HOW TO GET PAID FOR WHAT YOU DO
Quantum Mechanics, the branch of mechanics and physics that deals with the motion and interaction of sub-atomic particles, can teach us a lot about how to view coding and reimbursement issues. Coding and reimbursement is always a moving target. Decisions payors make, decisions we make, and decisions patients make, all interact like the sub-atomic particles that quantum mechanics looks at. Quantum mechanics utilizes two principles to better understand these interactions: (Heisenberg’s) Uncertainty Principle and the Correspondence Principle. The Correspondence Principle in essence states that a new theory should be able to produce under certain conditions the results of older, well established theories. Sounds like us trying to get codes and reimbursement for NTNT technologies which produce similar clinical results of older, established RF and laser. The other principle, Uncertainty Principle, asserts that there is a limit to the certainty that one can know the exact value of certain pairs of physical properties of a sub-atomic particle. Position and momentum for example. Similar to us knowing the exact requirements for preauthorization and the exact amount that will be reimbursed for a particular procedure. This issue of Vein Specialist approaches coding and reimbursement from many directions hoping to learn from the Correspondence and Uncertainty Principles.

Many of us do a lot of procedures in the office setting. Dan Monahan addresses this in his article, Coding and Reimbursement in the Office. Another office procedure, Duplex ultrasound, can be problematic when submitting for reimbursement. Anil Hingorani helps us to understand how to avoid pitfalls and get paid. Newer procedures can be challenging. Wendy Wifler and Lowell Kabnick address this in their article with a focus on Varithena™. Hal Welch expands on this and updates us on CMS coverage for all NTNT technologies. The article, Telehealth, Telemedicine, Telewhat?, by Lowell Kabnick, AJ Riviezzo, and Cheryl Nash sheds some light on how to incorporate these into your practice and get paid. While most of us (all of us) don’t perform lympho-venous bypasses, the article discussing hurdles to payment is instructive from a historical viewpoint.

Can we employ appropriate use criteria to help with appropriate reimbursement? Elna Masuda and Kathleen Oszvath address this with reference to a recent JVS-VL article that many of us were involved with. Industry has a stake in coding and reimbursement as well. Good news, the AVF Traveling Fellowship is back with sponsorship by Juzo. This is an investment in the future of AVF. At the end of this issue are reimbursement and coding references supplied by our industry partners. This is an invaluable resource as industry keeps these current. Keep this and use this to help disperse the fog of war that can occur as we try to make sure we get paid for what we do. Our principles are not Uncertainty and Correspondence. Our principles are doing what’s best for our patients and ourselves. Read on.
Coding and Reimbursement in the Office
– Dan Monahan, MD

**Coding:** Create your office charge sheet to include Diagnoses, E&M, and Procedure codes.

**Reimbursement:** Know your payors’ policies (have a binder for all the policies).

Construct EMR templates for H&P, each kind of encounter you have, and each procedure, that includes all the criteria that all your payors require, and document for every patient. Most of your documentation can be done by your staff, with you filling in details (especially the Impression and Recommendations). My H&P includes an ultrasound exam at the first encounter. Your staff needs to screen patients to avoid unnecessary exams (e.g., for spider veins).

The main criteria include:

1) Documentation of the degree to which symptoms interfere with activities of daily life.

2) Use of conservative measures, including leg elevation and compression (different payors require documentation of different durations of daily use of stockings, ranging from six weeks to six months – your staff person responsible for authorizations should be able to tell you what each of your payors requires, and you make sure you put at least that duration in your documentation).

3) Extent of disease. List all the revised VCSS criteria in your documentation of symptoms, and all the criteria for CEAP clinical Class in your exam. Include the rVCSS score and CEAP Clinical Class with your final Impression. Any C score below 2s does not qualify for medical necessity and insurance authorization.

4) Ultrasound documentation should include a full superficial and deep vein assessment for patency and reflux. Document duration of reflux and vein diameters for the veins to be treated. Many require documentation of reflux at the SFJ/SPJ. Document previous treatment, both clinically and evident on ultrasound exam.

If you get a denial for authorization, request a review with the Payor’s Medical Director. They will tell you what is missing in your documentation. Often you can provide the information, and they’ll authorize it right then. Learn from these encounters what you need to include in your evaluation and documentation, and add it to your EMR template. Treatment strategies should be optimized in the best interests of the patients. A track record of this will make medical directors positively disposed towards you.

I treat varicose veins with a staged strategy. If there are two or more truncal veins in a leg to be treated, do them at the same event. Treating one at a time to optimize reimbursement is not appropriate. Occasionally, it will be in the patient’s interest to not treat all at once, but document your rationale. I first ablate the truncal source(s) of reflux, then wait at least two months to allow for regression of the varices (which has been shown to reduce the amount of treatment to remaining varices more than 75%). After three months or so, I treat the remaining varices with sclerotherapy. Often there are refluxing tributaries from the ablated truncal vein that need to be treated with ultrasound-guided sclerotherapy. For whatever reasons, most
payors authorize three sclerotherapy sessions per leg per year. They generally reimburse less than $200 per session, regardless of how many veins are treated. I calculated that spending 15 minutes of office time, injecting 3-4 cc of STS or Polidocanol, just about breaks even. I inform the patient of this, and offer that they can speed up the process if they wish to pay cash. Most opt for multiple sessions paid by their insurer. We schedule the sessions monthly.

Here’s a tip. Compression after sclerotherapy is only necessary overnight. The recommendations for multiple weeks of compression after sclerotherapy were developed in a different setting than modern post-ablation treatment. Strategize your treatments with appropriate use criteria (now published), ethically, with the patient’s best interests as top priority, and using payor reimbursements to inform your use of resources.

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As I am new to this type of patient encounter, I needed to do my homework. Who likes homework? So, I called upon my experts: AJ Riviezzo and Cheryl Nash from American Physician. However, before I start asking them about this subject, perhaps I should start with the basic definitions. Telemedicine describes any remote medical services practiced by way of a digital platform. These services may include Telehealth, Telephone call, Telemonitoring, or online digital portal communications. Telehealth is defined by real-time online video/audio visits (telephone calls do not qualify.) Telemonitoring requires an approved monitoring devise typically used for CCM services (Glucose or O2 monitors.)

Lowell Kabnick: Let us take a deeper dive and ask our experts. What is the biggest challenge for adoption?

Cheryl Nash: The biggest challenge is understanding some of the new regulations and how exactly to add this service to each individual practice. I will discuss the following: technology, services, consent, site requirements, and credentialing.

LK: Cheryl, let’s begin with technology.

CN: The technology allowed includes Facetime, Skype, Zoom, Doxy, Facebook Messenger video chat, Google Hangouts, and similar systems. They must include video between provider and patient with some assurance of privacy.

LK: Great! What about privacy?

CN: That is a great question considering that anything can be hacked – look at Twitter. With privacy in mind, providers are required to notify the patient there could be a privacy risk. Any live story platform is not allowed such as Facebook Live, Twitch, Snapchat or similar public facing video.

LK: What services can you perform?

CN: Essentially, these are office visits. This includes the regular code range 99201-99215 for audio-visits and for phone only visits 99441, 2 and 3. However, this depends on the payer policy. For example, Medicare requires office visit codes to be billed with place of service (POS) 11 – office, or modifier 95 -services were rendered via synchronous telecommunication. While others may require POS 02 – telemedicine with 95, GQ modifier (an asynchronous telecommunications system) or GT modifier (interactive audio and video telecommunications systems.)

LK: Anything else?
CN: GT is the modifier that is most used for telehealth claims. Per the AMA, the modifier means “via interactive audio and video telecommunications systems.” You can append GT to any CPT code for services that were provided via telemedicine. Remember in addition to other coding factors, correct coding is also based upon time. It is best to record your visit; however, if you are not able to do so, make a notation in the chart how long the visit took and include start and stop times.

LK: What needs to be documented with regards to the encounter?

CN: Charting should include the same elements as a live encounter, except of the physical exam in which only a visual can be performed. Be sure to include the usual HPI, pertinent history, review of systems, visual physical exam, and any additional information to make a medical decision. In addition, I recommend notation should include the statement – “50% or more was spent on counseling appended to the total time of the visit.” One more thing, I advise to notate the originating site of the visit, for example the patients visit. Oh, one more thing, monitoring devices are coded and mandated differently and add another level of complexity. For the sake of time, suffice to say a Fitbit or Apple watch cannot be utilized.

LK: Does the provider need a patient consent for telehealth visits?

CN: You must have the consent of the patient. Any Telehealth visit must be initiated by the patient. Written or verbal consent will be accepted during the emergency window. This should be recorded prior to beginning of the visit or at least charted. However, Medicaid plans still require a written consent.

LK: What satisfies the initiation rule?

CN: Advising a patient of the availability of telehealth and allowing them to decide on the appointment type meets the patient’s initiation rule. Remember that visits still must be medically necessary and part of the patient’s care plan.

LK: What type of credentials are needed?

CN: Only licensed practitioners may provide telehealth services. These include physicians, nurse practitioners and physician assistants. Registered nurses and medical assistants do not qualify for telehealth. Remember that claims must be billed under the performing provider’s NPI.

LK: What about telehealth and your state licensing?

CN: Care, across state lines if it is adjoining, is permissible.

LK: What else do I need to know?

AJ Riviezzo: The current Public Health Emergency has extended into the Fall of 2020, allowing modified regulations. Telehealth can be implemented immediately during the national emergency once a compliant software is chosen. The rules that I talked about, apply for all Medicare and Medicare Advantage patients. Commercial payers have other rules to follow, and some plans may not cover these services. Several commercial payers have only opened telehealth for COVID-19 care, so be sure to check with each payer and plan benefits prior to scheduling! A helpful commercial payer site can be found here. Lastly, I advise checking the commercial websites frequently to see if the guidelines have changed. The situation is very dynamic, and rules are constantly be updated. Thank you for the opportunity to talk about Telehealth.

Lowell Kabnick: Thank you AJ Riviezzo and Cheryl Nash. And that’s a wrap!
COVID-Related Imaging and Anticoagulation Algorithms

–Peter Henke, MD

We remain in the midst of the worst viral pandemic since 1918, and unfortunately, cases continue to surge throughout the world. This pandemic affects everyone and everything, and has changed the world overnight.

In Michigan, we were hit relatively early with many COVID-19 cases, mostly in Southeast Michigan. However, we quickly had a large number of COVID-19 patients in our hospital system at Michigan Medicine. Many were very ill, and thrombotic complications were observed. Other viral illnesses have been linked with a hypercoaguable state, and COVID-19 infection seems no different.

The Vascular Surgery section runs the vascular ultrasound laboratory, and many requests came in to ‘rule out’ DVT, or to use the lower extremity exam as surrogate for PE. However, these resources are limited and put our sonographers at risk of exposure. We needed to balance the need to do these tests in patients who would benefit most, and for which the test would alter therapy, while keeping the patient as the focus.

As a large multispecialty group, we came up with four main algorithms for both DVT and PE, and how to balance testing with empirical anticoagulation and bleeding risks. Of note, this was derived based on early COVID-19 literature as well as our prior experiences with SARS in our ICU. We acknowledge these algorithms were not based on much evidence outside of experience and consensus. However, we are constantly assessing this with our front-line colleagues, and in particular, tracking bleeding events.

Please use this paper, written by two AVF Past-Presidents and an AVF Jobst Research Grant recipient, as you see fit and improve these algorithms specific to your institution.
Minimally invasive techniques for saphenous vein ablation include thermal (laser, RF) and non-thermal techniques. As the non-thermal techniques (foam, glue, MOCA) are “newer,” payers have been averse to provide coverage based upon a “lack of data.” However, use of these techniques has become more widespread, and with the advocacy of the American Venous Forum and the American Venous and Lymphatic Society, an increasing number of payers have decided to cover some or all of the non-thermal options (provided all of their criteria for medical necessity are met.) As you likely know, for CMS beneficiaries, there is no National Coverage Determination for venous disease, and coverage is determined by the Medicare Administrative Contractors (MACs) over their jurisdictions. I will try to summarize the non-thermal coverage by these MACs, with their corresponding LCD (Lxxxxx). The best advice, however, is to simply Google the LCD for your coverage area so that you can read the entire document for yourself. A note: when doing so, I discovered that CMS has been relocating codes from “LCDs and into local coverage Articles.” This may make your search a little more challenging.

L34209 Noridian Healthcare Solutions, LLC. This brief LCD actually makes no mention of foam, glue or MOCA, but only stripping and thermal ablation, so getting coverage of a NT technique may be very difficult.

L37762 First Coast Service Options, Inc. They too, have a proposed LCD (DL38720) which is written exactly the same as the proposed Novitas LCD. Again, the Health Care Policy Committees of the AVF and AVLS have participated in comments and we await the final documents.
ablation in a patient with Klippel-Trenaunay Syndrome (?), etc., but no mention of non-thermal techniques (either covered or excluded).

L34082 CGS Administrators, LLC. No mention of any non-thermal techniques in their coverage determination. (Of course, in their policy ‘Sources of Information’, they cite no reference more recent than 2009.)

L33575 National Government Services, Inc. I saved the best for last, and I mean that in a good way. This is an excellent policy, and verbatim from their coverage indications: “RFA and EVLA are classified as thermal tumescent (TT) techniques; PEM, CAE and MOCA are non-thermal non-tumescent (NTNT) techniques. Each endovenous ablation approach has advantages and disadvantages; which one is best depends on the unique clinical/anatomical scenario.

While saphenous vein ligation and stripping remains an important option in selected cases, it has been largely supplanted by endovenous ablation therapy as primary treatment of saphenous (axial/truncal) vein incompetence. The treatments to eliminate the saphenous vein reflux will be considered medically necessary if the patient remains symptomatic after a six-week trial of conservative therapy and has reflux in a saphenous vein.”

In summary, as venous practitioners have complained for years, CMS “policy” for venous disease treatment is inconsistent, so it is best to be familiar with your local CMS contractor’s coverage determination.
Billing appropriately can be extremely important for any practice. Besides affecting your bottom line, inappropriate billing can have very significant medico-legal ramifications as demonstrated in some recent, high-profile cases. Although there can be some variability from each local region and from each insurance company, we will review some of our local rules in South Brooklyn to serve as an example.

The CPT code for a complete bilateral venous duplex exam is 93970. This includes the entire superficial and deep system with examination and documentation for reflux and thrombosis. 93971 is the CPT for a unilateral or limited extremity venous duplex and applies for upper or lower extremity exams.

If a complete or limited bilateral study is done on both the upper and the lower extremities on the same day, the corresponding code can be reported once for each study performed (i.e., once for the upper extremities and once for the lower extremities.) Providers should append modifier 59, distinct procedural service, to the second code to indicate that two separate, distinct studies were performed.

For procedures, the venous duplex needs to specify the diameter and degree of reflux of the veins. There is some variability in exactly where the insurance company may want to have the vein examined. Checking with each specific company that your office accepts can be helpful.

In addition, specific documentation to obtain authorization for endovenous procedures is crucial and constantly shifting. What are the patient’s symptoms, the duration, their exacerbating factors and what helps them? Be specific. What conservative measures have been used? Have they tried NSAIDs, elevation and compression stockings? In general, we are required to have a trial on conservative therapy for three months but there is some variability. This includes if they have tried these in the past before coming to your office. Documenting how the venous insufficiency affects the activities of daily living of the patient is mandatory. Are they able to
stand to cook? Do they have difficulty standing or walking at work or going outside of the house? In addition, a few insurances require three months before another endovenous procedure on the ipsilateral lower extremity to assess the efficacy of the first procedure before a subsequent procedure.

Paying attention to these details can hopefully make the authorization process for the duplex exam and procedure go a bit smoother and help avoid the constant denials and peer to peer calls.

---

<table>
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**Impression:**

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<th>LEFT:</th>
<th>Negative</th>
<th>for thrombosis.</th>
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<td></td>
<td>GSV measured (diameter / depth):</td>
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<td>/ mm</td>
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<td>/ mm</td>
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<td>2.2</td>
<td>/ mm</td>
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<tr>
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<td>/ mm</td>
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<td>/ mm</td>
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<td>/ mm</td>
<td>ankle =</td>
<td>1.6</td>
<td>/ mm</td>
</tr>
</tbody>
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**Date of Service:** 08/12/2016  **Indication:** 183.009

**Venous Mapping Lower Bilateral**

**Diagnosis:** Varicose veins of lower extremity with stasis ulcer(83.009)
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<table>
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<td>proximal thigh = / mm</td>
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<tr>
<td>mid thigh = / mm</td>
<td>mid thigh = / mm</td>
</tr>
<tr>
<td>distal thigh = / mm</td>
<td>distal thigh = / mm</td>
</tr>
</tbody>
</table>

**IMPRESSION:**

**RIGHT**

No evidence of thrombosis. Enlarged incompetent GSV (thigh and leg) and SSV suitable for thermal ablation

**LEFT**

No evidence of thrombosis. Enlarged incompetent SSV suitable for thermal ablation.

Previous test on 4-21-2019, no significant changes since previous exam.

Technologist: [Redacted] RVT

Interpreting Physician: [Redacted] MD

Final Report. Signed by: [Redacted] MD

8/12/2019 10:17 AM
Chronic venous insufficiency (CVI) is a serious medical condition that left untreated can progress to more severe and debilitating disease states. Many factors impact reimbursement for varicose vein treatments; one of the most critical considerations is proper patient evaluation and classification. Patients with symptomatic varicosities that cause pain, wounds, disability and deteriorated quality of life should be evaluated for treatment. Reimbursement is predicated on coverage by the patient’s health plan and their prevailing medical policy. Clinically asymptomatic and cosmetic procedures are generally not eligible for insurance reimbursement.

Obtaining widespread reimbursement can be a lengthy process (Figure 1) and reimbursement for CVI procedures can be a sometimes complex formula of coding, payment, and coverage. As an example, Varithena® polidocanol microfoam 1% has established codes, and coverage has expanded significantly in recent years.

Coding: Treating varicose veins with Varithena is most often identified as CPT® 36465® single truncal vein ablation (non-compounded foam.) Some payers require tributary vein procedures be coded with standard sclerotherapy codes 36470/36471. It is not appropriate for billers to utilize codes 36465 or 36466 for procedures using physician compounded foam.

Payment: A robust national remittance database reports ~70% of Varithena procedures reported with 36465 and an average charge of $5,217. The 2020 Medicare national unadjusted payment for 36465 is $1,550, resulting in patient financial responsibility of ~$300 for most Medicare beneficiaries. With appropriate ICD-10 and CPT coding, Varithena payment is routine – claims are processed electronically and paid within 12-15 days.
Is coverage the crux of the complexity?
Varithena’s proven benefit as first line treatment for GSV incompetence has gained broad coverage nationally. Yet, some policies cover Varithena as an adjunctive/secondary procedure, in the same or separate treatment session, even fewer are silent, paying claims case-by-case. Just two major commercial payers exclude coverage for non-thermal modalities.7

Recently Proposed Local Coverage Determinations (LCDs) for the treatment of varicose veins published by Novitas and First Coast Service Options8 (FCSO) both clarify and complicate the question of coverage. The proposed policies group distinct procedures, potentially creating coding confusion for standard sclerotherapy and non-compounded foam procedures, and are inconsistent with other Medicare LCDs. Although these LCDs similarly cover Varithena, the coverage requirements may vary. On non-compounded foam, FCSO proposes to move from non-covered to silent and payment appears to be possible as categorized by the CPT codes in the accompanying Proposed Local Coverage Article. Moreover, LCDs and third-party payers do not necessarily follow current clinical guidelines, as is typically recommended by medical societies; therefore, it is imperative that stakeholders actively participate in the medical policy making processes to help define clinical rationales, medical necessity, coverage limitations and coding recommendations.

An example of the varying coverage is reflected in state and regional BlueCross Blue Shield (BCBS) organizations. Many state BCBS affiliates cover Varithena using the term Microfoam Sclerotherapy for primary or fist line treatment for symptomatic varicose veins/venous insufficiency of the great, small and accessory saphenous veins. Anthem, utilizes ultrasound guided foam sclerotherapy to describe and cover Varithena for treatment “of varicose tributary or extension veins (anterolateral thigh vein, anterior accessory saphenous vein (AASV) or intersaphenous vein[s])”9 at the same time as thermal treatment of residual or recurrent symptoms following surgical ligation, stripping, thermal ablation of the AASV, great or small saphenous vein. Health Care Service Corporation, a BCBS regional plan, adopted AMA coding guidelines which includes the following statement in their policy, “When Varithena is used to treat non-truncal veins exclusively, appropriate codes are 36470 or 36471, which include both the procedure and sclerosant.”10

In summary, it is incumbent on providers to understand prevailing payers’ reimbursement requirements and to establish best practices for complete thorough documentation to ensure appropriate and timely payment for services rendered. The standard of care for CVI procedures requires physicians to perform appropriate patient evaluations and administer appropriate treatment plans. Offices can facilitate timely payment by implementing stringent clinical and administrative practices that include setting charges appropriately, understanding variations across coverage policies and their limitations; obtaining Prior Authorization, when required; capturing timely, accurate documentation; utilizing consistent use of correct coding principles (global days, Medically Unlikely Edits, discounts for same-day multiple procedures); collecting patient’s co-pay and deductible; and submitting timely, accurately coded claims. The different societies should continue their quest for a National Coverage Determination which could streamline the multiple LCD varicose vein policies.
1. Varithena (polidocanol foam 1%) is for the treatment of incompetent great saphenous veins, accessory saphenous veins and visible varicosities of the great saphenous vein (GSV) system above and below the knee. Varithena improves the symptoms of superficial venous incompetence and the appearance of visible varicosities. For more information on Varithena indications, contraindications, warnings, precautions and adverse events, please go to https://www.bostonscientific.com/content/gwc/en-US/products/vein-ablation/varithena.html. Varithena was approved on an NDA in November 2013.

2. CPT 36465 Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (e.g., great saphenous vein, accessory saphenous vein).

3. AMA CPT Assistant March 2018. “Lower-extremity truncal veins include the great saphenous vein (GSV), small saphenous vein (SSV), anterior accessory of the great saphenous vein (AAGSV), posterior accessory of the great saphenous vein (PAGSV), and intersaphenous vein (vein of Giacomini).”

4. CPT 36470/36471 Injection of sclerosant; single incompetent vein (other than telangiectasia). CPT 36471 …multiple incompetent veins (other than telangiectasia), same leg.

5. CPT 36466 See 36465 …monitoring; multiple incompetent extremity truncal vein (e, great saphenous vein, accessory saphenous vein), same leg.


7. United Healthcare commercial and Humana commercial do not currently cover Varithena. Coverage varies across managed Medicaid plans.


Lymphedema (LE) is a chronic disease that has been shown to negatively impact patients functionally, medically, financially and psychosocially.\textsuperscript{1–6} LE affects more than 1 in 5 breast cancer survivors in the United States, as well as gynecologic and urologic cancer survivors, non-oncologic post-operative patients, trauma survivors, and even affects some patients congenitally.\textsuperscript{7} Lymphovenous bypass (LVB) is used both as a preventive technique, performed at the time of oncologic nodal surgery, as well as a surgical treatment for patients with early-stage, fluid-predominant disease.\textsuperscript{8–10} Fat-predominant LE is better treated initially with suction-assisted lipectomy.\textsuperscript{11–14} Surgical prevention and treatment of LE is still considered investigational by most insurance companies. Therefore, there has been almost no standardization in coding for these procedures. Lymphatic surgeons are currently relying on CPT codes for other procedures, often sourced from remarks in the literature or newsletters. The codes commonly cited for LVB were sourced from a “Coding Perspective” found in a 2014 meta-analysis on surgical treatments for LE.\textsuperscript{15} These codes are 35206 for repair of an upper extremity blood vessel, 35226 for repair of a lower extremity blood vessel, and 69990 for the use of an operating microscope.\textsuperscript{15} In the spring 2020 issue of Plastic Surgery News, a “CPT Corner” article suggested using unlisted CPT 38999, and cross-walking that code to those for vascular repair; CPT 35206 for upper extremity and 35226 for lower extremity.\textsuperscript{16} These codes are merely a workaround, as they do not accurately reflect the procedure being done, nor take into consideration the technical expertise required to proficiently perform microsurgical technique.

In Massachusetts, we successfully proposed criteria to Blue Cross Blue Shield to deem surgical treatment for LE medically necessary.\textsuperscript{17} The criteria published in BCBS-MA Policy 037 regarding LVB are:

1. Patient must meet all diagnostic criteria for LE
2. Patient must meet all surgical eligibility criteria.
3. Patient must not have certain other diagnoses including transient lymphedema, lipedema without lymphatic dysfunction, pregnancy, dye anaphylaxis, and active infection of the affected extremity. Other comorbidities must be optimized, including venous disease, CHF, medication-induced swelling, liver disease, and nephropathy.
4. Surgery must be performed by a certified lymphedema center of excellence.

The diagnostic criteria for LE include:

1. Signs and symptoms consistent with LE
2. Diagnosis of lymphedema stage ≥1 (International Society of Lymphology Staging System).
3. At least one quantitative measurement consistent with LE
   a. For patients with unilateral disease, quantitative measurement can include a volumetry differential, bioimpedance differential, or certain lymphoscintigraphy findings.
   b. For patients with bilateral lymphedema, lymphoscintigraphy must be used.

The surgical eligibility criteria include:

1. BMI ≤ 35kg/m2
2. ICG lymphography confirming the presence of lymphatic channels.
3. Completion of lymphedema therapy for a minimum of 20 hours/week for 6 months.
4. A demonstrated ability to tolerate post-operative compression and physical therapy

When working up, treating and surveilling our patients, we support our work with extensive documentation that addresses these criteria. Although the policy publication by BCBS-MA is a huge step forward for our field, there remains a great need for nationwide efforts to ensure patients can access the care they need for this disease.
References


Case: A vascular surgeon reported problems with an insurer refusing reimbursement for ablation of the great saphenous vein (GSV) unless the patient was documented with saphenofemoral junction reflux. The patient had symptomatic painful veins and some discoloration at the ankle. The surgeon asked the Appropriate Use Criteria (AUC) writing group what would be the proper response.

The AUC team responded to the query by citing the Appropriate Use Criteria published in JVS-VL July 2020 issue¹ which pointed out that reflux of the SFJ is not absolutely needed when axial reflux is documented, for symptomatic cases. The source of reflux and communication to the deep system could be via other routes such as an incompetent thigh perforator or neovascularization after high ligation of the SFJ, or via an incompetent anterior accessory saphenous vein (AAGSV.)

Background of the AUC
Over the last two decades, the numbers of endo-venous ablations and venous interventions have skyrocketed. As venous technology advanced, practitioners learned to treat their patients in less invasive ways. The new technology of thermal ablation (TA) and non-thermal, non-tumescent ablation (NTNT-A) revolutionized the care of those patients with venous disease, and was the result of training of practitioners, sonographers and associated health care workers including patients, driven by strong physician and industry driven programs.

As a consequence, venous practitioners came from all backgrounds of training, without any real overview or supervision from medical governing entities or societies. Unfortunately, a small set of practitioners developed less than honorable practices thought to focus of quantity and payments instead of quality of care. The American Venous Forum ad hoc committee on Appropriate Use developed a project which included multiple other societies including the Society for Vascular Surgery, American Venous and Lymphatic Society and the Society of Interventional Radiology. Together, the group of venous experts from these academic societies addressed the question of appropriate use in the
treatment of venous disease. Following very strict criteria, the panelists answered questions in many scenarios to ultimately publish an article of their findings in the Journal of Vascular Surgery Venous and Lymphatic Disease.¹

**Findings that may help bridge the gap**

It was not surprising that MOST scenarios reached a complete or near complete agreement as defined by the AUC process. However, it was clear that there are some scenarios resulting in disparity of ratings especially for those presenting with edema. This further enforces the need for more clinical research to be done. Additionally, some of the nomenclature used will need further modification. There are no absolute guidelines or AUC that can easily be used in EVERY patient case. The treatment of venous disease must be individualized in some cases, as presentations, anatomy, and treatment options are sometimes variable.

During the process several areas were identified where reimbursements did not match the findings of AUC or Guidelines. Two clear examples are treatment of symptomatic AAGSV and/or symptomatic tributaries. Of course, final determination of best treatment would need to take into account other patient related factors, and exceptions can be expected. However when given appropriate indications supported by valid test results, proper reimbursements should be provided by the patient’s insurer.

**How can the data be used for future reimbursements?**

The necessity for treatment and payment for venous interventions can vary not only at the level of the provider, but definitely vary among payors. Local coverage determinations (LCDs) differ from region
to region. This makes it very difficult for providers to provide consistently similar treatment to their patients across the country. Insurers have tried to limit the use of technology at times in contradiction to guidelines and possibly now AUC’s. Newer treatments are not available to patients uniformly across the USA as they may be deemed “experimental.” Unfortunately, payors are looking at the technology used, instead of focusing on the indications for treatment of the diseased vein. As an example, shouldn’t endovenous ablation of the great saphenous vein be covered in symptomatic patients by technology the provider deems best i.e. thermal, mechanic-chemical, glue, or foam sclerotherapy? With payors deciding the “appropriate” technology, an adversarial relationship forms between payor and provider with the patient suffering as a consequence. Professional societies need to continue to bridge the gap between data driven optimal treatment and appropriate payor coverage.

Research is greatly needed in the treatment of venous disease. As societies bring these issues to light, hopefully more experts will focus on research, funding will be more available, and some of the difficult questions will be answered. Efforts to bridge the gap between best practices and proper reimbursement will continue to require close communication and trust between physicians and insurers. By developing data driven options, combined with proper education of providers, sonographers and payors, we will likely better succeed in providing optimal treatment for our patients.

Reference:
Journal of Vascular Surgery (JVS) Captures Number One Ranking in Top 100 Most-Cited Chronic Venous Disease (CVD) Articles

–Peter Gloviczki, MD & Peter Lawrence, MD

August, 2020. JVS is the number one journal in publishing the most impactful CVD articles world-wide.

According to Drs. Jun and Hwang from the Hallym Medical University in Korea, who performed a bibliometric analysis of the world's scientific literature through 2019, the JVS published 36 of the top 100 most-cited articles, encompassing a total of 5,356 citations – both metrics ranking number one compared to other journals publishing venous work.

Their data was published in the Journal of INTERNATIONAL MEDICAL RESEARCH 48(4), pages 1-15 and includes the Table below.

Congratulations to all the authors and editors of the JVS!

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Table 2. Journals of the 100 most-cited chronic venous disease articles.

<table>
<thead>
<tr>
<th>Journal title</th>
<th>Impact factor</th>
<th>5-year impact factor</th>
<th>Number of manuscripts</th>
<th>Number of citations</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Journal of Surgery</td>
<td>5.433</td>
<td>6.051</td>
<td>13</td>
<td>1,965</td>
</tr>
<tr>
<td>Dermatologic Surgery</td>
<td>2.471</td>
<td>2.587</td>
<td>10</td>
<td>1,536</td>
</tr>
<tr>
<td>European Journal of Vascular and Endovascular Surgery</td>
<td>3.877</td>
<td>3.498</td>
<td>9</td>
<td>1,046</td>
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<tr>
<td>Phlebology</td>
<td>1.513</td>
<td>1.413</td>
<td>6</td>
<td>626</td>
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<tr>
<td>Journal of Vascular and Interventional Radiology</td>
<td>2.758</td>
<td>3.078</td>
<td>3</td>
<td>721</td>
</tr>
<tr>
<td>Circulation</td>
<td>18.881</td>
<td>17.902</td>
<td>3</td>
<td>582</td>
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<tr>
<td>Angiology</td>
<td>3.022</td>
<td>2.250</td>
<td>3</td>
<td>462</td>
</tr>
</tbody>
</table>
As a member of the Alliance of Wound Care Stakeholders, AVF submitted comments to CMS this month urging the Agency to update select wound care coverage and payment policies in light of the needs of wound patients and front-line wound care providers amid the pandemic. While many waivers have been granted across the healthcare system to better enable medical care amid the public health emergency, the Alliance’s July comments to CMS’s COVID-19 Public Health Emergency Second Interim Final Rule focused on additional flexibilities needed in wound care related to: codes to be utilized when billing for wound care services via telehealth that has been temporarily relocated to a patient’s home; dNPWT telehealth billing; standard written order provisions, provisions that currently disallow total contact casting on the same date of service as another procedure; Merit-based Incentive Payment System (MIPS) program relief, and a range of other issues. AVF is a member of the Alliance, which brings together the advocacy voices of more than 20 clinical and physician associations whose members practice wound care.
Beginning in 1997, and continuing for more than a decade, the American Venous Forum and SIGVARIS offered a Traveling Fellowship in Venous Disease for early career members of the AVF. This enabled venous practitioners to learn from pioneers in the field and to begin their personal leadership journeys.

To say that this Fellowship was a success would be an understatement. Three of the first nine awardees have served as Presidents of the AVF, one is the President-Elect and another serves on the Board of Directors. Their contributions to the field are indisputable.

“My experience with the Traveling Fellowship was one of the most significant highlights of my career. I was able to meet and learn from my hosts in a way that otherwise would not have been possible. They were giants in the field of venous disease and they willingly took the time to teach me about how they cared for venous patients, but also showed me how to be a gracious host and that will never be forgotten. They helped fuel my interest in venous disease as well as my participation in the American Venous Forum.”

Dr. Harold Welch – AVF President

Under the leadership of Dr. Welch and with the generous support of Juzo, the American Venous Forum has re-established the AVF-Juzo Traveling Fellowship in Venous Disease in support of the AVF’s mission to advance science, education and advocacy in venous and lymphatic disease.

“Juzo is excited to collaborate with the American Venous Forum to help advance and broaden the spectrum of venous disease training and education.”

Annerose Zorn-West – Managing Director
A single Fellowship will be awarded annually, beginning at the 2021 AVF Annual Meeting. The selected candidate will have up to two years to complete his or her fellowship and will be required to present a summary of his or her experiences at a future AVF Annual Meeting. The selection and administration process will be guided by the AVF-Juzo Traveling Fellowship Committee which will include prior Traveling Fellowship awardees. Additional details will be released next month when the call for submissions opens.

Recipients of this special award will benefit significantly from meeting with, and learning from, some of the brightest researchers, educators, and practitioners in the field of venous and lymphatic disease. They will enjoy access to AVF mentorship opportunities and will receive consideration for future committee and leadership roles within the AVF upon completion of their learning experience. The AVF-Juzo Traveling Fellowship will restore a pipeline of future venous KOL’s and AVF leaders.
Reimbursement Resources Provided by Our Industry Partners

AngioDynamics

Boston Scientific
Boston Scientific Varithena® Reimbursement Website: https://www.varithena.com/en-us-hcp/support/varithena-reimbursement-and-coverage.html
Boston Scientific Reimbursement Support: PIREIMBURSEMENT@bsci.com, 1.800.CARDIAC (227.3422)

Cook Medical
https://www.cookmedical.com/support/reimbursement/
In relation to thrombectomy, filter placement and retrieval I’ve included the links below.
Thrombectomy
Filter Placement and Retrieval

Inari:
1. Be sure to dictate/document every aspect of the procedure when using the Inari products, capturing in as much detail as possible both the ICD-10-PCS codes (inpatient procedure) and the CPT® codes (outpatient & hospital physician services).
2. Properly/accurately diagnose using the ICD-10-CM codes (diagnosis) and corresponding DRGs.
3. Capture any major complications and comorbid conditions the patient has at the time of the procedure.
Inari Medical, Inc. 2020 Procedural Reimbursement Guide

Medtronic
Medtronic Patient Insurance Benefit Verification Form

Philips Image Guided Therapy
https://www.usa.philips.com/healthcare/finance/reimbursement/philips-igtd-reimbursement-resources
We all have a few. You know, those cases that you see once or twice in a career. Those cases you want to tell your friends about. Those cases that were tougher than usual or maybe didn’t go well.

Share these with your fellow AVF colleagues. Our October VEIN SPECIALIST issue will be just that. Send us these types of cases: a brief history and physical, key imaging, procedure done and outcome. Some literature references if it was an unusual or unique case. Everything doesn’t need to have worked out fine. We all learn from adverse or less than perfect outcomes.

Here are some guidelines:

• Up to 500 words
• Written for a newsletter not a peer-reviewed medical journal
• Catchy title so as to gain attention
• Include images, tables, charts, photos, highlight boxes
• Submission deadline is September 30th, 2020
• Content will be reviewed and approved by the newsletter’s editors

All submissions should be sent to: Laura Richards, AVF Associate Director, laura@veritasmeetingsolutions.com.

We hope to hear from you,

Steve

Steve Elias, MD, FACS, FAVLS, DABVLM
Editor-In-Chief, AVF VEIN SPECIALIST
AVF-JOBST Research Grant 2021
Open for submissions until September 30, 2020

Click here for more details.

Now Accepting 2021 AVF-JOBST Grant Submissions

The American Venous Forum (AVF) and the American Venous Forum Foundation (AVFF) seek to advance knowledge, excellence, and innovation in venous and lymphatic health through education, research, and public advocacy. In 1995, the AVF, in collaboration with JOBST, initiated the JOBST Research Grant in Venous and Lymphatic Diseases. For more than 20 years, the research developed by grant recipients has helped advance the understanding and treatment of venous and lymphatic diseases.

The AVF Foundation is proud to announce that they are now accepting submissions for the 2021 AVF-JOBST Research Grant which will provide a $90,000 grant over two years for original, basic or clinical research in venous or lymphatic disease. The competition is open to residents and fellows in a vascular training program, as well as physicians who have completed their training within the past five (5) years. Applicants are AVF members and based within the United States.

The deadline to submit an application is September 30, 2020.

New AVF Members – Welcome to the Community!

Jaineet Chhabra
Shin Chan
Kirtha Bellamkonda
Angela Jellison
Anand Brahmandam
Kirolus Sourial

Medical Student Member, West Virginia
Medical Student Member, Connecticut
Medical Student Member, Connecticut
Physician Membership - National, Massachusetts
Member in Training, Connecticut
Member in Training, Ohio