

The Value of Colonoscopy

John I. Allen

Yale University School of Medicine, New Haven, Connecticut

Welcome to the first edition of the AGA Board Strategic Update, a bi-monthly column that will be published in both Gastroenterology and Clinical Gastroenterology and Hepatology. In each column we will ask an AGA member to update you on key strategic initiatives and issues for the AGA. Our goal is to provide you with insights into the reasoning behind AGA's programs and policies. The AGA Governing Board councillors will oversee the column. This month, Community Private Practice Councillor Lawrence Kim, MD, AGAF, asked AGA President-Elect John I. Allen, MD, AGAF, to address the board's response to recent attacks on colonoscopy. The board has had a number of spirited conversations about recent media attention and how we can approach the issue in a robust and thoughtful way. We hope you will enjoy John's column and future columns.

Anil K. Rustgi, President, AGA

Hashem B. El-Serag, Editor, *Clinical Gastroenterology and Hepatology*

M. Bishr Omary, Editor, *Gastroenterology*

The current era of colonoscopy can be traced in part to February 15, 1973, when Drs William Wolff and Hiromi Shinya described their experience of removing 303 polyps from 218 patients in the lead article of the *New England Journal of Medicine*.¹ They stated, "Apprehensive patients may require mild sedation. Most are given none and require none if time is taken to discuss the examination with them." There was one adverse event, a postpolypectomy bleed, which was managed easily with transfusions. In an accompanying editorial, Bloom et al discussed their similar experience at the Peter Bent Brigham Hospital.² The cost of colonoscopy under their care (they were surgeons) was \$1075 compared with \$3241 for conventional laparotomy. At that time, colonoscopy included a 2- to 3-day hospitalization.

Colonoscopy Is Under Attack

Where do we find ourselves now? The road forward is neither clear nor encouraging. On many fronts, gastroenterology is under attack and a major portion of our clinical focus (colorectal cancer [CRC] screening and prevention) may be reduced in volume and discounted. A series of articles in both professional and lay publications have

placed us on the defensive and forced us to examine some fundamental assumptions.

On March 21, 2012, Liu et al published an article in the *Journal of the American Medical Association* using claims data from both Medicare and commercially insured patients. They found that use of an anesthesia professional during endoscopic procedures increased from 14% in 2003 to 30% in 2009, about two-thirds of which occurred in low-risk patients.³ The cost (in 2009) of anesthesia services per procedure was approximately \$150 for Medicare patients and \$500 for patients with commercial insurance. They estimated that the total cost of anesthesia services provided to low-risk patients undergoing outpatient endoscopic procedures in 2009 was more than \$1.1 billion.

On June 1, 2013, Elizabeth Rosenthal published an article in *The New York Times* titled "The \$2.7 Trillion Medical Bill: Colonoscopies Explain Why U.S. Leads the World in Health Expenditures."⁴ She cited charges for colonoscopy for 3 patients that ranged from \$6385 to \$19,438. She stated, "While their insurers negotiated down the price, the final tab for each test was more than \$3500." "The high price paid for colonoscopies mostly results not from top-notch patient care...but from business plans seeking to maximize revenue." Rosenthal's exposé was followed on July 20, 2013, by an article in *The Washington Post* titled "How a Secretive Panel Uses Data That Distort Doctors' Pay," highlighting the work of the American Medical Association/Specialty Society Relative Value Scale Update Committee and using colonoscopy as the example of how specialists exaggerate procedural times to their economic advantage.⁵

In June 2013, the US Government Accountability Office published a study titled "Action Needed to Address Higher Use of Anatomic Pathology Services by Providers Who Self-Refer."⁶ After analyzing Medicare claims from 2004 to 2010, Cosgrove et al found that "referrals for anatomic pathology services by dermatologists, gastroenterologists, and urologists substantially increased the year after they

Abbreviations used in this paper: AGA, American Gastroenterological Association; CRC, colorectal cancer.

© 2014 by the AGA Institute
1542-3565/\$36.00

<http://dx.doi.org/10.1016/j.cgh.2013.12.013>

Key Items for AGA Members to Know

- On many fronts, gastroenterology is under attack and colorectal cancer screening and prevention may be reduced in volume and discounted.
- For you to succeed in the coming world of accountability and transparency, you will need to provide quantifiable data on both quality and cost. AGA offers guidelines, clinical service lines, and education and training to help you provide high-value care.
 - Online resources: gastro.org/practice/roadmap-to-the-future-of-gi
- AGA and our sister societies have engaged in a public relations effort to set the record straight on colonoscopy. We are educating policymakers and patients that colonoscopy is a good deal and that gastroenterologists provide lifesaving care with integrity.
 - Online resources: gastro.org/openletter
- AGA is developing a colonoscopy bundled payment model that practices can use to negotiate with payers or accountable care organizations. This methodology cuts through the opaqueness of current bills and re-establishes a direct and transparent relationship between doctor and patient.
 - Online resources: gastro.org/practice/quality-initiatives/Bundled_Payments.pdf

began to self-refer.” The term “self-refer” indicates arrangements in which pathology services are incorporated into a physician’s practice and are billed in conjunction with a surgical procedure (such as colonoscopy).

Finally, our specialty is facing a series of time surveys emanating from the Relative Value Scale Update Committee, a panel that advises the Centers for Medicare & Medicaid Services on what the numeric values of our 106 endoscopic Current Procedural Terminology (CPT) codes should be in relation to the other 7000 medical service codes (thus determining our reimbursement). This fall, the colonoscopy family (45xxx) of codes will be surveyed and revalued, a situation that places reimbursement for colonoscopy in jeopardy.

As a gastroenterologist, I feel under attack. I am proud of the clinicians, scientists, researchers, and entrepreneurs who attacked the enigma of colon cancer, developed safe and effective methods to detect it in its earliest stages, and then built a distributed network of

low-cost, patient-friendly surgical suites where people undergo lifesaving colonoscopy procedures. Our combined efforts, both scientific and business, have helped reduce the number of Americans who die of CRC each year. Yet, in a variety of public forums, we have been portrayed as solipsistic, so enhanced regulation and price controls have been demanded. How can we, together, regain a rational, patient-centered focus in our mission to make CRC death an even rarer event?

What Is the American Gastroenterological Association Doing to Help You?

The American Gastroenterological Association (AGA) has worked diligently to help you maximize the value of your CRC prevention efforts. The value of your service depends on excellent quality (outcomes) delivered at a reasonable cost. Specifically, Value = Quality/Cost. For you to succeed in the coming world of accountability and transparency, you will need to provide quantifiable data for both the numerator and denominator of the value equation. Therefore, the AGA has developed unique programs (described in the following text) when appropriate and has also worked with the American College of Gastroenterology and the American Society for Gastrointestinal Endoscopy when external threats have demanded a collaborative response.

Guidelines

The AGA’s broad initiative, the “Roadmap to the Future of GI Practice,” begins with high-quality practice guidelines. These are developed using Grading of Recommendations Assessment, Development and Evaluation (GRADE) methodology; the technical review is written by internationally recognized content experts, and the medical position statement is derived from a multi-stakeholder panel composed of content experts, related specialists, primary care physicians, representatives from the payer community, and patients, who together write final (published) recommendations.

Clinical Service Lines

Once guidelines are published, the AGA creates “Clinical Service Lines,” a portfolio of practice tools that include performance metrics, clinical care algorithms, professional education, Maintenance of Certification and Practice Improvement Modules, patient education, standard order sets, and data definitions that can be

Download English Version:

<https://daneshyari.com/en/article/3281754>

Download Persian Version:

<https://daneshyari.com/article/3281754>

[Daneshyari.com](https://daneshyari.com)