Heart Rhythm Society

Potential Unintended Consequences of Proposed CMS Cuts to AF Ablation Codes

Patient Access

- Will be a negative incentive for physicians to recommend ablation at a time when the prevalence and detection of atrial fibrillation (AF) are increasing.
- Reimbursement is a significant influencer in physician and facility behavior. The cuts will undoubtedly have a negative impact on how the EP community takes care of patients.
    - Will reduce the number of physicians offering ablation
    - Will result in longer procedure wait times for patients
    - Will result in longer travel distances for patients
- Access issues will be more acutely experienced in smaller hospitals and rural and underserved areas. Many of these hospitals are unable to increase their efficiency to offset the cuts. They often have limited procedural rooms and trained staff.

Impact to Patients if Ablation Is Not Performed

- Limited access to AF ablation will diminish the patient's quality of life and increase hospitalizations.
    - Recent CABANA data shows ablation to be economically favorable with a mortality benefit, particularly among patients with heart failure.
    - Recent data shows that early ablation improves outcomes. Delaying ablation due to lack of reimbursement can have a negative effect on outcomes.
- Ultimately, these cuts may lead to increased utilization of health care resources.

Impact on Trainees

- AF ablation is a technically demanding procedure that requires multiple skills gained over years of experience. A sudden change of reimbursement can affect volume, and consequently, limit experience.
- Attendings may feel pressured to spend less time doing in-lab, hands-on training/teaching (which is time-consuming) to move cases along faster
- Trainees will be driven to other specialties, particularly given the length of post-graduate training:
    - Medical School: 4 years
    - Internal Medicine: 3 years
    - Cardiology: 3 years
    - Electrophysiology: 2 years
- By reducing interest in the field, innovation and improvements in outcomes will be stifled.

Impact on clinical practices

- Bundling 3D mapping without an appropriate increase in reimbursement will pressure physicians and hospitals to decrease its use and cause a rollback of the advances the field has made over the past decade. This will lead to patients undergoing more procedures, more hospitalizations, and more radiation exposure.
- A sudden change in reimbursement will be very disruptive to patient care.

- Private practices with significant ablation volumes will see a 20-30% reduction in reimbursement for their primary procedures.
    - Staff will be let go.
    - This will negatively impact patient experience.

Impact on Overall Healthcare Costs

- Reduction in reimbursement will affect patient access to this curative procedure for AF. As such, more untreated patients will require a significant increase in hospital utilization services. In a 2009 study of managed care patients, researchers estimated that the total hospitalization and outpatient cost of treating AF patients in the U.S. was $12.7 billion, with hospitalizations accounting for 63 percent of the total.[1] In a 2008 study, researchers indicated that Medicare alone pays $15.7 billion annually to treat newly diagnosed AF patients.[2] These costs are largely driven by the greater utilization of healthcare services associated with AF complications such as stroke, HF, acute myocardial infarction, and tachycardia.
- Outpatient and inpatient hospital expenses for untreated AF patients will greatly offset and significantly exceed the cost savings achieved with the proposed cut to the existing CPT code. Previous studies have conclusively demonstrated that untreated AF patients have high hospital outpatient and physician services utilization with an average of 12 hospital outpatient visits and 67 physician encounters during a 5-year follow-up period.[3]
- The proportion of admissions or re-admissions for atrial fibrillation assigned to the IPPS DRG (with major complication or comorbidity) would additionally increase. In a retrospective cohort study of managed care patients, researchers found that inpatient expenses were about 80 percent of the total costs to treat hospitalized AF patients.[4] A similar study estimated that 73 percent of total U.S. AF costs were for inpatient costs.[5]

References
[1] Kim, Michael H., Jay Lin, Mohamed Hussein, Charles Kerilick, and David Battleman, “Cost of Atrial Fibrillation in United States Managed Care Organizations.” Adv Ther. (2009) 26(9):847-857.
[2] Lee W. Lamas G. Balu S, et al. “Direct treatment cost of atrial fibrillation in the elderly American population: a Medicare perspective.” Journal of Medical Economics. (2008): 281-298.
[3] Health Services Utilization and Medical Costs Among Medicare Atrial Fibrillation Patients / September 2010. Avalere Whitepaper. https://avalere.com/research/docs/Avalere-AFIB_Report-09212010.pdf
[4] Kim, Michael H., Jay Lin, Mohamed Hussein, Charles Kerilick, and David Battleman, “Cost of Atrial Fibrillation in United States Managed Care Organizations.” Adv Ther. (2009) 26(9):847-857.
[5] Coyne K., et al. “Assessing the Direct Costs of Treating Nonvalvular Atrial Fibrillation in the United States.” Value in Health. 9 (2006) 5:348-356.