Economic Forecast And Recommendations for Venous Intervention

Peter F. Lawrence, M.D.
Director, Gonda Vascular Center
Chief of Vascular Surgery
David Geffen School of Medicine

Annual Medicare Vein Stripping / Ablation

6,371% Increase in annual treatments

Do We Have A Problem with Veins?

- 6,000% increase in treatments not likely due to increased disease prevalence
- Prevalence of disease may be increasing
- Vein treatment advocates say less invasive treatment shifts risks/benefit/QOL curve
- CMS exerts its easiest means of control, Payment Reduction

Does Payment Drive Vein Treatment?

CPT 36475 Radiofrequency Ablation
2014 Fee Schedule

<table>
<thead>
<tr>
<th>Site of Service</th>
<th>Medicare Payment to Physician</th>
<th>Medicare Payment to Hospital</th>
<th>Total Medicare Payment</th>
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</thead>
<tbody>
<tr>
<td>Hospital Outpatient</td>
<td>$371</td>
<td>$2,139</td>
<td>$2,510</td>
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<tr>
<td>Physician Office</td>
<td>$1699</td>
<td>$0</td>
<td>$1699</td>
</tr>
</tbody>
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Ambulatory Venous Treatment Site
Per Cent Endovenous Ablation Performed in Office Setting – Medicare FFS data

CMS Response to Rapid Growth in Vein Treatment
- RFA & Laser caught in screen for rapid growth
- RUC survey, multiple specialties
- Survey skin-to-skin time down 25%
- Work RVU = Time x Complexity
- CMS cut RVU’s in 2015
- Will pay cut curb volume???

Future Issues
- **RUC: Saphenous Vein**
  - All endovenous procedures are better reimbursed in the office setting
  - Newer techniques coming down the pipeline
    - MOCA (NTNT) is being surveyed at the RUC at the next meeting
    - The problem with valuing these codes will be the fact that there is less physician work in performing them, i.e. no tumescent anesthesia
    - Shorter procedure times and less intensity compared to thermal ablation techniques. MOCA will probably be about 2/3rd to ½ the value of RFA and EVLT
    - Key to MOCA will be the practice expenses associated with the procedure, but these also appear to be less than ablation
    - Glue and Foam sclerotherapy may have an even harder uphill battle at the RUC
  - Irony: less invasive options for the patients will reimburse less than the more invasive thermal procedures

Future Issues
- **RUC: Perforators**
  - The venous ablation codes are specifically written as "treatment first vein" and "treatment additional veins" to cover perforators
  - As this procedure becomes increasingly common, there will need to be a dedicated code
  - The RUC has discussed creating a perforator code but have resisted due to the risk of revaluing all of the existing endovenous codes
  - The SVS and AVF need to work on CMS and the regional carriers to increase coverage

Future Issues
- **RUC: Venous Stents**
  - Venous stents are a big problem- the increased utilization will eventually hit a screen and be revalued
  - The increase has mostly been driven by nephrology doing "venous" angioplasties and "venous" stents
  - In the new coding scheme for dialysis that is currently out for survey, the RUC specifically wrote new codes to segregate dialysis circuit and angioplasty/stenting of central veins related to dialysis access from central venous treatments for venous disease
  - This may keep venous stents off the radar for a while

Questions Raised By Trends in Venous Disease Management and Reimbursement
- Does an office-based environment improve or reduce quality for most patients?
- Should accredited labs be required for documentation of venous insufficiency?
- What specialties should be reimbursed for venous disease treatment?
- How should issues of quality be addressed in the office setting?
- How should issues of fraud be addressed in the office setting?
- Venous disease management still must remain a significant focus of vascular surgeons