


Decreasing Unnecessary And Potentially Harmful Endovascular Procedures In Patients With IC Which Are Almost Never Justified And Should Not Be Reimbursed

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 - Society for Vascular Surgery



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Current Paradigm in Surgery




Outcomes
Quality
Costs




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Current Paradigm in Surgery

Opportunity?




Outcomes
Quality
Costs




4

What About Preemptive Change?





Outcomes
Quality
Costs



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Claudication



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Claudication Treatment – Best Practices

1st Line

2nd Line

Logos: SVS, AMERICAN COLLEGE of CARDIOLOGY, American Heart Association, ESC

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Claudication Treatment – 3rd Line

Logos: JOHNS HOPKINS

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Choosing Wisely

Society for Vascular Surgery (SVS)

Five Things Physicians and Patients Should Question

1. Avoid routine ultrasound tests for patients with asymptomatic telangiectasia
2. Avoid routine ultrasound and fistulogram evaluations of well-functioning dialysis accesses
3. Don't use IVC filters as primary prevention of pulmonary emboli in the absence of an extremity clot of prior PE
4. Don't use interventions (including surgical bypass, angiogram, angioplasty, or stent) as first-line of treatment for most patients with intermittent claudication
5. Avoid use of ultrasound for routine surveillance of carotid arteries in the asymptomatic healthy population

Logos: JOHNS HOPKINS

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Claudication Practice Patterns

Medicare 2015-2017
194,972 Patients
5,664 Physicians

Fig. National distribution of physician-level early peripheral vascular intervention (PVI) rate.

Hicks et al., J Vasc Surg, 2020 Jan;71(1):121-130.e1.

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Economic Burden

6,286 early PVIs	==	\$77,832,218
Outlier PVIs	==	\$17,766,467
5%		23%
<u>Inlier Physicians</u>		<u>Outlier Physicians</u>
Median \$0/patient		Median \$1,983/patient

Hicks et al., J Vasc Surg, 2020 Jan;71(1):121-130.e1.

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Reinterventions after Early PVI

- 187,442 patients with new diagnosis of claudication
- Median follow-up = 4.4 years

aHR 6.89* (6.42, 7.40)

*Adjusted for patient age, sex, race, ESRD, diabetes, HTN, smoking, urban/rural residence, census region, physician sex, years in practice, urban/rural practice, census region, specialty, PVI volume, ASCOGL use

Sorber et al. J Vasc Surg. 2023; 2023 Mar;77(3):836-847.e3.

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Other Outcomes

Outcome	Early PVI (N=6,069)	No Early PVI (N=181,373)	P-value
Time to first PVI reintervention (days, median (IQR))	346 (130, 743)	554 (221, 1013)	<0.001
Receipt of open bypass (N, %)	2.8%	0.49%	0.001
Major amputation (N, %)	0.97%	0.37%	<0.001
Conversion to CLTI (N, %)	16.4%	7.8%	<0.001

Sorber et al. J Vasc Surg. 2023; 2023 Mar;77(3):836-847.e3.

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Possible Payor-Based Solutions

- Episode-based care for claudication
- Decrease reimbursement for PVI
 - Increase preauthorization requirements
 - Reduce payments
 - Decline payments

For Lack of:

- Statin RX
- Antiplatelet RX
- Smoking cessation attempt
- Documented attempt at SET
- Lack of imaging

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Imaging Studies for Claudication SVS

Recommendation: Diagnosis of peripheral arterial disease (PAD)

	Grade	Level of evidence
2.1. We recommend using the ABI as the first-line noninvasive test to establish a diagnosis of PAD in individuals with symptoms or signs suggestive of disease. When the ABI is borderline or normal (<0.9) and symptoms of claudication are suggestive, we recommend an exercise ABI.	1	A
2.2. We suggest against routine screening for lower extremity PAD in the absence of risk factors, history, signs, or symptoms of PAD.	2	C
2.3. For asymptomatic individuals who are at elevated risk, such as those aged >70, smokers, diabetic patients, those with an abnormal pulse examination, or other established cardiovascular disease, screening for lower extremity PAD is reasonable if used to improve risk stratification, preventive care, and medical management.	2	C
2.4. In symptomatic patients who are being considered for revascularization, we suggest using physiologic noninvasive studies, such as segmental pressures and pulse volume recordings, to aid in the quantification of arterial insufficiency and help localize the level of obstruction.	2	C
2.5. In symptomatic patients in whom revascularization treatment is being considered, we recommend anatomic imaging studies, such as arterial duplex ultrasound, CTA, MRA, and contrast arteriography.	1	B

ABI, Ankle-brachial index; CTA, computed tomography angiography; MRA, magnetic resonance angiography.

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Lack of Imaging Prior to PVI for Claudication

Medicare patients who underwent index PVI for claudication, 2017-2023

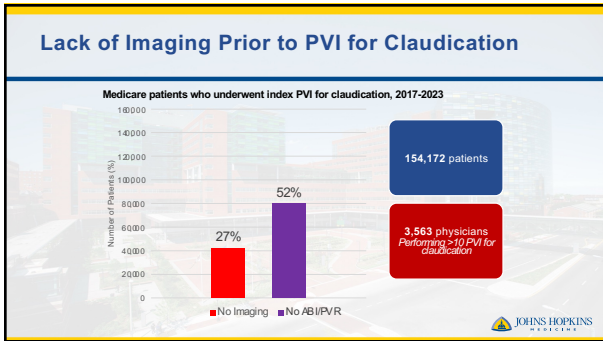
154,172 patients

3,563 physicians Performing >10 PVI for claudication

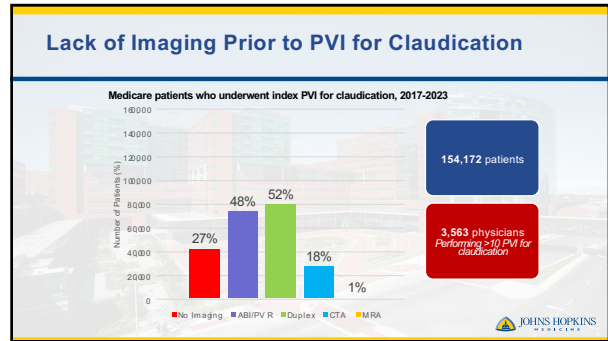
27% No imaging

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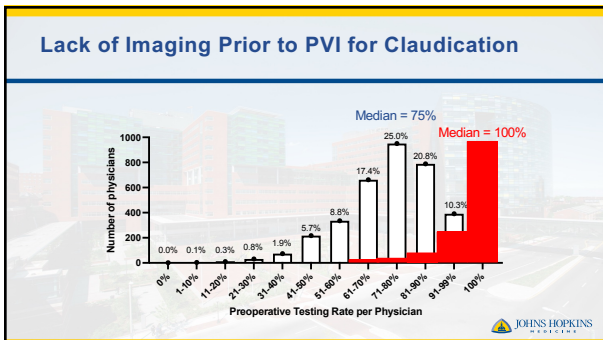
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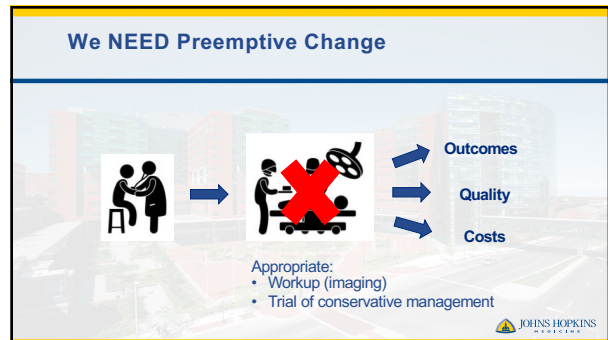
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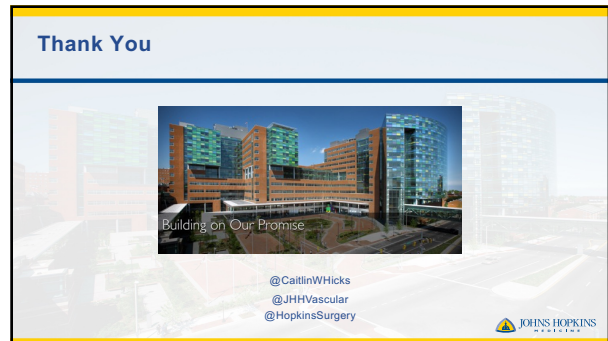
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- ### Conclusions
- Early interventions for claudication happen more often than they should
 - Associated with poor patient outcomes
 - Room for improvement in workup and conservative management
 - Specifically, pre-intervention imaging
 - “We” need to come together to rethink / standardize our management of patients with claudication
 - Physicians of all specialties & payors

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