What is the Future of Venous Reimbursement?

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Disclosures

• BTG

The Future is moving to Outpatient Setting

• Carriers and CMS have created a reimbursement structure that pushes cases to outpatient setting
• All Outpatient settings are not created equal
• Facility vs Non-Facility
• Carriers and CMS will reimburse for absorbing (and managing) overhead

Facility vs “Non-facility” - RVUs

• Facility = Hospital or Article 28
• Non- Facility = Office based setting
• For a given procedure - total RVUs comprised of: work, PE (Practice Expense), Malpractice
• Work and Malpractice components unchanged for facility or non-facility (office based)
• Practice Expense changes significantly
• Facility – scheduling, setting up PST, phone calls etc
• Non-Facility – above PLUS cost of space, personnel, disposables

Most Carriers follow this CMS/RVU model – Make sure it is the case for local carriers/procedure

RUC - Structure

• RUC – Relative Value Scale Update Committee
• Advises CMS on reimbursement for medical procedures
• 31 MDs (mostly specialists appointed by specialty societies) who meet to discuss and vote by secret ballot on reimbursement rates for over 10,000 procedures. Recommendations then passed on to CMS
• Recommendations almost always accepted by CMS
• RUC sends surveys to society members for “misvalued” codes
• Triggers for RUC Review include spikes in volume growth of procedures and billing of multiple associated procedures simultaneously (unbundling)
**Why is Venous Reimbursement An Issue?**

**Medicare Endovenous Ablation Claims**

![Graph showing Medicare Endovenous Ablation Claims]

**ACA — Decrease RVUs – High Volume Procedures- Venous Ablation**

- Codes for venous ablation recently reviewed by CMS
- Use RUC surveys to lower payments per procedure — asked SVS to survey members to assess RVUs for procedure and office based component

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**Saphenous vein ablations**

**Facility Total RVUs (Effective Jan 1, 2015)**

<table>
<thead>
<tr>
<th>CPT</th>
<th>2014</th>
<th>2015</th>
<th>% change</th>
<th>procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>36475</td>
<td>10.35</td>
<td>8.11</td>
<td>22%</td>
<td>RF-1st vein</td>
</tr>
<tr>
<td>36478</td>
<td>10.25</td>
<td>8.06</td>
<td>21%</td>
<td>Laser-1st vein</td>
</tr>
</tbody>
</table>

**Non-Facility Total RVUs (Effective Jan 1, 2015)**

<table>
<thead>
<tr>
<th>CPT</th>
<th>2014</th>
<th>2015</th>
<th>% change</th>
<th>procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>36475</td>
<td>47.43</td>
<td>34.65</td>
<td>21%</td>
<td>RF-1st vein</td>
</tr>
<tr>
<td>36478</td>
<td>37.81</td>
<td>34.09</td>
<td>10%</td>
<td>Laser-1st vein</td>
</tr>
</tbody>
</table>

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**Managing Overhead**

- Efficient use of disposables (devices, balloons, catheters, stents)
- Consolidate space, efficient scheduling, room turnover
- Calculate up front costs

**Percutaneous Deep Venous Procedures**

- 37238 Venous stent, initial
- 37239 Venous stent, subsequent
- 36010 Non-selective IVC catheterization
- 75825 IVCgram
Percutaneous Venous Procedures
RVUs – Facility v Non-Facility

<table>
<thead>
<tr>
<th>CPT code</th>
<th>2015 Facility</th>
<th>2016 Facility</th>
<th>2015 Non-facility</th>
<th>2016 Non-facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>37238</td>
<td>9.31</td>
<td>9.21</td>
<td>117.08</td>
<td>119.20</td>
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<tr>
<td>37239</td>
<td>4.66</td>
<td>4.39</td>
<td>58.04</td>
<td>57.70</td>
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<td>36010</td>
<td>3.55</td>
<td>3.56</td>
<td>14.25</td>
<td>14.14</td>
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<tr>
<td>75825</td>
<td>1.63</td>
<td>1.61</td>
<td>3.86</td>
<td>3.86</td>
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</tbody>
</table>

2016 IVUS Coding

<table>
<thead>
<tr>
<th>CPT</th>
<th>wRVU Facility</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>

Coverage Policies

- All private and governmental carriers have some form of vein coverage requirements
- Vary across the country among LCDs (CMS)
- Vary among third party payers
- Policies continually change which makes experienced billing / scheduling staff invaluable to a practice

Conservative Therapy

In addition to the requirement for failure of a six-week trial of conservative treatment and the symptoms described above, coverage of worsening edema/ulceration is limited to patients with:

- A maximum venous diameter of 20 mm for lower amputation;
- Absence of thrombosis or vein thrombosis, which would impair calf or ankle swelling; and
- Absence of significant peripheral artery disease.

Insurance and NAD policies are similar

Treatment for symptomatic chronic venous insufficiency orcompetent valves (Vv), in the absence of bleeding, phlebitis or non-healing, may be covered as medically necessary with:

1. A documented trial of conservative measures including graduated compression stockings with a maximum of 20 mmHg, weight reduction to BMI 25 or, if medically elevated, and an exercise program of at least 60 minutes of walking or 45 minutes of running each week as well as results in limited venous symptoms is met, and
2. Absence of Deep Venous Thrombosis, and
3. Documentation of a trial of at least 6 weeks of the mandatory measures at the discretion of the patient, referring provider, and Surgically.

Novitas and WPS policies are similar

The treatment of symptomatic varicose veins or symptomatic incompetent vein without a 4 mm or more of venous reflux or a pressure of venous ulceration, by any technique, will be considered cosmetic and therefore not covered.

Conservative Therapy

- Ulcer, bleeding, & phlebitis exceptions

Regardless of indication:
- Previous insole treatment(s) of varicose veins (if any)
- Failure or intolerance of medically supervised conservative management, including but not limited to compression stocking therapy (reference processor’s manual)

Varicose Ulcer

There is documentation of one or more of the following indications:
- Ulcer secondary to venous stasis that fails to respond to compression therapy, OR
- Recurrent superficial thrombophlebitis that fails to respond to compression therapy, OR
- Nonhealing or recurrent bleeding episodes from a ruptured superficial varicose, OR
- Persistent pain, swelling, itching, burning, or other symptoms associated with the ulceration, AND the symptoms significantly interfere with activities of daily living, AND conservative management including compression therapy (reference processor’s manual)
Regarding a Recent Aetna and United Policy

- On a recent peer to peer call — “actually I agree this makes no sense, and actually, I’m not your peer”.

Coverage of new Procedures

- MOCA (Mechano – Chemical Ablation ) for truncal varicose veins. (Clarivein) – currently use unlisted procedure code - 37799
- Proposal for new code submitted to CMS by joint proposal from SVS, ACP, SIR, AVF
- If approved – could be on CMS fee schedule for 2017

BC/BS Massachusetts - IAC

News alert

Endovascular ablation accreditation required for claims to pay

| Date Issued: | Aug 26, 2015 |
| Effective Date: | Jan 1, 2016 |
| From: | The physicians and facilities that offer endovascular ablation to our members |

In January, we notified you that we would require all providers who currently perform endovascular ablation to be able to perform Endovascular Ablation Commission (IAC) vein center accreditation by September 30, 2015. For current participating providers who need additional time to complete the accreditation process, we have extended the deadline to January 1, 2016.

All Blue Cross Blue Shield of Massachusetts physicians who are currently privileged to perform endovascular ablation must be listed as approved on the IAC-approved provider list for IAC Vein Center Accreditation by January 1, 2016. As of February 1, 2016, we will remove procedures listed by those providers who are not on their IAC Vein Center provider list. All providers and facilities that are not listed as approved on the IAC Vein Center provider list as of January 1, 2016 will be excluded from the Blue Cross Blue Shield of Massachusetts provider network. This decision was made to be consistent with the IAC and ensure that our members receive treatment from providers and facilities that meet current standards of care for these procedures.

Summary

- Procedure RVU values are similar in 2016
- Move to “non-facility” based procedures when appropriate and feasible
  - Non-Facility RVUs significantly higher, manage overhead

Action Plans

- Respond to policy changes from CMS/third-party payers (organized, evidence based guidelines)
- Adhere to accepted medical indications – possible move to IAC Vein Center Accreditation
- Possible NCD (National Coverage Determination) for some procedures such as varicose veins – to address variation in current LCD policies.

Let’s Not Let It Come to This…
Thank You