

Current Issues with Hysterectomy



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KEYWORDS

• Hysterectomy • Morcellation • Reimbursement • Quality • Health care reform

KEY POINTS

- Prevalence of leiomyosarcoma in women with uterine fibroids may be overstated.
- Surgical registries may provide clinicians with prospective data to assess risks associated with different types of hysterectomies.
- Reimbursement models are changing to align outcome and quality measures with value.
- Health care reform has led to the correlation of outcome and process measures with reimbursement that may have significant impact on hysterectomy payments in the future.

INTRODUCTION

Hysterectomy is the second most common surgical procedure and the most common gynecologic surgery. One in 9 women will undergo a hysterectomy in their lifetime.¹ The last 30 years witnessed advancements in different types of endoscopic techniques for minimally invasive hysterectomies. The many different techniques offer distinct benefits and risks over the traditional vaginal or abdominal approach. Data to support one route versus another are lacking, especially in relation to robotic-assisted hysterectomy. There has been a strong marketing campaign targeting physicians and hospitals to adopt newer technology despite level 1 evidence of increased costs without benefit.² The wide acceptance of other minimally invasive surgical techniques coincided with the launch and use of electric power morcellators. These devices have also been heavily marketed by industry and were adopted widely, despite the absence of safety data.³

Technological advancements in surgery must balance safety, quality, costs, and patient engagement. The informed consent process is moving toward patient-centered valuing of surgical risks and benefits and the development of shared decision-making

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Abbreviations	
ACO	Accountable Care Organizations
ACOG	American College of Obstetrics and Gynecology
APM	Alternate Payment Model
CMS	Centers for Medicare and Medicaid Services
COEMIG	Center of Excellence in Minimally Invasive Gynecologic Laparoscopists
EHR	Electronic health record
FDA	US Food and Drug Administration
LMS	Leiomyosarcomas
MACRA	Medicare Assess and CHIP (Children’s Health Insurance Program) Reauthorization Act of 2015
MIPS	Merit-based Incentive Payment System
MU	Meaningful use
NQF	National Quality Forum
PQRS	The Physician Quality Reporting System
QCDR	Qualified Clinical Data Registry
SGR	Sustainable growth rate
VBPM	Value-based payment modifier

tools and processes for interventions.⁴ Growth in patient autonomy has coincided with a reactionary media and political climate that often battles with a medical culture wherein technology is being implemented faster than evidence-based medicine can fully assess all of the risks and benefits. Despite acceptance of minimally invasive hysterectomy techniques, including the use of uterine power morcellation devices, patient perceptions of risk and benefits are often different than their physicians’ perceptions. Health care is changing to align physicians, patients, hospitals, and payers to control costs and link reimbursement with improved care, quality, and safety.

The passage of the Medicare Assess and Children’s Health Insurance Program Reauthorization Act of 2015 (MACRA) ended the controversial fee-for-service sustainable growth rate (SGR) reimbursement model that had been in place since 1997 and replaced it with reimbursement models based on quality outcome measures and value. What outcome measures are used and how value is defined in performing a hysterectomy should encourage the specialty to focus on the relationship between quality, safety, and cost. It may also allow physicians to compare outcomes of different treatments, control costs, and engage patients in their treatment choices and align their values with their care.

MORCELLATION

The most common indication for hysterectomy is uterine leiomyoma, accounting for an estimated 40% of all hysterectomies performed in the United States.⁵ Traditionally, either hysterectomy or myomectomy has been performed through abdominal incisions. Morcellation, a process whereby tissue is divided into smaller pieces so it can be removed from the body, enables surgeons to remove an enlarged uterus or fibroids through scalpel-morcellation vaginally or with mini-laparotomy incisions. As minimally invasive approaches evolved, surgeons first used hand-operated cutting devices to remove the leiomyoma through small laparoscopic incisions. Unfortunately, this technique was hindered by surgeon hand fatigue, development of carpal tunnel and elbow issues in high volume providers, and increased operative times.^{6,7} Because of the problems with hand fatigue and longer operative times, the development of an electromechanical-assisted morcellator in 1993 enabled surgeons to now efficiently remove large volumes of tissues efficiently during minimally invasive procedures, leading to a rapid adoption of the procedure. After the introduction of

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