Outlook For Vascular Surgeons’ Incomes In A Changing Health Care Environment

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Medicare Conversion Factor

- **2017**
  - MACRA \(\uparrow 0.50\%\)
  - 2014 SGR patch (ABLE statute) \(\downarrow 0.09\%\)
    - Last year of cuts with this legislation
  - Budget neutrality \(\downarrow 0.10\%\)
- NET CHANGE \(\uparrow 0.31\%\)
- **2017** $35.9996

Hemodialysis Access Endovascular Therapy
CPT Codes 36901-36909

- Created for 2017 as a result of CPT/RUC mandated bundling efforts
- Based on survey data, the RUC recommended work RVU values for these 9 codes to CMS
  - CMS rejected these proposed values
  - CMS reduced the RUC values even further for 2017
- CMS received significant negative feedback from multiple societies and interested parties
- In 2018, CMS is actually increasing the RVUs to the original RUC recommended values (\(\uparrow 1\%-5\%\))

EVAR Coding/Reimbursement in 2018

- Codes 34802, 34812, 34825 hit a RUC screen
- Referred to CPT for bundling and revaluing
  - SVS, SIR, SCAI, ACC, STS, ACS, AATS
- Effective January 2018
- Now usable for indications besides “aneurysm”
- Coding based on configuration of the main body:
  - Aortic tube, Aorto-uni-iliac, Aorto-bi-iliac, Iliac
  - Rupture versus non-rupture

EVAR Coding/Reimbursement in 2018
What Is Separately Reportable From The Main Body Code

- New codes for percutaneous access
  - Only usable if the sheath access is \(\geq 12\) french
  - Also usable for TEVAR and FEVAR
- New codes for open axillary/subclavian artery access with and without conduit
- Code for “enhanced fixation” (eg, stapling)
- Decompressive laparotomy after rupture
  - EVAR \(\rightarrow\) additionally report code 49000
EVAR Coding/Reimbursement in 2018
What Is Bundled Into The Main Body Code
• All proximal aortic stentgraft extensions that terminate below the lowest renal
• All distal common iliac artery stentgraft extensions
• Radiology supervision and interpretation
• Non-selective aortic catheterization(s)

Fortunately, CMS accepted the RUC values
Similar to open ruptured AAA repair coding, the new ruptured EVAR codes have been assigned higher RVUs than elective EVAR
The reduction in reimbursement is directly proportional to the number of stentgraft extensions that a provider typically implants
↑ # of stentgraft extensions = ↑ cut in reimbursement

CPT and RUC 2018
New Adhesive Vein Ablation
Follows the same structure as RF and laser

2018 Adhesive Vein Ablation 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>36482</td>
<td>3.50</td>
<td>5.13</td>
<td>60.06</td>
<td>First vessel</td>
</tr>
<tr>
<td>36483</td>
<td>1.75</td>
<td>2.56</td>
<td>4.08</td>
<td>Subsequent vessel(s)</td>
</tr>
</tbody>
</table>

2018 Medicare CF is $335.9996

CPT and RUC 2018
Non-Compounded Foam Vein Ablation
Follows the same structure as sclerotherapy

The foam sclerosant cannot be made by the MD and must be purchased directly from the manufacturer to use these codes
Follows the same structure as sclerotherapy
CPT and RUC 2018
Non-Compounded Foam Vein Ablation

Injection of non-compounded foam sclerosant with ultrasound compression maneuver to guide dispersion of the injectate, including all imaging guidance and monitoring; single superficial extremity truncal vein, great saphenous vein, accessory great saphenous vein.

Only usable in a truncal vein (ie, GSV, LSV, or lateral accessory saphenous) & NOT usable for branch veins or perforators

2018 Compounded Foam Vein Ablation 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>36465</td>
<td>2.35</td>
<td>3.46</td>
<td>45.12</td>
<td>First vessel</td>
</tr>
<tr>
<td>36466</td>
<td>3.00</td>
<td>4.40</td>
<td>47.14</td>
<td>Subsequent vessel(s)</td>
</tr>
</tbody>
</table>

2018 Medicare CF is $35.9996

Vascular Lab Payments
Deficit Reduction Act “DRA” of 2005

- DRA caps office-based technical payment for ultrasound since 2007 at the lesser of:
  - Hospital Outpatient Payment Fee Schedule
  - Medicare Physicians Fee Schedule
- The re-assignment of three ultrasound studies to a lesser APC by CMS will cause a significant cut to their technical payment

Hospital Vascular Lab Technical APCs in 2018
Vascular Lab Studies fall into 4 APCs

Physiologic Testing
- APC 5734 “limited”
- APC 5721 “complete”

Ultrasound
- APC 5522 “limited”
- APC 5523 “complete”

APC Technical Payments 2017-2018

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiologic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>APC 5734 (limited)</td>
<td>$99.98</td>
<td>$105.03</td>
</tr>
<tr>
<td>APC 5721 (complete)</td>
<td>$127.05</td>
<td>$136.31</td>
</tr>
<tr>
<td>Duplex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>APC 5522 (limited)</td>
<td>$112.69</td>
<td>$118.74</td>
</tr>
<tr>
<td>APC 5523 (complete)</td>
<td>$225.81</td>
<td>$245.22</td>
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</tbody>
</table>

APC Technical Payments 2017-2018

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiologic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>APC 5734</td>
<td>↑5.1%</td>
<td>$105.03</td>
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<tr>
<td>APC 5721</td>
<td>↑7.3%</td>
<td>$136.31</td>
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<tr>
<td>Duplex</td>
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<td></td>
</tr>
<tr>
<td>APC 5522</td>
<td>↑5.4%</td>
<td>$118.74</td>
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<tr>
<td>APC 5523</td>
<td>↑8.6%</td>
<td>$245.22</td>
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</table>
Reclassified Vascular Lab Ultrasounds
Moved From Complete to Limited APC

<table>
<thead>
<tr>
<th>CPT</th>
<th>2017 TC</th>
<th>2018 TC</th>
<th>% Change</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>93880</td>
<td>$165</td>
<td>$119</td>
<td>↓28%</td>
<td>Bilateral carotid</td>
</tr>
<tr>
<td>93970</td>
<td>$165</td>
<td>$167</td>
<td>↑1%</td>
<td>Bilat venous extremity</td>
</tr>
<tr>
<td>93925</td>
<td>$223</td>
<td>$228</td>
<td>↑2%</td>
<td>Bilateral LE arterial</td>
</tr>
<tr>
<td>93926</td>
<td>$113</td>
<td>$119</td>
<td>↑5%</td>
<td>Unilateral LE arterial</td>
</tr>
<tr>
<td>93975</td>
<td>$226</td>
<td>$231</td>
<td>↑2%</td>
<td>Complete abdominal</td>
</tr>
<tr>
<td>93990</td>
<td>$113</td>
<td>$119</td>
<td>↑5%</td>
<td>Complete Aorta/iliacs</td>
</tr>
<tr>
<td>G0365</td>
<td>$113</td>
<td>$119</td>
<td>↑5%</td>
<td>1st AV access</td>
</tr>
</tbody>
</table>

Carotid Duplex TC Payments

- The 2018 APC assignment for 93880:
  - Cuts the hospital TC by 47% compared to 2017
  - Pays 40% LESS than CMS' own TC estimate ($198 geometric mean cost but assigned $119)
- SVS and other societies have complained to CMS and CMS is reviewing our concerns
- We are also seeking a legislative solution

Conclusions

- Medicare CF will increase by 0.31%
- HD access angiography and endovascular intervention will see an increase in 2018
- Significant coding changes for EVAR
- Two new vein ablation modalities will have CPT codes in the fee schedule
- Three vascular lab technical payments will decrease due to the HOPPS APC changes