Payment System Updates

ASCs saw an average rate increase of 2.9%, though their APC conversion factor is typically lower than hospitals. For certain cardiac CT codes, CMS reassigned these to higher-paying APCs to better reflect procedural costs.[3] While CMS refrained from adding new surgical procedures to the Covered Procedures List (CPL), they left in place the addition of cardiac, vascular, and orthopedic procedures from recent years, allowing providers to keep pace with procedural shifts to ASCs.[4]

Table 4 illustrates the reimbursement differences for certain procedures when performed in a hospital outpatient setting versus an ASC. At first glance, it's clear that reimbursement rates for categories like cath/PCI, devices, and vascular procedures are lower in the ASC setting compared to the hospital outpatient setting.[3] However, this comparison does not account for the typically lower expenses associated with performing these procedures in an ASC, where costs can decrease by approximately 30%-40%, resulting in similar profit margins between ASCs and hospitals despite the lower reimbursement rates in ASCs.[5]

Physician Fee Schedule (PFS) Updates

The calendar year 2025 PFS brings a 2.8% conversion factor reduction to $32.35. CMS added six new Merit-Based Incentive Payment System (MIPS) metrics and refined telehealth service definitions, allowing coverage for two-way audio when video is unavailable.[6] For telehealth providers, distant practitioners can now report enrolled practice locations rather than home addresses when delivering services remotely. CMS also introduced add-on payments for certain office and outpatient Evaluation and Management (E/M) visits.[6]

Conclusion

The CMS 2025 updates introduce substantial changes across Medicare's payment systems, with a strong focus on incentivizing high-quality, efficient, and patient-centered care. From new technology add-on payments to mandatory episode-based payment models, these updates reflect CMS's commitment to modernizing healthcare reimbursement and supporting innovative treatments that improve outcomes. Corazon strongly believes that all organizations must prepare for the future by allocating appropriate resources, scheduling necessary training, and keeping clinical and financial teams apprised of required policy and/or procedure changes. By understanding and adapting to these updates, healthcare providers can better align their services with CMS's goals, navigating both inpatient and outpatient settings with an emphasis on cost-effectiveness and quality. As we move into 2025, these changes will be essential for providers aiming to optimize reimbursement, enhance patient care, and stay competitive in an evolving healthcare landscape. ■

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