

VEIN SPECIALIST

NEWSLETTER



HOW TO GET PAID FOR WHAT YOU DO

CODING & REIMBURSEMENT



American Venous Forum
Promoting venous and lymphatic health

Want to receive monthly updates? Click [here](#) to be added to the email list.

THE FOG OF WAR:

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



—Steve Elias, MD

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 Ozsvath 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



– Dan Monahan, MD




American Venous Forum
Promoting venous and lymphatic health

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.



VENOUS EDUCATION SERIES

**Connect and network
with like minded peers
in this virtual
four-session series**

REGISTER TODAY

veinforum.org



Kellie Brown, MD
Program Director
& Series Host

FOR RESIDENTS, FELLOWS & EARLY CAREER PRACTITIONERS



The AVF is providing training and education from our Distinguished Faculty for the specialties of vascular surgery, interventional radiology, interventional cardiology, vascular medicine, general surgery and associated programs.

[REGISTER NOW.](#)

October 13 • October 27 • November 12 • December 1

These 90-minute Sessions will focus on:

- Venous Thromboembolic Disease
- Superficial Venous Disease
- Abdominal and Pelvic Venous Disease
- Interesting and Challenging Venous Disorders

*Residents & Fellows attend at no cost. Early Career AVF Members \$125/ Non-Members \$250.



Ruth Bush, MD
Session Host



Ellen Dillavou, MD
Session Host



Steve Elias, MD
Session Host



Mark Meissner, MD
Session Host



@VeinForum



@americanvenousforum



american-venous-forum



American Venous Forum
Promoting venous and lymphatic health

Telehealth, Telemedicine, Telewhat?

–Lowell S. Kabnick, MD, A.J. Riviezzo, MBA, CEO, American Physician, & Cheryl Nash, Dir. of Operations, American Physician

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 device 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.

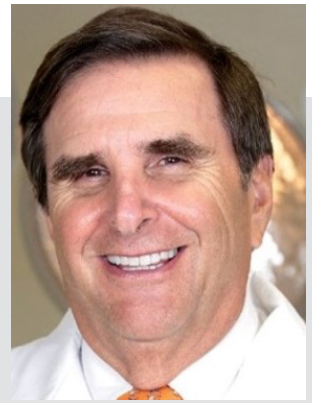
LK: Great! What about privacy?

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.

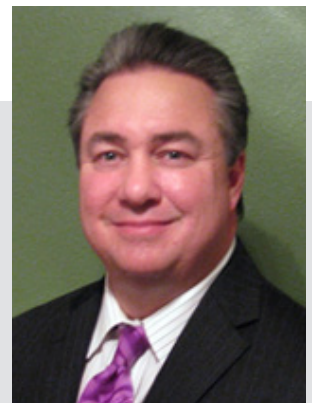
LK: What services can you perform?

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.)

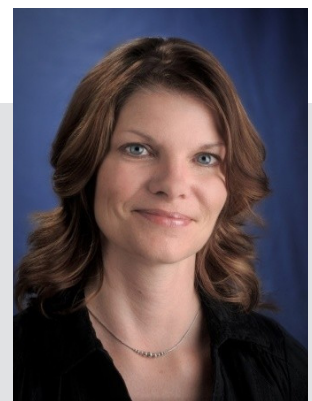
LK: Anything else?



– Lowell S. Kabnick, MD



– A.J. Riviezzo, MBA, CEO, American Physician



– Cheryl Nash, Dir. of Operations, American Physician



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 patient's 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 hypercoagulable 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.



– Peter Henke, MD



American Venous Forum
Promoting venous and lymphatic health

Update on CMS Coverage for Non-Thermal Ablation Techniques

–Harold J. Welch, MD

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.

L37796 Novitas Solutions, Inc. This is a proposed LCD (DL34924) for the coverage of CVI of the LE's and was open for public comment until August 1. They propose treatment coverage for CEAP Class C2-C6 disease of ‘incompetent saphenous veins’ with “Ultrasound Guided foam Sclerotherapy” (although Varithena is not specifically mentioned,) “chemical adhesives,” and “Mechanochemical ablation (MOCA).” The venous societies (AVF, AVLS) have responded to this proposed LCD, and we await the final document. So again, if this is your CMS contractor, I would obtain the final document this Fall.

L33762 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.



– Harold J. Welch, MD

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.

A57707 Noridian Healthcare Solutions, LLC. When I tried a new Google search, this is what came up, a Local Coverage ‘Article’ as opposed to a ‘Determination,’ and was effective 12/1/19, but it really is only all venous billing codes.

L34536 Wisconsin Physicians Service Insurance Corporation. Again, a very brief LCD with no mention of non-thermal saphenous ablation techniques.

L33454 Palmetto GBA. This was the latest LCD concerning treatment of varicose veins, but it was retired last year. After a thorough search of Palmetto’s website and CMS failed to turn up any new LCD from them, I googled “Does Palmetto GBA cover varicose vein treatment?” and was led to a document from Palmetto (updated 5/14/20) that looks like an LCD, but is not. A typical MAC policy: three months of conservative therapy, can’t do an



American Venous Forum
Promoting venous and lymphatic health

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.



New Dates!

veinforum.org



MARCH 17-20, 2021

33RD ANNUAL MEETING

LA CANTERA RESORT & SPA
SAN ANTONIO, TEXAS

VENOUS2021

AMERICAN VENOUS FORUM



American Venous Forum
Promoting venous and lymphatic health

Billing for Venous Duplex Exams and Venous Procedures: Ways to Avoid Pitfalls

–Anil Hingorani, MD, and Sharon Feiler

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.

Trying to combine a venous and arterial code on the same patient on the same day, in general, raises the chances of a denial unless you clearly document why both exams are needed the same day.

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



– Anil Hingorani, MD



– Sharon Feiler



American Venous Forum
Promoting venous and lymphatic health

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.

Total Vascular Care

960 50TH STREET

BROOKLYN, NY 11219-3472

Phone : 718-438-3800 Fax : 718-438-3131

Name : [REDACTED]

Acc No : [REDACTED]

Gender : FEMALE

Order No : [REDACTED]

Age : [REDACTED] Year(s) [REDACTED] Month(s) [REDACTED]

Order Date : 8/12/2019 8:09:36 AM

Ordering Physician : [REDACTED]

Venous Mapping Lower Bilateral

Diagnosis : Varicose veins of lower extremity with stasis ulcer(I83.009)

Date of Service : 08/12/2016

Indication : I83.009

VEIN	RIGHT			LEFT		
	Clot	Flow	Reflux(ms)	Clot	Flow	Reflux(ms)
Common Femoral	NO	REFLUX	1438	NO	NORMAL	
Deep Femoral	NO	NORMAL		NO	NORMAL	
Femoral	NO	REFLUX	1753	NO	NORMAL	
Popliteal	NO	NORMAL		NO	NORMAL	
Calf muscular	NO	NORMAL		NO	NORMAL	
Posterior tibial	NO	NORMAL		NO	NORMAL	
Peroneal	NO	NORMAL		NO	NORMAL	
GSV SFJ	NO	REFLUX		NO	NORMAL	
GSV Leg	NO	REFLUX	5728	NO	REFLUX	
SSV SPJ	NO	REFLUX	5457	NO	REFLUX	2890
Accessory						

IMPRESSION:

RIGHT:	Negative	for thrombosis.	LEFT:	Negative	for thrombosis.
GSV measured (diameter / depth):			GSV measured (diameter / depth):		
SFJ =	6.2	/ mm	SFJ =	5.7	/ mm
prx thigh =	5.4	/ mm	prx thigh =	5	/ mm
mid thigh =	3.8	/ mm	mid thigh =	3.1	/ mm
distal thigh =	3.2	/ mm	distal thigh =	2.5	/ mm
knee / proximal leg =	6.2	/ mm	knee / proximal leg =	2.2	/ mm
mid leg =	3.5	/ mm	mid leg =	1.7	/ mm
ankle =	2.6	/ mm	ankle =	1.6	/ mm



American Venous Forum
Promoting venous and lymphatic health

SSV measured (diameter / depth) :				SSV measured (diameter / depth) :			
SPJ =	7.8	/	mm	SPJ =	1.6	/	mm
proximal calf =	5.7	/	mm	proximal calf =	4.8	/	mm
mid calf =	5.9	/	mm	mid calf =	3.7	/	mm
ankle =	3.7	/	mm	ankle =	1.6	/	mm

Accessory Saphenous vein (diameter/depth):				Accessory Saphenous vein (diameter/depth):			
proximal thigh =		/	mm	proximal thigh =		/	mm
mid thigh =		/	mm	mid thigh =		/	mm
distal thigh =		/	mm	distal thigh =		/	mm

IMPRESSION:

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

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

Technologist : ■■■■■, RVT

Interpreting Physician ■■■■■, M.D.

Final Report. Signed by ■■■■■, MD

8/12/2019 10:17 AM



Reimbursement for Varicose Vein Treatments: The Complex Intersection of Coding, Coverage and Payment

–Wendy E. Wifler, Lowell S. Kabnick, MD

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%¹ has established codes, and coverage has expanded significantly in recent years.

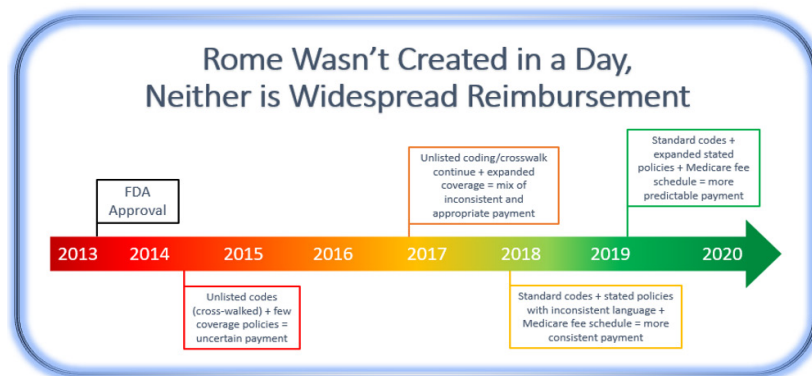


Figure 1. Varithena Experi-

Coding: Treating varicose veins with Varithena is most often identified as CPT® 36465² single truncal vein³ ablation (non-compounded foam.) Some payers require tributary vein procedures be coded with standard sclerotherapy codes 36470/36471.⁴ It is not appropriate for billers to utilize codes 36465 or 36466⁵ for procedures using physician compounded foam.

Payment: A robust national remittance database⁶ 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.⁶ With appropriate ICD-10 and CPT coding, Varithena payment is routine – claims are processed electronically and paid within 12-15 days.



– Wendy E. Wifler
Lead Author



– Lowell S. Kabnick, MD
Corresponding Author



American Venous Forum
Promoting venous and lymphatic health

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 first 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.



Lead author:

Wendy E. Wifler

Vice President, Global Market Access

Peripheral Interventions, Boston Scientific Corporation, Maple Grove, MN

Corresponding Author:

Lowell S. Kabnick, MD

Vice President, Union of International Phlebology

All trademarks are the property of their respective owners.

CPT Copyright 2019 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association.

For information purposes only. The content of this article/publication is under the sole responsibility of its author/publisher and does not represent the opinion of Boston Scientific Corporation.

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.
6. IQVIA. 77,852 claims dated Jan 2018 to March 2020.
7. United Healthcare commercial and Humana commercial do not currently cover Varithena. Coverage varies across managed Medicaid plans.
8. Medicare contractors for jurisdictions JH, JL and JM; 16 states/territories. Policies and articles DL34924, DA55229, DL38720, DA58520.
9. Anthem BlueCross Medical Policy "Treatment of Varicose Veins (Lower Extremities)," Document # SURG.00037, Last Review Date 11/07/2019. Accessed 7/29/2020. https://www.anthem.com/dam/medpolicies/abc/active/policies/mp_pw_a053323.html.
10. BCBS of Texas Medical Policy "Varicose Vein Management," Number SUR707.016, Effective Date 09/01/2019. Accessed 7/29/2020. <http://www.medicalpolicy.hcsc.net/medicalpolicy/activePolicyPage?lid=jzqvav43&corpEntCd=TX>.



American Venous Forum
Promoting venous and lymphatic health

A Coding Perspective on Lymphovenous Bypass

–Melisa D. Granoff¹, BA; Dhruv Singhal, MD¹

1. Division of Plastic and Reconstructive Surgery, Department of Surgery,
Beth Israel Deaconess Medical Center, Harvard Medical School, Boston, MA, USA.

Lymphedema (LE) is a chronic disease that has been shown to negatively impact patients functionally, medically, financially and psychosocially.^{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.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.^{8–10} Fat-predominant LE is better treated initially with suction-assisted lipectomy.^{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.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.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.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.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 $\leq 35\text{kg/m}^2$
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.



American Venous Forum
Promoting venous and lymphatic health

References

1. Klernäs P, Johnsson A, Boyages J, Brorson H, Munnoch A, Johansson K. Quality of Life Improvements in Patients with Lymphedema After Surgical or Nonsurgical Interventions with 1-Year Follow-Up. *Lymphat Res Biol*. Published online December 5, 2019. doi:10.1089/lrb.2018.0065
2. Cemal Y, Jewell S, Albornoz CR, Pusic A, Mehrara BJ. Systematic Review of Quality of Life and Patient Reported Outcomes in Patients with Oncologic Related Lower Extremity Lymphedema. *Lymphat Res Biol*. 2013;11(1):14-19. doi:10.1089/lrb.2012.0015
3. Chachaj A, Małyszczak K, Pyszel K, et al. Physical and psychological impairments of women with upper limb lymphedema following breast cancer treatment. *Psychooncology*. 2010;19(3):299-305. doi:10.1002/pon.1573
4. Pyszel A, Małyszczak K, Pyszel K, Andrzejak R, Szuba A. Disability, psychological distress and quality of life in breast cancer survivors with arm lymphedema. *Lymphology*. 2006;39(4):185-192.
5. Boyages J, Kalfa S, Xu Y, et al. Worse and worse off: the impact of lymphedema on work and career after breast cancer. *SpringerPlus*. 2016;5. doi:10.1186/s40064-016-2300-8
6. Boyages J, Xu Y, Kalfa S, et al. Financial cost of lymphedema borne by women with breast cancer. *Psychooncology*. 2017;26(6):849-855. doi:10.1002/pon.4239
7. DiSipio T, Rye S, Newman B, Hayes S. Incidence of unilateral arm lymphoedema after breast cancer: a systematic review and meta-analysis. *Lancet Oncol*. 2013;14(6):500-515. doi:10.1016/S1470-2045(13)70076-7
8. Yamamoto T, Koshima I. Subclinical lymphedema: understanding is the clue to decision making. *Plast Reconstr Surg*. 2013;132(3):472e-473e. doi:10.1097/PRS.0b013e31829acdd0
9. Yamamoto T, Narushima M, Yoshimatsu H, et al. Minimally invasive lymphatic supermicrosurgery (MILS): indocyanine green lymphography-guided simultaneous multisite lymphaticovenular anastomoses via millimeter skin incisions. *Ann Plast Surg*. 2014;72(1):67-70. doi:10.1097/SAP.0b013e3182605580
10. Yamamoto T, Yamamoto N, Numahata T, et al. Navigation lymphatic supermicrosurgery for the treatment of cancer-related peripheral lymphedema. *Vasc Endovascular Surg*. 2014;48(2):139-143. doi:10.1177/1538574413510979
11. Brorson H, Ohlin K, Olsson G, Nilsson M. Adipose tissue dominates chronic arm lymphedema following breast cancer: an analysis using volume rendered CT images. *Lymphat Res Biol*. 2006;4(4):199-210. doi:10.1089/lrb.2006.4404
12. Hoffner M, Peterson P, Månsson S, Brorson H. Lymphedema Leads to Fat Deposition in Muscle and Decreased Muscle/Water Volume After Liposuction: A Magnetic Resonance Imaging Study. *Lymphat Res Biol*. 2018;16(2):174-181. doi:10.1089/lrb.2017.0042
13. L T, P P, H B, S M. Assessment of Subfascial Muscle/Water and Fat Accumulation in Lymphedema Patients Using Magnetic Resonance Imaging. *Lymphat Res Biol*. 2018;17(3):340-346. doi:10.1089/lrb.2018.0027
14. Trinh L, Peterson P, Brorson H, Månsson S. In vivo comparison of MRI-based and MRS-based quantification of adipose tissue fatty acid composition against gas chromatography. *Magn Reson Med*. Published online May 7, 2020. doi:10.1002/mrm.28300
15. Basta MN, Gao LL, Wu LC. Operative treatment of peripheral lymphedema: a systematic meta-analysis of the efficacy and safety of lymphovenous microsurgery and tissue transplantation. *Plast Reconstr Surg*. 2014;133(4):905-913. doi:10.1097/PRS.0000000000000010
16. Figura L. Contrasting the differences of lipedema, obesity and lymphedema. *Plastic Surgery News*. May 2020:10.
17. Medical Policy: Surgical and Debulking Treatments for Lymphedema. Published online May 20, 2019. https://www.bluecrossma.com/common/en_US/medical_policies/037%20Surgical%20and%20Debulking%20Treatments%20for%20Lymphedema%20prn.pdf



How Can We Bridge the Gap Between Payors and Appropriate Patient Care?

–Elna Masuda, MD & Kathleen Ozsvath, MD

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 sapheno-femoral 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



– Elna Masuda, MD



– Kathleen Ozsvath, MD



American Venous Forum
Promoting venous and lymphatic health

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

2020 Appropriate Use Criteria for Chronic Lower Extremity Venous Disease

	American Venous Forum		Society for Vascular Surgery	Multi-Society Document		AMERICAN VEIN & LYMPHATIC SOCIETY		Society of Interventional Radiology
Great Saphenous Vein (GSV) ablation				Perforator vein treatment				
CEAP 2-6*		Appropriate		CEAP 4-6*, with high outward flow and large diameter directed toward affected area		Appropriate		
Below-knee In CEAP 4-6*		Appropriate		CEAP 1-2*, with high outward flow and large diameter directed toward affected area		Rarely Appropriate		
Small Saphenous Vein (SSV) ablation				CEAP 1-2 in asymptomatic patient				
CEAP 2-6* when reflux directed to affected area		Appropriate		Never Appropriate				
CEAP 4-6* when reflux to GSV or thigh veins		Appropriate						
Anterior Accessory Saphenous Vein (AASV) ablation				Iliac vein or inferior vena cava (IVC) stenting				
CEAP 2, 4-6* when reflux directed to affected area		Appropriate		CEAP 4-6,* for obstructive disease <i>without</i> superficial truncal reflux		Appropriate		
Ablation of any vein				CEAP 3 (edema),* for obstructive disease <i>with or without</i> superficial truncal reflux		May Be Appropriate		
CEAP 1-2 for <i>asymptomatic</i> disease and visible veins		Rarely Appropriate		In asymptomatic patient for iliac vein compression (such as May-Thurner compression), found as incidental finding by imaging, with or without teleangiectasia (CEAP 1)		Never Appropriate		
NO reflux		Never Appropriate						
<div>*in symptomatic patients</div>								
 Journal of Vascular Surgery Venous and Lymphatic Disorders				Masuda et al. <i>J Vasc Surg Venous Lymphat Disord</i> , July 2020				
Copyright © 2020 by the Society for Vascular Surgery®				 @JVascSurg  @TheJVascSurg				

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.

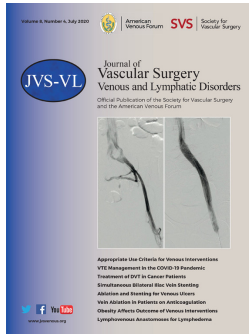
Reference:

1. Masuda EM, Ozsvath K, Vossler J, Woo K, Kistner R, Lurie F, Monahan D, Brown W, et. Al. The 2020 appropriate use criteria for chronic lower extremity venous disease of the American Venous Forum, the Society for Vascular Surgery, the American Vein and Lymphatic Society, and the Society of Interventional Radiology. J Vasc Surg: Venous and Lym Dis 2020: 1-21.



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

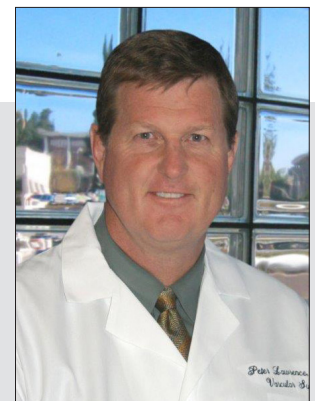
2019, the JVS published 36 of the top 100 most-cited articles, encompassing a total of 5,356 citations – both metrics ranking number one compared to other journals publishing venous work.

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!



– Peter Gloviczki, MD



– Peter Lawrence, MD

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

Journal title	Impact factor	5-year impact factor	Number of manuscripts	Number of citations
Journal of Vascular Surgery	3.294	3.477	36	5,356
British Journal of Surgery	5.433	6.051	13	1,965
Dermatologic Surgery	2.471	2.587	10	1,536
European Journal of Vascular and Endovascular Surgery	3.877	3.498	9	1,046
Phlebology	1.513	1.413	6	626
Journal of Vascular and Interventional Radiology	2.758	3.078	3	721
Circulation	18.881	17.902	3	582
Angiology	3.022	2.250	3	462



American Venous Forum
Promoting venous and lymphatic health

Wound Care Community Advocates CMS to Modify Wound Care Coverage and Payment Policies in Light of Front-Line Clinical Experience During the Pandemic

–Mark Iafrati, MD

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.



– Mark Iafrati, MD



American Venous Forum
Promoting venous and lymphatic health

The AVF Traveling Fellowship is Back!

–Jeff Mendola, AVF Director of Mission Advancement

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



– Jeff Mendola

Past Recipients of the AVF Traveling Fellowship

1997	Mark H. Meissner, MD
1998	Paul R. Cordts, MD
1999	E. John Harris, Jr., MD
2000	Harold J. Welch, MD
2001	David L. Gillespie, MD
2002	Joseph D. Raffetto, MD
2003	Audra Noel, MD
2004	Robert McLafferty, MD
2005	Antonios P. Gasparis, MD



American Venous Forum
Promoting venous and lymphatic health

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.



Dr. Gasparis (left), Dr. Meissner (right)



Dr. Harris

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.



Dr. Raffetto (center)



Dr. McLafferty



Reimbursement Resources Provided by Our Industry Partners

AngioDynamics

AngioVac - <https://www.angiodynamics.com/img/documents/2020-AngioVac-Reimbursement-guide-USVIMS19Rev03-584588.pdf>

Venacure - <https://www.angiodynamics.com/img/documents/2020-Venacure-EVLT-Reimbursement-Guide-USVIMS17Rev01-276375.pdf>

Boston Scientific

Boston Scientific Varithena® Reimbursement Website: <https://www.varithena.com/en-us-hcp/support/varithena-reimbursement-and-coverage.html>

CMS Physician Fee Schedule Lookup: <https://www.cms.gov/apps/physician-fee-schedule/license-agreement.aspx>

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

https://www.cookmedical.com/wp-content/uploads/2020/01/RG_PI_PMTRG_RE_202003.pdf

Filter Placement and Retrieval

https://www.cookmedical.com/wp-content/uploads/2020/01/RG_PI_DRFRG_RE_202002.pdf

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>



American Venous Forum
Promoting venous and lymphatic health

AVF Member *Community*



VEIN SPECIALIST Wants to Share Your Story in the October Edition: Unique, Unusual and Difficult Cases.

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



American Venous Forum
Promoting venous and lymphatic health

AVF-JOBST Research Grant 2021

Open for submissions until September 30, 2020

[Click here](#) for more details.



American Venous Forum
Promoting venous and lymphatic health



**AMERICAN VENOUS FORUM
FOUNDATION**
Healthy Veins for Healthy Life

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

Medical Student Member, West Virginia

Shin Chan

Medical Student Member, Connecticut

Kirtha Bellamkonda

Medical Student Member, Connecticut

Angela Jellison

Physician Membership - National, Massachusetts

Anand Brahmandam

Member in Training, Connecticut

Kirolus Sourial

Member in Training, Ohio



American Venous Forum
Promoting venous and lymphatic health

VEIN SPECIALIST PUBLICATION

EDITOR-IN-CHIEF: Steve Elias, MD

EXECUTIVE EDITOR: John Forbes, MBA

PUBLICATION EDITOR: Laura Richards

EDITORIAL BOARD:

Windsor Ting, MD

Haraldur Bjarnason, MD

Edgar Guzman, MD

Andrea Obi, MD

Alessandra Puggioni, MD

Maxim Shaydakov, MD

Eric Hager, MD

Anil Hingorani, MD

Want to receive monthly updates?

Contact us 847-752-5355 or info@avfmail.org

VEIN SPECIALIST welcomes your thoughts and comments.

Please send all comments to info@avfmail.org.



American Venous Forum
Promoting venous and lymphatic health

**Disclaimer: The information featured in this newsletter selected by AVF, which offers educational materials, are not intended to be representative of patients with venous disease generally and should not be considered medical advice. Patients should consult their doctor to determine the best treatment decision for their individual disease.*



[@americanvenousforum](https://www.facebook.com/americanvenousforum)



[@VeinForum](https://twitter.com/VeinForum)



[American Venous Forum](https://www.linkedin.com/company/American-Venous-Forum)



[@veinforum](https://www.instagram.com/veinforum)