Outpatient Procedure Adoption versus Overutilization

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Disclosures

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Overutilization-

- Occurring for decades—Stark I 1989
- Procedures and Testing- ”Unnecessary”
  Appropriateness—Appropriate Use Criteria (AUC)

- All Sites of Service-
  -Offices and Office Lab Testing
  -Academic Hospitals-Training Facilities
  -Imaging Centers
  -Hospital Inpatient or Outpatient Procedure Suites
  -Ambulatory Surgery Centers
  -Office Interventional Suites

- Difficult to measure

Examples of Overutilization for Peripheral Vascular Intervention:

- Interventions on asymptomatic patients without physiologic data
- Exclusive device use preference regardless of lesion morphology
- Poor results and outcomes leading to restenosis and repetitive procedures
- Multiple planned staged procedures on same leg regardless of symptoms or clinical need
- Consistent suboptimal outcomes by untrained or new operators who decline education and practice improvement

Overutilization- Drivers

Physicians-

-FFS- payment regardless of outcome

-Lack of training, lack of peer review

Patients-

-Uninformed expectations

-Disconnect from payment

-Deductible cost “incentives”-timing cycles

Industry-

-Sales force incentivized by volume

Overutilization- Drivers (cont.)

Payers-

-Third parties cover majority of costs

Hospitals and Corporate Systems-

-Revenue needs and demands, employed-physician incentives

-Subsidize losses of other services

Organized Medicine-

-Vagaries and lack of concordance in appropriateness criteria and guidelines

-Self-policing challenges

WHO IS TO BLAME? ALL OF US

Oversite and Review—Tools and Mechanisms

Outliers-

- Physician Open Payments
- Medicare Physician Payment Data
- Comparative Billing Reports (CBR)

Investigations-

- DOJ- OIG
- MACs—Medicare Administrative Contractors

Standards-

- AUC
- Societal Guidelines

Response from Payers- Potential Consequences

Individuals:

- Extract penalties and/or repayment
- Exclude from insurance panels

All providers:

- Cut reimbursement—Revaluation of codes
  Change access to care or patterns of care
- Restrict coverage through LCD policy changes
- Transparency reporting- Physician level feedback

CBR- Comparative Billing Reports

- Comparative Billing Reports: Peripheral Vascular Intervention for Claudication (CBR #: CBR202004)

- CMS contracted with RELi Group to perform analytics, reports, physician education

- Identified outliers for performing PVI on IC patients and no supervised exercise training (SET) billed in the same calendar year.
- Based on Medicare claims in 2015-17 (PVI and SET CPT's and IC ICD's)

QBR

- Percent of claims for PVI performed on beneficiaries with IC without SET

- The article (Cooke-Methodist) continues to say the following: "Supervised exercise programs are the gold standard ... Home-based exercise programs may represent a feasible alternative for those unable or unwilling to exercise under supervision."

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Improving Wisely

- Collaboration between Johns Hopkins, Robert Wood Johnson Foundation and American Venous and Lymphatic Society (AVLS)
- Perceived overutilization of venous ablation procedures
- Identify outliers based on Medicare claims data
- Educate the provider about outlier status compared to peers
  - 2 standard deviations from the median

  - Acknowledge limitations of the data set
  - Follow up to assess if behavior (procedure counts) changed after reports issued

Significant physician practice variability in the utilization of endovenous thermal ablation in the 2017 Medicare population

Margaret Mann, MD, Peiqi Wang, MD, MPH, Marlin Schul, MD, MBA, Neil M. Khilnani, MD, Angela Park, BS, Martin A. Makary, MD, MPH, Caitlin W. Hicks, MD, MS

Journal of Vascular Surgery: Venous and Lymphatic Disorders
Volume 7 Issue 6 Pages 808-816.e1 (November 2019)

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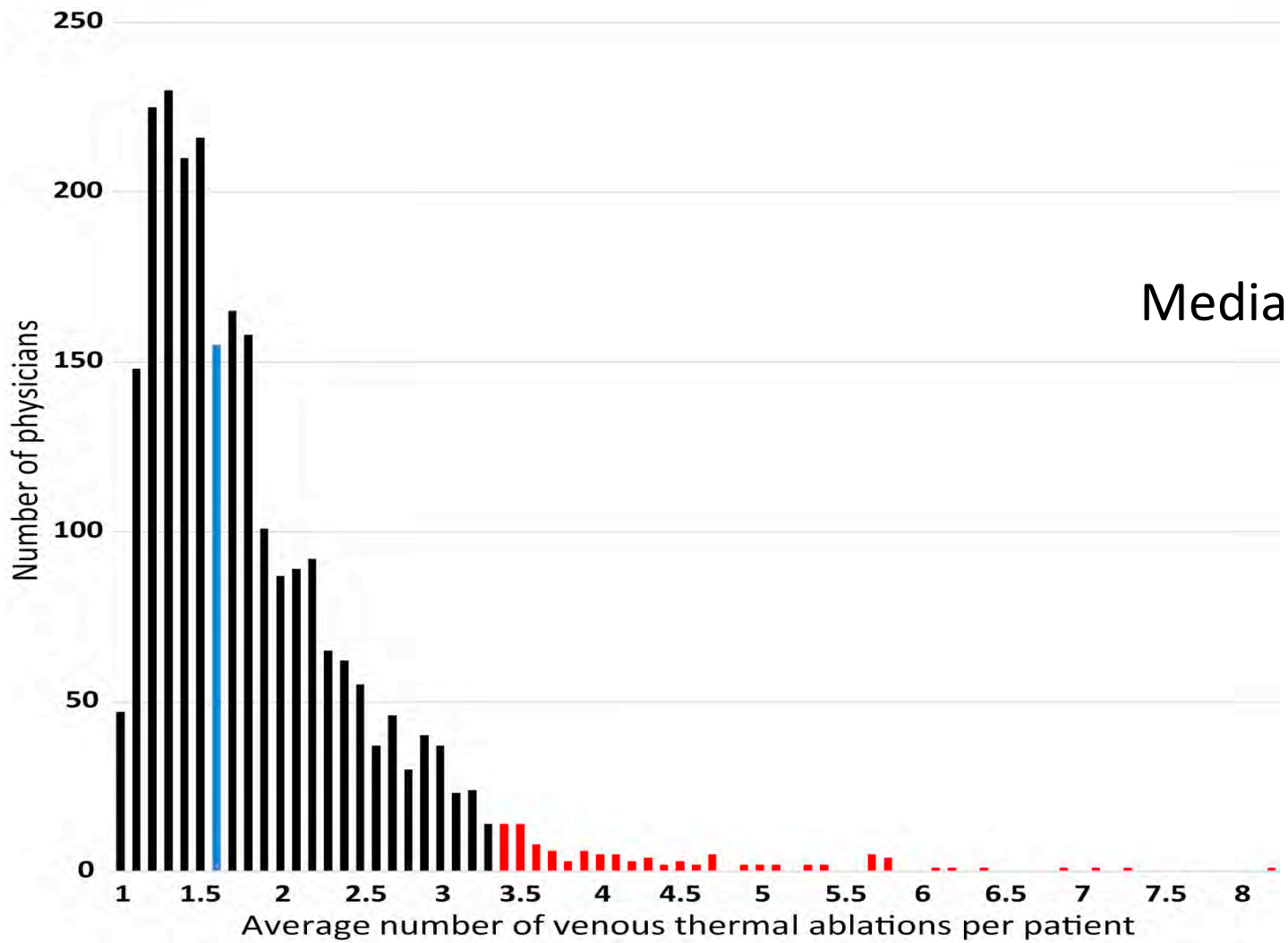
Thermal Ablations/pt.



Median = 1.6 ablations/pt.

Fig. National distribution of physicians' average number of endovenous thermal ablations (EVTAs) per patient. Note: *Blue bars* represent the median number of thermal ablations per patient (1.6), and *red bars* represent outlier physicians.

- How should outliers get called out?
- Do we self-police?
- What role should societies like OEIS play?
- How can you demonstrate what you're doing?

OEIS Quality Initiatives:
SCOCAP in the OIS

- Safety-Accreditation
- Credentialing
- Outcomes Measures-Registry
- Compliance
- Appropriateness
- Peer Review

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Societal Guidelines and Appropriate Use Criteria Resources

- Cardiac procedures— ACC/AHA & SCAI/ACC, SCAI Tool Kit
- IR procedures— SIR/ACR
- Peripheral Vascular Interventions
  - SVS– 2015 Asx PAD and IC (JVS)
  - ACC/AHA— 2016- AHA/ACC Guideline on the Management of Lower Extremity Peripheral Artery Disease
  - SCAI— 2017 Update on AUC for PVI
  - ACC/AHA/SCAI/SIR/SVM JOINT CONSENSUS— JACC 2018
    - 1ST MULTISOCIETY AUC FOR PVI
    - A,M, OR R (RARELY APPROPRIATE)—
    - 45 CLINICAL SCENARIOS

NATIONAL REGISTRY

Summary

- Overutilization occurs in all sites of service and subjects all to potential reimbursement cuts
- Outliers are increasingly subject to physician level feedback reports and potential penalties
- Self-policing and transparency through registry and society work is preferred
- Providers should practice with best clinical judgment taking into account best level of evidence, guidelines, and value of procedures to the patient and systems paying for their care