

# **Opening the Real Stenosis**

**Improve Patient Outcomes, Increase Profits in  
Your Health Care System by Implementing  
Increased Diagnostic Testing for PAD**

# Increasing Vascular Referrals and Interventions with PAD Testing

**Summary** Recent studies show that although awareness of peripheral artery disease (PAD) is increasing among patients and physicians, **the lack of PAD diagnosis and subsequent referral to vascular specialists is still severely limiting the number of patients that would benefit from vascular interventions to help control their PAD.** From the perspective of a health care organization, increasing diagnosis may multiply income from vascular interventions many times over by keeping patients in your system. Earlier diagnosis will also reduce costs of care by reducing some of the considerable costs associated with advanced PAD.

## A Serious Disease

Far from being a benign disease with symptoms primarily of intermittent claudication, PAD is now recognized as a manifestation of systemic atherosclerotic disease that leads to increased mortality, amputations, stroke, and MIs, as well as diminished quality of life. It is also expensive: treatment for the initial intervention and first year follow-up costs more for PAD than for cardiovascular disease.

## A Large Universe of Potential Patients

Recent studies from the SAGE group<sup>1</sup> now indicate that as many as 18 million people in the US had PAD in 2010. Those at most risk include:

- Over age 65 (about 20% over age 70 have PAD)
- Over 50 with a history of smoking or diabetes (about 30-40% have PAD)
- Known atherosclerotic coronary, carotid, or renal arterial disease
- Leg symptoms with exertion or ischemic rest pain or abnormal pulse
- About 30% of those diagnosed with PAD should have a vascular intervention (and about 40-50% of those need both lower limbs)

## But a Lack of Diagnostic Testing and Referrals Is a “Stenosis” Limiting the Flow of Patients to Further Treatment

The PARTNERS study<sup>3</sup> showed that 29% of the at risk population above has PAD. If dependent on the classical diagnostic signs of claudication, only 11% would be diagnosed. Even including other symptoms, it is estimated that only 16% of those with PAD are currently diagnosed. Almost 50% have no pain or symptoms and were only found by ABI testing. Only about 15% of those even with claudication are referred to a vascular specialist.

## The key to opening this stenosis is to increase the number of at risk patients undergoing testing for PAD.

As an example of how this “stenosis” can impact the revenues for a health care organization, consider the following comparison of two theoretical possibilities. In the first case little if any testing is done in the primary care setting. Only those with intermittent claudication are referred for testing and to vascular specialists. Compare this to an organization where all the at risk patients are screened in the primary care setting and those with abnormal ABI values are further evaluated with a more extensive test (reimbursable at a national average of \$114) and referred to vascular specialists. The percentage of those undergoing a vascular intervention is the same in

both cases, 30% of those with PAD. The average revenue for an intervention is estimated at \$15,000. It can be as much as \$35,000 for an amputation.

Consider 1000 “at risk” patients – over age 65, over 50 with diabetes or smoking history, other cardiovascular history, etc.

	Current: No Testing	With Testing and Screening	ACO/MAP
At risk patients	1000	1000	1000
Those with PAD	290	290	290
Recognized PAD	32	290	290
Testing revenue*	\$3,650	\$33,060	<b>\$870,000</b>
Vascular interventions	10	87	-
Intervention revenue	\$150,000	<b>\$1,305,000</b>	-

\*For ACO/MAP (Medicare Advantage Palns) revenue is derived from adjustment factors for disease. For vascular disease, the increased revenue is ~\$3000.

This example does not include the fact that many patients that have an initial intervention will have recurring rehospitalizations and repeat revascularizations within two years following the initial procedures, as shown in the most recent results from the REACH study<sup>3</sup>.

## You Can Facilitate More Testing and Referrals

Based on analyses similar to the above example, some healthcare organizations have recognized that it can be cost effective to provide the primary care offices with diagnostic systems for PAD screening, thus increasing revenues and improving patient care simultaneously. In return for the use of the diagnostic systems, offices agree to provide information/referrals to the organizations if further evaluation or intervention is required.

Our Newman Medical PAD/ABI diagnostic and screening systems are significantly less expensive than previous products, making it feasible for many more practices to screen for PAD. Newman Medical reimbursable computer based systems can be less than \$3000. The reimbursable simpleABI systems meet all the newest reimbursement criteria, unlike some other equipment. We provide not only the products you and your referring practices need, but also training, educational materials, and marketing suggestions to bring more of the at risk patients into your system and increase referrals.

**Contact us for further information regarding multiple systems for PAD diagnosis.**

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1. Yost, ML, Critical Limb Ischemia Volume I. United States Epidemiology, The Sage Group, Atlanta, GA.
2. Hirsch AT, Criqui MH, Treat-Jacobsen D, et al. Peripheral arterial disease detection, awareness, and treatment in primary care. JAMA 2001;286:1317-24.
3. Mahoney MM, Vascular Hospitalization Rates and Costs in Patients With Peripheral Artery Disease in the United States, Circ Cardiovasc Qual Outcomes, 2010;3;642-651.