AMERICAN VEIN &
LYMPHATIC SOCIETY

AVLS COMMENTS TO CMS REGARDING CY2022 PHYSICIAN FEE SCHEDULE PROPOSED RULE: CMS-1751-P

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AMERICAN VEIN & LYMPHATIC SOCIETY

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September 13, 2021

The Honorable Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services
Attention: CMS–1751–P
7500 Security Boulevard
P.O. Box 8016
Baltimore, MD 21244-8016
Submitted electronically via: http://www.regulations.gov

Re: CY 2022 Physician Fee Schedule Proposed Rule: CMS-1751-P

Greetings Administrator Brooks-LaSure,

The American Vein & Lymphatic Society is a professional medical association of approximately 1,800 members with a 30-plus year history of advancing patient care and scientific research in venous and lymphatic disorders. We are the largest US professional medical association devoted to venous disorders, and are committed to evidence-based patient care, research, and public education in venous and lymphatic health. Members of our Society come from multiple specialties including vascular surgery, radiology, general surgery, cardiology, dermatology, family practice, and others. Nearly all of our physician members have made venous and lymphatic care their exclusive professional clinical focus. Most of our membership are diplomates of the American Board of Venous and Lymphatic Medicine, the credentialing entity for the clinical domain. Most of our membership is office-based, practicing in solo or small groups, and many of our members own their offices and directly employ their clinical and administrative staff. Venous and Lymphatic medicine is not a CMS-recognized specialty, so it does not appear in the proposed rule specialty impact table. This is a key concern of our Society and something we will discuss below, and share a detailed analysis we have prepared showing the proposed 2022 PFS impact is greatly amplified if venous care were a distinct CMS specialty domain.

As a medical condition, venous disease is more prevalent in the United States than coronary artery disease, peripheral artery disease, congestive heart failure, and stroke combined. (https://www.sciencedirect.com/science/article/pii/S0749379718312030). Some venous patients can be successfully managed with conservative care, but patients with more advanced chronic venous insufficiency require procedures to solve the underlying venous cause of

progressive damage to the skin and soft tissues of the extremities. In our view, venous leg ulceration patients are the most underserved group of wound patients in the current US healthcare system and caring for these patients is known to be quite costly to the Medicare Trust Fund. However, we would assert that for vein care, the patient return on investment is robust, resulting in improved quality of life, reduced disability, and reduced pain.[i] Chronic venous insufficiency patients frequently will need treatment several years after their initial treatment, which is why following these patients longitudinally by a specialist is important. Typically, patients who have no follow-up have venous recurrence of approximately 20-25% at 10 years, caused by perforated collateralization. Almost always, these patients who need follow-up care can be treated in the office with very cost-effective modalities, such as ultrasound-guided foam sclerotherapy.

Venous leg ulcers are the leading cause of a non-healing leg wounds. Chronic venous disease impacts up to 40% of the population and up to 4% of patients 65 years and older will suffer from venous leg ulceration. Venous leg ulcers (VLU) alone consume nearly 2% of the total healthcare budget in developed countries. The average annual incidence of VLU is 2.2% in Medicare and 0.5% in private insurance populations.[ii] VLUs are a $15 billion a year public and private payer burden in the United States.[iii] To put this in perspective, diabetic foot ulcers are only a $9-13 billion a year burden because the prevalence of venous disease is much higher than diabetes. Venous leg ulcer patients make up most patients in wound care centers, however, the recurrence rate of venous leg ulcers without venous intervention is shown to approximate 30% per year even under the best medical management. Leg ulcer patients in wound care centers often are not properly screened for venous disease even though venous disease is well-known to be the leading cause of leg ulcers. We note the landmark 2018 *New England Journal of Medicine* study, "*A Randomized Trial of Early Endovenous Ablation in Venous Ulceration*", showing how ulcer patients who do not receive diagnosis and treatment of their underlying venous disease have ulcers that heal more slowly and recur more often.[iv]

We consider it a privilege to care for Medicare beneficiaries, and we are often solicited to offer our insight and advice to Medicare Administrative Contractors regarding venous and lymphatic disorders. Our Society has a demonstrated commitment as good stewards of the Medicare Trust Fund. Our commitment is evidenced by several significant investments we have made in recent years including our AVLS *PRO Registry* and our ***Improving Wisely*** partnership with the research collaborative team at Johns Hopkins University partnership with the Robert Wood Johnson Foundation. The 2019 study of venous claims and provider utilization that was done under the ***Improving Wisely*** partnership[v] notified physicians of their rates of saphenous vein ablation in Medicare patients compared to statistical peer norms. The initial study was published in the *Journal of Vascular Surgery: Venous and Lymphatic Disorders*.[vi] An updated report shows a positive change (a mean decrease) in 2019 utilization rates compared with 2017 for those practitioners who were categorized as utilization outliers in their vein ablation rates compared to the national mean. This follow up study will be presented at our annual meeting next month and has been submitted for peer-reviewed publication to a national medical journal.

We appreciate the opportunity to comment to CMS on the following issues.

Supply adjustments for CY 2021 & CY 2022

In the Part B Fee Schedule Final Rule for CY 2021 (CMS-1734-F), the Agency acknowledged and discussed stakeholder comments and submitted invoices for three key supply items that are commonly used in thermal venous treatments: SA026(*Radiofrequency Introducer*), SD155 (*Radiofrequency venous catheter*), and SA074 (*Endovenous Laser kit).*

We greatly appreciate the Agency's review of these three items that were conducted for the 2021 Final Rule, and for making adjustments for CY2021 and CY2022 in the Market-Based supply pricing list.

We do note with concern that ramifications of the Public Health Emergency, plus global supply chain issues, have caused a significant increase in common office-based supply costs in the past 18 months. The fully adjusted 2022 supply prices for many common items that the Agency lists in the Market-Based Supply list do not reflect this recent surge in pricing for these common medical items and which will probably persist for the foreseeable future.

Proposed CY 2022 Rule (1751-P): Physician Fee Schedule and Part B Rule

Proposed Conversion Factor for CY2022: We urge the Administration and CMS to work with Congress and all clinical stakeholders to maintain the Conversion Factor at the 2021 rate for CY2022. As small practices continue to deal with the impact of the Public Health Emergency, we echo the concerns of many others and urge CMS not to implement a scheduled 3.75 percent cut to the conversion factor in 2022. Other simultaneous legislative actions, such as sequestration and the PAY-GO cuts, are occurring at this same time. During the pandemic, it has been office-based clinicians who have worked to care for patients and to keep patients out of the hospital setting, and to preserve hospital capacity. Allowing non-facilities to care for patients outside of a hospital setting seems a sound public health strategy.

Clinical Labor Update: On pages 48-56, and in a Regulatory Impact Analysis, the agency asks for comment on a proposed update to Clinical Labor rates and discusses how this update may impact different specialties. The Proposed Rule includes an estimate if this update were to occur all in CY2022, and CMS also asks for public comment if this update were to be phased in over four years.

The AVLS joins with multiple other specialties that have commented on this matter to the Agency. We urge CMS to fully appreciate the impact that this update will have on some office-based clinicians, and the predictable consequences on patient care. To financially execute the Clinical Labor Update, the Agency is proposing to alter the direct scaling factor, which is proposed to decrease 24% from 0.5916 in 2021 to 0.4468 in 2022. This causes a steep drop in total NF RVUs for CPT codes that use necessary supply items, and the impact on lower extremity vein care will

be severe and long lasting. This especially impacts clinicians who specialize in caring for venous patients, and the CPT codes commonly used for medically necessary venous procedures. We support the presentation made by the American Venous Forum to CMS on September 8th, and we echo the concerns that ***proposed PE rates will be less than the actually direct supply costs for many key venous care CPT codes.*** The Clinical Labor Update, as proposed, or even phased in with annual decreases in the scaling factor, will cause systemic disruptions and patients to be denied access to care. We cannot foresee a path in the coming years where the typical venous non-facility will be able to operate and care for patients under these Medicare payment rates. Furthermore, these Medicare rates will flow down to Medicare Advantage carriers and private payers in short course.

This Labor Update proposal, even if implemented over four years, will create unintended consequences that will decrease patient access to venous care, amplify health inequities, cause non-facilities to close with staff layoffs, cause care to migrate to more expensive hospitals and ASCs, and increase total Federal spending. CMS and the Administration must work with all stakeholders, especially Congress, to craft a solution that keeps the non-facility setting accessible to Medicare seniors. For vein care offices, radically cutting total NF RVUs for key venous CPT codes will have an easily predictable outcome of offices closing, care denied, and adding more costs to the Medicare Trust Fund as care shifts to other sites of service.

We explore in detail our concerns and share in full an analysis (summary memo attached) that our Society has conducted that will underscore how a deep cut to key venous CPT codes will impact Medicare beneficiaries.

As noted above, Vein and Lymphatic specialists do not have a specialty code recognized by CMS and would appear under a range of specialty codes. In the Proposed rule, on Table 6, CMS showed the clinical labor pricing change effect on specialties that have distinct specialty codes. The impacts ranged from positive 10% for portable X-ray suppliers to -6% for diagnostic testing facilities. ***According to our analysis of a large sample of our AVLS membership, the impact of the Clinical Labor Update and other changes affecting PE RVUs on the specialty of Venous and Lymphatic Medicine would be a staggering -12%. Proposed 2022 reductions for key vein procedural CPT codes range all the way to almost -23%.(e.g., 36475, RF Ablation, first vein treated).***

Based on the modeling analysis that AVLS conducted with Braid-Forbes Research, using NPIs of 541 of our members, who cut across specialties but ***who are focused almost exclusively on venous and lymphatic medicine as evidenced by being members of the AVLS.*** The summary results of our simulation for vein and lymphatic specialists are listed below.

- Vein and lymphatic physician specialists would see a 12% payment decrease for their practices across all the services they provide under the 2022 proposed rule payment rates. This is due to a 15% decrease in the practice expense portion of the payment.

- Some of this decrease is due to a decrease in the conversion factor. When holding the conversion factor constant between 2021 and 2022, these physicians see a 9% decrease resulting

from the changes in the RVUs. This is due to a 12% decrease in the PE RVU, which is double the percent decrease due to the clinical labor changes that CMS calculated for the worst hit specialty.

- Nine of the top volume codes for vein and lymphatic specialists have proposed cuts in payment of greater than 10%, with five codes facing cuts of at least 22%. The weighted total payment rate cut for these codes was 20%. (Table 1 below)

- For these nine codes, 374 vein and lymphatic specialists provide 30% of all of the procedures performed on Medicare beneficiaries.

- The payment rates for six of these nine codes had already declined over 20% since 2018, before the equipment and supply adjustment, while the conversion factor declined 7% over this same time period. This is due to the large decreases in the practice expense RVU. (Table 2)

Table 1: High volume codes for Vein and Lymphatic specialists, volume and payment rates

HCPCS	Description	Total Selected VL Specialists	Total Medicare	Selected VL specialists % of Medicare total	2021 CN Total Nonfacility Payment Rate	2022 Proposed Total Nonfacility Payment Rate	Payment Rate % Change
36465	Njx noncmpnd sclrsnt 1 vein	3,843	11,616	33%	$1,545.42	$1,204.69	-22%
36466	Njx noncmpnd sclrsnt mlt vn	3,663	8,342	44%	$1,723.72	$1,344.06	-22%
36473	Endovenous mchnchem 1st vein	1,299	7,890	16%	$1,441.43	$1,119.72	-22%
36474	Endovenous mchnchem add-on	117	408	29%	$295.20	$249.54	-15%
36475	Endovenous rf 1st vein	24,804	99,843	25%	$1,317.56	$1,015.94	-23%
36476	Endovenous rf vein add-on	2,028	7,206	28%	$312.64	$280.77	-10%
36478	Endovenous laser 1st vein	24,337	64,927	37%	$1,107.51	$932.99	-16%
36479	Endovenous laser vein addon	2,765	6,820	41%	$329.04	$292.86	-11%
36482	Endoven ther chem adhes 1st	7,277	26,156	28%	$1,941.10	$1,517.36	-22%
	Total	***70,133***	***233,208***	***30%***	***$1,275.63***	***$1,017.54***	***-20%***

Table 2: Payment rate trends since 2018 for high volume codes

		2018	2019F	2020F	2021 CN	2022P	2018 to 2022P change
36465	Njx noncmpnd sclrsnt 1 vein	$ 1,624.30	$ 1,572.75	$ 1,550.05	$ 1,545.42	$ 1,204.69	-26%
36466	Njx noncmpnd sclrsnt mlt vn	$ 1,697.02	$ 1,653.11	$ 1,719.67	$ 1,723.72	$ 1,344.06	-21%
36473	Endovenous mchnchem 1st vein	$ 1,541.50	$ 1,492.02	$ 1,458.38	$ 1,441.43	$ 1,119.72	-27%
36474	Endovenous mchnchem add-on	$ 283.32	$ 283.63	$ 297.02	$ 295.20	$ 249.54	-12%
36475	Endovenous rf 1st vein	$ 1,549.42	$ 1,463.19	$ 1,404.97	$ 1,317.56	$ 1,015.94	-34%
36476	Endovenous rf vein add-on	$ 300.96	$ 308.13	$ 317.95	$ 312.64	$ 280.77	-7%
36478	Endovenous laser 1st vein	$ 1,236.23	$ 1,156.86	$ 1,092.07	$ 1,107.51	$ 932.99	-25%
36479	Endovenous laser vein addon	$ 317.88	$ 325.43	$ 334.91	$ 329.04	$ 292.86	-8%
36482	Endoven ther chem adhes 1st	$ 2,162.14	$ 2,089.91	$ 1,949.92	$ 1,941.10	$ 1,517.36	-30%

We can assert with confidence if that the Clinical Labor Update is implemented for 2022, or even spread out over four years, office-based vein practices will not be able to care for patients under these circumstances. **We strongly urge CMS to withdraw this proposal** and to keep the scaling factor at the 2021 current rate. We ask the Agency to work with all stakeholders on a proposal that does not place the burden of this Labor Update squarely on a subset of office-based clinicians. We urge CMS and HHS to coordinate with Congress on fundamental reform to the PFS through legislation this year in light of the fact that the "budget neutrality" provision in the 2021 PFS Final Rule E/M policy is still causing major negative impacts.

Systemic shifts in care will also result from the Clinical Labor Update

Most venous and lymphatic care for the Medicare population is office-based. We are deeply concerned that the drastic proposed drop in total NF RVUs will push almost all offices to a situation where they cannot remain open and will incentivize a migration of care to the more costly hospital outpatient setting, some ambulatory surgery centers, and drive further employment of physicians into more costly networks.

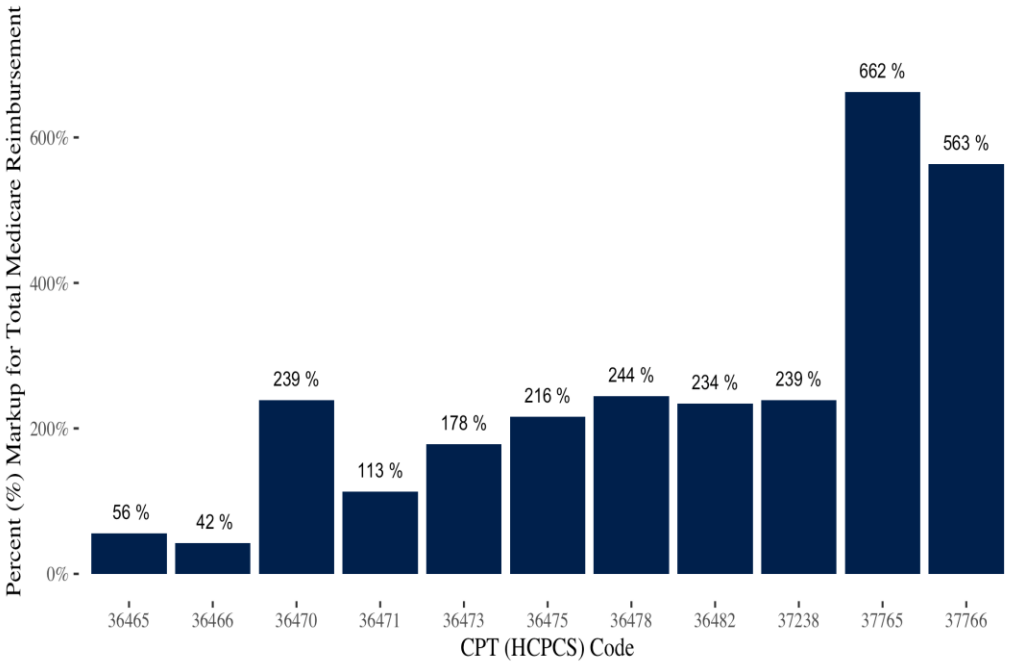
We see no benefit or reason to believe that Medicare patients would benefit from this migration and care consolidation. The literature on site of service and pricing differences in care settings is substantial. Specific to vein care, we worked with a noted healthcare economist on a basic model of how the Proposed Rule would impact venous care, and how much Federal spending will increase if care migrates to the hospital outpatient department (HOPD) setting.

Some of the key findings of our analysis include:

- For many physicians, confronted with proposed Medicare reimbursement cuts, there is concern that the resulting changes to financial circumstances will lead them to reconsider where they perform these procedures and shift more of them to hospital settings, as their only alternative. Moreover, some physicians may become more willing to sell their practice outright to a local hospital or health system, which would then lead to a full case load reallocation to hospital facilities.
- For other office-based physicians, early retirement and closing their office altogether may be the only alternative.
- Any adjustments in site of care can have large spending implications for the Medicare Trust Fund as well as its beneficiaries. Figure 1 details the looming (2022) markup for hospital outpatient (HOPD) delivery over physician office delivery for each of our procedures of interest. On the low-end, **Medicare will pay approximately 40% more** for the same procedure performed in a HOPD, even if it is by the same physician and for the same patient. ***On the high-end, the HOPD rate will eclipse the physician office rate by 662%!*** Beyond generating greater financial outlays per case for the Medicare program (and thereby taxpayers), these site-of-care differentials also translate to substantive cost-sharing obligation differences for Medicare beneficiaries (Figure 2). A seemingly small

change in healthcare delivery location can mean hundreds of dollars more in spending for each affected beneficiary and/or the supplemental insurer. For example, Current Procedural Terminology (CPT) code 36471, which was the most commonly performed procedure among this group, would more than double the **copayment amount** from about $40 to about $86. Similarly, CPT code 36475, which was the second most frequent procedure in 2019 among these CPTs, would increase the cost-sharing burden on the affected beneficiary by approximately $455.

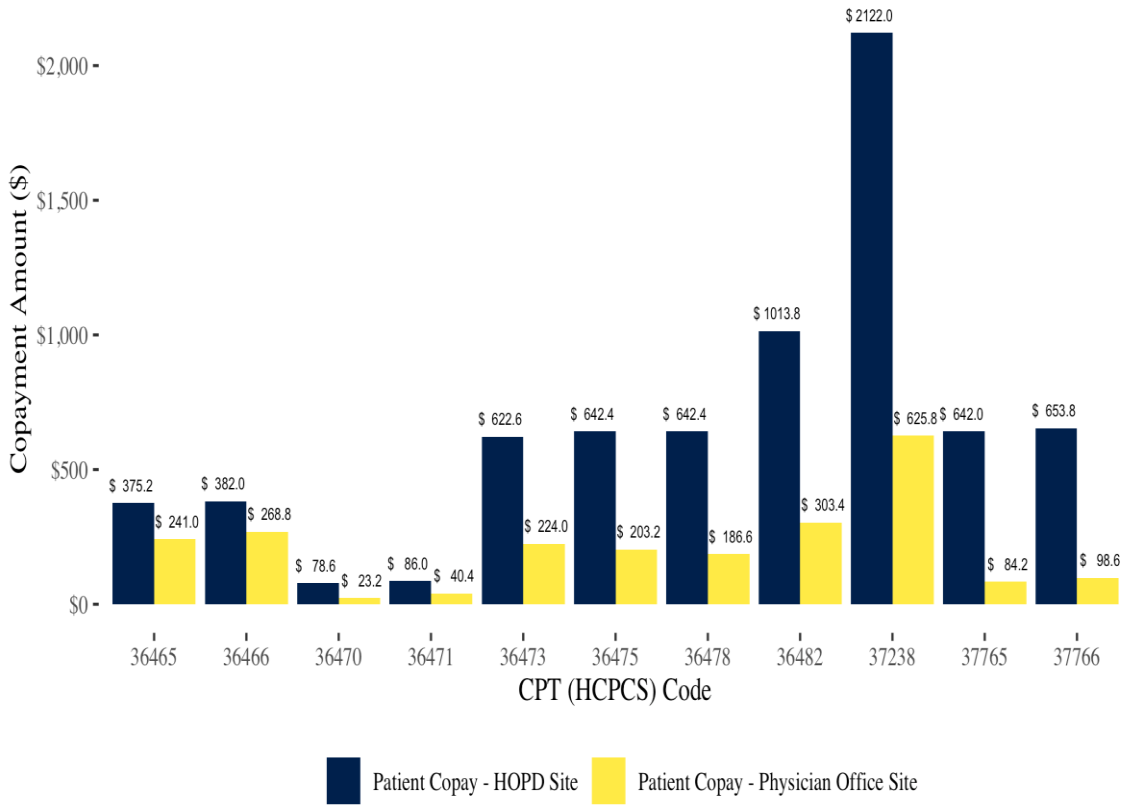
Figure 1: Proposed 2022 Fee Schedule Markup for the HOPD Setting over the Physician Office Setting



Notes: CPT stands for Current Procedural Terminology. A 0% markup implies parity in reimbursement between physician office and hospital outpatient department (HOPD) settings. The HOPD reimbursements include the physician professional component and the facility component.

Medicare patients, like other patients, prefer to receive their care in the more efficient and patient-friendly office setting, which is also where co-pays are significantly less. Our analysis below indicates beneficiary cost sharing, and copayments.

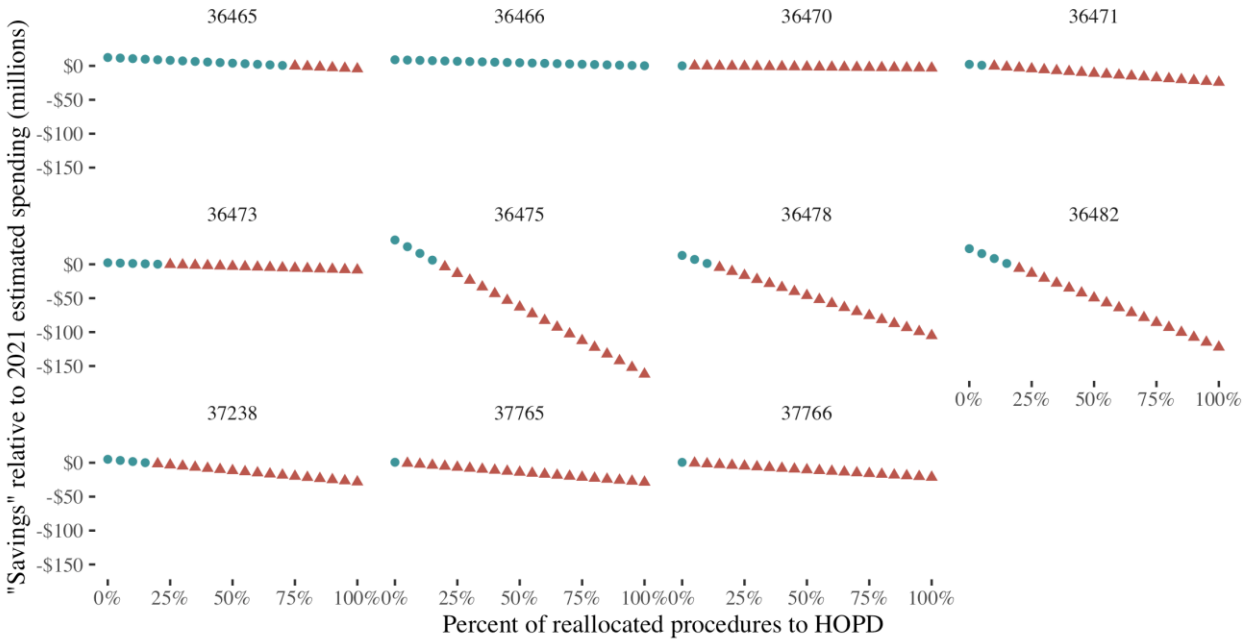
Figure 2: Medicare Beneficiary Cost-Sharing Obligations by Procedure and Site of Care



Notes: Each dollar amount corresponds to the 20% coinsurance rate for traditional Medicare applied to the corresponding total cost of care for a given procedure performed at a given setting (i.e., HOPD versus physician office).

Our analysis further shows that, for many procedures, even a modest shift to the HOPD setting quickly diminishes the projected savings and ultimately flips the estimated savings from positive to negative values, with negative values implying **greater Medicare spending** when compared to the status quo spending level.

Figure 3: Net Savings to Medicare Based under Scenarios with Procedure Reallocations from Office Settings to HOPD Settings



Notes: Each procedure-specific graphic uses a 0-100% x-axis that corresponds to zero reallocation to HOPDs (0%) to full reallocation to HOPDs (100%) and all scenarios in between. The dots represent Medicare savings of greater than or equal to 0, and the triangles represent negative savings.

The key takeaways from our analysis indicate that as care migrates from the office setting to hospital outpatient departments, total Federal spending will increase. Patient behavior will also likely change, because of co-pays, and secondary effects of decreased office-based care sites.

Secondary Impacts - Physician Behavior and Changes

When forecasting the potential reallocation of PFS Part B funds because of the Clinical Labor Update, we note and highlight the importance of considering a variety of plausible physician behavioral responses. Above, we have intentionally focused on the risk of reallocating more cases to HOPD settings due to changes in physician practice patterns as well as outright consolidation (i.e., more physicians selling their practices to hospitals) in response to the Medicare drop in office-based payment. Because the average age of a AVLS member is 54, some offices will close as physicians simply decide to retire.

Under a variety of scenarios that differ in degree of reallocation effect, the net savings can be substantially smaller and even eliminated, leading to higher net spending by Medicare when compared to the status quo (or baseline) estimates for the affected venous procedures.

Beyond the risk of unintended spending consequences, moving more procedural care to hospital-based settings will sacrifice convenience for patients as well as physicians. Patients may have to travel farther and wait longer for care as well as pay more out-of-pocket since every single case shifted to a HOPD means higher cost-sharing for the affected beneficiary. Physicians may struggle to efficiently schedule cases and avoid case disruptions/cancellations. Furthermore, the cost implications we have noted above may also be an underestimate, if hospital-delivery adds supplemental costs (e.g., more intensive anesthesia services, cath lab or operating room charges) not incorporated into our spending counterfactual exercises. Additionally, the analysis does not include physician payment in the HOPD setting for the operating physician or for anesthesia professional charges. Finally, evidence also suggests that changing referral patterns for Medicare patients is likely to be mirrored for physicians' other patients belonging to different payers (*Geruso and Richards 2021; Richards, Seward, and Whaley 2021*). This could, in turn, translate to higher spending for private insurance plans covering these vascular procedures but also for other federal plans (e.g., TRICARE) that would be affected by a shift in physicians' choice of procedural setting. Private insurers could be additionally disadvantaged if the proposed Medicare fee reductions inadvertently encourage greater provider consolidation that weakens private insurers' bargaining leverage in subsequent price negotiations.

The concerns described above raise important implementation considerations for the Proposed 2022 Medicare Physician Fee Schedule updates and underscore the potential for systemic disruption caused by a steep drop in office-based payment. We support and echo the views of the current Secretary of Health and Human Services, who expressed concern in his confirmation hearing regarding care consolidation and narrowing of choice that patients are confronted with when seeking care. We also note President Biden's *Executive Order on Promoting Competition in the American Economy,* which expressed concern that the Administration has regarding health system consolidation and narrowing of patient choice. The cuts CMS is proposing will only create more burdens for non-facilities to care for patients. The literature on patient safety and infection differences between hospital settings and offices is robust. We are very concerned that a shift in care from office-based settings to hospital will result in more hospital acquired infections for CMS beneficiaries. CDC data on hospital acquired infections is tracked, and on a typical day, about one in 31 hospital patients has at least one healthcare-associated infection.[vii] For infection control reasons alone, for CMS to undertake policy actions which might accelerate shift in care to hospital settings seems to increase infection risks for Medicare seniors.

In summary, **we respectfully urge CMS not to implement the Clinical Labor Update proposal, but to work with all stakeholders on substantive reform that does not penalize a small group of office-based clinicians and the Medicare beneficiaries they care for**. During the ongoing Public Health Emergency, offices have largely stayed open, caring for patients and providing needed services. For CMS to propose any action now that diminishes the viability of office based

specialist care and creates hurdles to easy patient access seems inimical to the best interests of Medicare seniors.

Vein Care and Health Equity

In the Proposed Rule, the Agency discusses, and CMS leadership has made subsequent press statements, regarding the importance of equity in Medicare services. Our members are on the front lines of that issue, and we see every day the consequences of delayed care and inattentive follow up vein care, especially in our underserved populations.

Just as a snapshot, below is data regarding African-American patients and venous disease:

- In 2019, black patients (N=6,931) underwent less venous ablation procedures per patient compared to white patients (N=99,515) (2.20 vs.2.28, p=0.017).
- In addition, Black patients (n=6,329) with leg pain/swelling/inflammation underwent fewer venous ablation procedures per patient compared to white patients(n=93,551) (2.19 vs. 2.29, p=0.005).

For this short analysis, all numbers are based on 2019 Medicare claims and capture the key venous modalities.[viii] In sum, a higher proportion of African-American patients present with ulcer vs. less severe venous disease. This 2019 claims analysis confirms earlier published literature regarding African American venous patents and severity of disease presentation.[ix] The literature on rural populations and barriers to care is also extensive, and we are concerned that the proposed steep drop in total NF RVUs for vein care codes will make it impossible for venous offices to operate in these underserved areas.

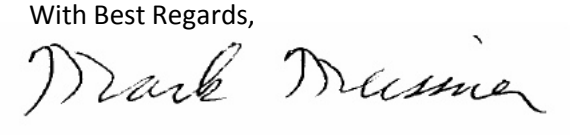
SUMMARY

The proposed 20 to 23% reduction in payment for the majority of the procedures which are performed in the office setting for venous patients will cause **IRREVERSIBLE HARM TO PATIENTS by limiting choice and severely narrowing access to care.** Office-based clinicians offer a safe, cost-effective means to care for patients in a setting most patients prefer. Our members cannot continue providing this care in an environment that pays them less than their cost of supplies, drugs, and devices for many venous procedures. CMS should be working with physicians to expand the procedures available in the specialty office setting rather than making it operationally impossible for non-facility practices to care for patients.

AMERICAN VEIN & LYMPHATIC SOCIETY

We appreciate the opportunity to comment on the Proposed Rule, and the AVLS is readily available to CMS for additional discussions or questions. Please direct questions to our Healthcare Policy Committee Chair, Dr. Stephen Daugherty, and to our Executive Director, Mr. Dean Bender. Dr. Daugherty may be reached at SDaugherty@clarksvillesurgical.com, and Mr. Bender at dbender@myavls.org

With Best Regards,



Mark H. Meissner M.D., FAVLS
President

ATTACHMENT

- Braid-Forbes Research Memo on NPIs and AVLS membership

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[i] Long-term Clinical and Cost-effectiveness of Early Endovenous Ablation in Venous Ulceration
A Randomized Clinical Trial. *JAMA Surg*. 2020;155(12):1113-1121. doi:10.1001/jamasurg.2020.3845
Published online September 23, 2020.

[ii] Rice JB, Desai U, Cummings AK, Birnbaum HG, Skornicki M, Parsons N. Burden of venous leg ulcers in the United States. J Med Econ. 2014 May; 17(5):347-56.

[iii] Rice JB, Desai U, Cummings AK, Birnbaum HG, Skornicki M, Parsons N. Burden of venous leg ulcers in the United States. J Med Econ. 2014 May; 17(5):347-56.

[iii]Rice JB, Desai U, Cummings AK, Birnbaum HG, Skornicki M, Parsons NB. Burden of diabetic foot ulcers for medicare and private insurers. Diabetes Care. 2014 Sep; 37(9):2660.

iv *A Randomized Trial of Early Endovenous Ablation in Venous Ulceration*, May 31, 2018
N Engl J Med 2018; 378:2105-2114 (DOI: 10.1056/NEJMoa1801214
(https://www.nejm.org/doi/full/10.1056/nejmoa1801214)
Delayed referral of venous ulcers increases resource usage: Journal of Vascular Surgery- Venous and Lymphatic Disorders
https://doi.org/10.1016/j.jvsv.2021.04.011

[v] *Significant physician practice variability in the utilization of endovenous thermal ablation in the 2017 Medicare population.* Journal of Vascular Surgery: Venous and Lymphatic Disorders.
https://doi.org/10.1016/j.jvsv.2019.06.019

[vi] *Significant physician practice variability in the utilization of endovenous thermal ablation in the 2017 Medicare population, Journal of Vascular Surgery, Venous and Lymphatic Disorders* , https://doi.org/10.1016/j.jvsv.2019.06.019

[vii] https://www.cdc.gov/hai/data/index.html

[viii] Unpublished data, (Hicks, Stonko, Den). Johns Hopkins University, 2021 *Improving Wisely Collaborative*

[ix] https://journals.sagepub.com/doi/abs/10.1177/1538574416682175

Braid-Forbes
Health Research

Data analysis informing sound policy

TO: Robert J. White and Dean Bender, American Vein & Lymphatic Society (AVLS)

FROM: Mary Jo Braid-Forbes and Michelle McCrea

DATE: September 7, 2021

RE: 2022 proposed payment rate cuts for vein and lymphatic physician specialists

We simulated what the Medicare physician payment rate cuts would be for vein and lymphatic physician specialists if the payment rates in the 2022 proposed rule went into effect. The change in payment rates in the 2022 proposed rule are largely due to practice expense changes resulting from the update in the clinical labor cost inputs. The final year of the phase in of updates to supplies and equipment prices has some effect on the rates as does the 3.75% decrease in the conversion factor.

Vein and Lymphatic specialists do not have a specialty code recognized by CMS and would appear under a range of specialty codes. CMS showed the clinical labor pricing change effect on specialties that have distinct codes.[1] The impacts ranged from positive 10% for portable X-ray suppliers to -6% for diagnostic testing facilities. The results of our simulation for vein and lymphatic specialists are listed below.

- We estimate that vein and lymphatic physician specialists would see a 12% payment decrease for their practices across all the services they provide between 2021 and 2022 under the 2022 proposed rule payment rates. This is due to a 15% decrease in the practice expense portion of the payment.
- Some of the decrease is due to a 3.75% decrease in the conversion factor. When holding the conversion factor constant between the two years, these physicians see a 9% decrease resulting from the changes in the RVUs. This is due to a 12% decrease in the PE RVU, which is double the percent decrease due to the clinical labor changes that CMS calculated for the worst hit specialty.
- The nine of the top volume codes for vein and lymphatic specialists have proposed cuts in payment of greater than 10%, with five codes facing cuts of at least 22%. The weighted total payment rate cut for these codes was 20%. See table 1.
- For these nine codes 374 vein and lymphatic specialists provide 30% of all of the procedures performed on Medicare beneficiaries. See table 1.
- The payment rates for six of these nine codes have declined over 20% since 2018 before the equipment and supply adjustment, while the conversion factor declined 7% over this same time period. This is due to the large decreases in the practice expense RVU. See table 2.

[1] 86 Fed. Reg. 39122-39123 (July 23, 2021)

Table 1: High volume codes for Vein and Lymphatic specialists, volume and payment rates

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36465	Njx noncmpnd sclrsnt 1 vein	3,843	11,616	33%	$1,545.42	$1,204.69	-22%
36466	Njx noncmpnd sclrsnt mlt vn	3,663	8,342	44%	$1,723.72	$1,344.06	-22%
36473	Endovenous mchnchem 1st vein	1,299	7,890	16%	$1,441.43	$1,119.72	-22%
36474	Endovenous mchnchem add-on	117	408	29%	$295.20	$249.54	-15%
36475	Endovenous rf 1st vein	24,804	99,843	25%	$1,317.56	$1,015.94	-23%
36476	Endovenous rf vein add-on	2,028	7,206	28%	$312.64	$280.77	-10%
36478	Endovenous laser 1st vein	24,337	64,927	37%	$1,107.51	$932.99	-16%
36479	Endovenous laser vein addon	2,765	6,820	41%	$329.04	$292.86	-11%
36482	Endoven ther chem adhes 1st	7,277	26,156	28%	$1,941.10	$1,517.36	-22%
	Total	***70,133***	***233,208***	***30%***	***$1,275.63***	***$1,017.54***	***-20%***

Table 2: Payment rate trends since 2018 for high volume codes

		2018	2019F	2020F	2021 CN	2022P	2018 to 2022P change
36465	Njx noncmpnd sclrsnt 1 vein	$ 1,624.30	$ 1,572.75	$ 1,550.05	$ 1,545.42	$ 1,204.69	-26%
36466	Njx noncmpnd sclrsnt mlt vn	$ 1,697.02	$ 1,653.11	$ 1,719.67	$ 1,723.72	$ 1,344.06	-21%
36473	Endovenous mchnchem 1st vein	$ 1,541.50	$ 1,492.02	$ 1,458.38	$ 1,441.43	$ 1,119.72	-27%
36474	Endovenous mchnchem add-on	$ 283.32	$ 283.63	$ 297.02	$ 295.20	$ 249.54	-12%
36475	Endovenous rf 1st vein	$ 1,549.42	$ 1,463.19	$ 1,404.97	$ 1,317.56	$ 1,015.94	-34%
36476	Endovenous rf vein add-on	$ 300.96	$ 308.13	$ 317.95	$ 312.64	$ 280.77	-7%
36478	Endovenous laser 1st vein	$ 1,236.23	$ 1,156.86	$ 1,092.07	$ 1,107.51	$ 932.99	-25%
36479	Endovenous laser vein addon	$ 317.88	$ 325.43	$ 334.91	$ 329.04	$ 292.86	-8%
36482	Endoven ther chem adhes 1st	$ 2,162.14	$ 2,089.91	$ 1,949.92	$ 1,941.10	$ 1,517.36	-30%

Methodology

We estimated the impact to vein and lymphatic physicians using the National Provider Identifiers (NPIs) you provided of 560 physicians. Of the NPIs you provided, 97% (541) had office-based procedures in the 2018 Medicare Provider Utilization and Payment Data Physician and Other Supplier Public Use File (PUF).[2] We used the procedure codes and associated office volume reported for each physician to estimate the Medicare payments to these physicians in 2021 and for the 2022 proposed rates. Only codes with RVUs on the physician fee schedule were included. Drugs paid under the Average Sales Price (ASP) methodology were not included. The physician utilization data at the code level contains counts of services for codes that are billed for more than 10 beneficiaries by a physician. A second physician file provides the total services billed by each physician. Our subset of office-based code level data contained 78% of the total services for these physicians.

In an additional analysis, we estimated the percent of total Medicare volume accounted for by vein and lymphatic specialists for the top procedure codes. We used the Physician Supplier Procedure Summary File for 2018 to calculate the total number of services performed for Medicare beneficiaries by all providers in the office setting and compared this to the volumes from the Physician PUF file used to identify vein and lymphatic specialist codes.

[2] The 2018 file was the most recent data available at the time the analysis was conducted. CMS has since released the 2019 data.