Impact Of Changing Reimbursement For Outpatient Hemodialysis Procedures On Hospital IR Workflow

Ziv J Haskal MD FSIR FACS FCIRSE FAHA
Professor of Radiology / Interventional Radiology
University of Virginia
Editor in Chief, Journal of Vascular and Interventional Radiology

The ‘Hospital IR Workflow’— all specialties providing access interventions in a hospital environment

- The move to outpatient access interventions matured many years ago.
- Outpatient access reimbursement were strong and individual practice or larger corporate entities created OBLs to provide interventions for profit opportunities.
- The emergence of specialty of Interventional nephrology was potentiated by the new landscape of places to practice, obviating the (still ongoing) struggles in some hospitals between multiple competing specialties, in-house

- So What’s ‘new’ in reimbursement?

Some defining differences: OBLs

ASC, some relative billing advantages

<table>
<thead>
<tr>
<th>Am Surg Center (ASC)</th>
<th>Office Based Lab (Place of Service code 11)</th>
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<tbody>
<tr>
<td>- Hemodialysis decals</td>
<td></td>
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<tr>
<td>- AVF surgery</td>
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<td>- Venous stents</td>
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<td>- Ports</td>
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<td>- eg</td>
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</tbody>
</table>

- Most endovascular work

Disclosures

- Speaker/ Consulting: Becton Dickinson, WL Gore, Varian, Bendit, BlackSwan, Fluxx

Location and setting

- Location based reimbursements have all dropped, though are significantly in the outpatient access intervention center, leading pure access intervention to be either less profitable or, frankly, lose money.
- Those changed incentives have driven many outpatient centers to seek alternate higher reimbursement procedures to offset losses, regain profits
- Hence, well known moves into PAD, and, for example ‘exaggerated’ drive to perform arteriography (often a sole intervention in OBLs)

<table>
<thead>
<tr>
<th>CPT Description</th>
<th>RVU</th>
<th>ACH</th>
<th>Category</th>
<th>Payment</th>
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</thead>
<tbody>
<tr>
<td>Hemodialysis circuit, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit, including all imaging and radiological supervision and interpretation</td>
<td>14.9</td>
<td>10.42</td>
<td>ICH</td>
<td>12.91</td>
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<td>Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis segment, including all imaging and radiological supervision and interpretation</td>
<td>36904 $388 $1,914</td>
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<td>Intravenous access, including all imaging and radiological supervision and interpretation</td>
<td>36905 $465 $2,407</td>
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<td>In - hospital</td>
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<tr>
<td>Open heart surgery, including all imaging and radiological supervision and interpretation</td>
<td>85257 $61,774 $10,773</td>
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<td>Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, including all imaging and radiological supervision and interpretation</td>
<td>36906 $537 $6,723</td>
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<tr>
<td>Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis segment, including all imaging and radiological supervision and interpretation</td>
<td>10.42</td>
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<tr>
<td>Introductions of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the access segment and adjacent artery through entire venous outflow</td>
<td>9.23</td>
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<tr>
<td>Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic imaging and documentation and report; with transcutaneous placement of intravascular stent(s), per peripheral dialysis segment, including all imaging and radiological supervision and interpretation</td>
<td>6.39</td>
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<td>Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis segment, including all imaging and radiological supervision and interpretation</td>
<td>8.64</td>
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<tr>
<td>Intravenous access, including all imaging and radiological supervision and interpretation</td>
<td>36905 $465 $2,407</td>
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ESCO (12/2015—12/2020)

- Dialysis clinics and nephrology practices (and other providers) join to create an ESCO to provide accountable care for entire medical needs of ESRD matched Medicare beneficiaries
- Paid annual per patient $ for all costs
- Entirely of cost care is included, eg dialysis, access care, CHF, GI bleed, oncology (eg metastatic lung cancer, etc)
- Creates shared savings loss risk agreements between practice, dialysis facilities (large and <300 site small), hospital based etc. Smaller programs may have less risk of shared losses
- Annual per patient incentive to control cost, improve quality, limit excessive costly care—including costly-site care

Example

- Reduce visits to emergency departments for fluid overload. All do-able good goals.
- Partner with cardiology groups to, say, reduce auto-ordering of $$$ tests at all ‘natural’ points, (eg Echocardiograms) to control costs – likely that nephrology groups might not be able to manage all aspects alone (given the dependency upon other specialties for ESRD care)
- Home hemodialysis is ~20% less expensive, and ESCOs may drive far more home HD (as will Trump ETC)
- Change the thresholds for referring patients for access interventions (eg flow rates during dialysis, site events etc) to reduce intervention its
- Consider costly interventions as part of access care (eg costly stents, pAVF etc)

Some CMS Quality measures for CECs

- Each center's data, including financials, are plain to see.
- Where do you imagine 'added' expensive hospital access care will fit in this model??

HHS’ Executive Order overhauling kidney disease care. July 2019

- ~ETC (ESRD Treatment Choices) plan: Will Adjust Medicare $ up/down based upon home dialysis and rates of kidney/kidney/panc transplants
- Goal: ~50% ESRD centers/clinicians participate
  Payments/ETC model begins Jan 2020-June 2026

Will this stumble? Who knows

- The quoted peer country with greater home HD rates: Hong Kong
- HK has govt supported universal healthcare
- Affordable care act approaching ruin (extended healthcare for millions)
- Home dialysis for unsuitable patients; hospitalizations, infections, possibly worse outcomes at higher costs
- Regardless, it's a good goal to aim for. Will this affect IR workflow and hospital based Access Interventions?—does not seem to directly do so, yet.


Strong and clearcut incentive to not refer access care to an expensive in-hospital environment, excepting certain potential scenarios.

What might some of those be?
- Existing allegiances between referrers, practices and in hospital outpatient providers
- Unique care delivered by hospital based providers
- Specific care, eg DCB used in hospital (now absent a pass through) cost is close, even occ less, than in an OBL setting, pending other devices (or OBL does not wish to stock those expensive options, as economic per patient eventual-cost-savings argument might yet be made (or not compelling)

But, “allegiances will ultimately fail, over time, ifas ESCO model expands”
- PTA in OBL ~1300$, hospital APC >3000$
Conclusions

IR lab/ In hospital lab
IR is but a small part of a far larger puzzle.

- Whether the ESCO model persists as is or not (probably won’t), the dynamic will be the same: providers will have cost/value interest in all aspects of care, including and especially vascular access.
- Quality and value in the IR lab might/might not justify additional costs.
- Consider, even, that the occ long delays of access care in a hospital outpatient setting means less patients in dialysis center chairs getting dialyzed ($$)
- In Hospital APC provider has little or no competitive control over their costs, as is hospital tech fees/charges that define the disincentive

* one hospital that bars in the $200 fee range for a PAE (c/w $10-25)

11/23/2019