Appropriate care for venous disease

Check for updates

Endovenous ablation of varicose veins has become the best and least invasive method to treat most varicose veins that are associated with truncal reflux. These procedures have excellent outcomes, whether they are performed for symptomatic CEAP 2 varicose veins or for more advanced venous insufficiency, such as lipodermatosclerosis or venous leg ulcers related to superficial venous reflux.

The paper by Crawford and coauthors[1] in this issue of the *Journal of Vascular Surgery: Venous and Lymphatic Disorders* examines the Medicare database to determine the number of ablation procedures performed per treatment session, related to physician specialty and region of the country. Because the Medicare database is limited to older patients, its relevance to younger patients is speculative but probably valid because indications do not vary by age. Also, the Medicare database does not distinguish patients with different CEAP classes, so the severity of the disease treated by each specialty and region of the country is unknown. However, it can be assumed that patients with more advanced chronic venous insufficiency require more procedures in each leg and that those patients with bilateral disease would also require more procedures.

Despite these limitations, this paper provides important information because Medicare patients with venous insufficiency have similar needs, irrespective of the specialty that treats them or the region of the United States. What is particularly disturbing about the data is that physicians who have no formal venous disease training in their residency, and who represent one-third of the procedures, are doing more procedures than those formally trained. Why would there be such variation in the number of procedures, particularly by those physicians who are more than 1 or 2 standard deviations from the mean of 1.8 procedures per patient? There are a number of possibilities.

1. The training of those performing ablation procedures is variable, with some specialties, such as vascular surgery, interventional radiology, and cardiology, incorporating venous disease training in their residencies. The "other" category has physicians who have no formal residency training, so presumably they were "learning on the job."
2. There may be different complexities of venous disease in different practices. A patient with unilateral varicose veins should need fewer venous ablations than a patient with more advanced disease and bilateral venous leg ulcers.
3. The duplex ultrasound imaging used to identify venous reflux and to justify venous ablations may not have been done in an accredited laboratory. Flash reflux, which can be provoked in almost any patient, and large-diameter veins at the saphenofemoral and saphenopopliteal junction that are not associated with reflux in a normal-sized vein below the junction must be evaluated at the correct location and with the patient standing.
4. Some physicians may not be aware of the published literature and practice guidelines,[2,3] which provide the evidence and criteria for treating patients with superficial venous reflux.
5. Some physicians may erroneously bill Medicare patients for separate access sites in the same vein, even though correct billing is for only one *Current Procedural Terminology* code, even if two access sites are used.
6. The office-based laboratory has become the site of service for most venous ablation procedures. There is essentially no oversight in an office-based laboratory, as opposed to a hospital or outpatient center, where the physician's credentials and training documentation and facility accreditation are required.
7. Last, but it is hoped rarely, fraud is involved.[4] A patient with leg pain may have it from many causes, and the pain must be correlated with an appropriate level of reflux. Some patients with venous reflux have no symptoms and should not be treated. Technologists who perform duplex ultrasound studies must not be incentivized to show reflux because every patient can be made to have flash reflux, even when the veins are normal.

How does this study help physicians who want to appropriately treat superficial truncal venous disease? Most important, it benchmarks the appropriate average number of ablations per procedure. Any physician who routinely does more than two ablations in a single setting should examine their indications and vascular laboratory. The data from this study should also be used by Medicare and other insurers to investigate fraudulent venous care. Anyone who routinely performs six to eight ablation procedures in a single setting is either fraudulently billing or doing inappropriate procedures. At the least, these individuals should lose their access to Medicare reimbursement, and other insurers should ban them as providers. Last, societies can use this information to both educate their members and to ostracize members who are performing inappropriate numbers of procedures.

The authors are to be congratulated for bringing this information to *JVS-VL* readers. It should lead to

J Vasc Surg: Venous and Lym Dis 2019;7:469-70
2213-333X

https://doi.org/10.1016/j.jvsv.2019.03.005

improvement in patient care by well-intentioned venous practitioners and prosecution of those performing inappropriate procedures on Medicare patients.

Peter F. Lawrence, MD
Peter Gloviczki, MD
Editors, Journal of Vascular Surgery Publications

REFERENCES

1. Crawford JM, Gasparis A, Almeida J, Elias S, Wakefield T, Lal BK, et al. A review of United States endovenous ablation practice trends from the Medicare Data Utilization and Payment database. J Vasc Surg Venous and Lym Dis 2019;7:471-9.
2. Gloviczki P, Comerota AJ, Dalsing M, Eklof B, Gillespie D, Gloviczki M, et al. The care of patients with varicose veins and associated chronic venous diseases: clinical practice guidelines of the Society for Vascular Surgery and the American Venous Forum. J Vasc Surg 2011;53(Suppl):2S-48S.
3. O'Donnell TF Jr, Passman MA, Marston WA, Ennis WJ, Dalsing M, Kistner RL, et al. Management of venous leg ulcers: clinical practice guidelines of the Society for Vascular Surgery and the American Venous Forum. J Vasc Surg 2014;60(Suppl):3S-59S.
4. Lawrence P. "Better" (sometimes) in vascular disease management. J Vasc Surg 2016;63:260-9.

Submitted Mar 21, 2019; accepted Mar 25, 2019.