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ENDOSCOPY SUITE

ASGE Unveils New Training Facility

By Brigid Duffy

As the global home of endoscopy, the American Society for Gastrointestinal Endoscopy (ASGE) was long in need of a training facility worthy of its stellar reputation. After nine years of planning,

see IT&T, page 28

WEO Provides Global Training In Endoscopy

By Victoria Stern

Early last year, the World Endoscopy Organization (WEO) organized the first Program for Endoscopic Teachers (PET). The aim of the two-day program, held in Hyderabad, India, was to provide

see PET, page 35

NATIONAL COLORECTAL CANCER AWARENESS MONTH

FOBT Shows 'Striking' Results for Long-Term Reduction in CRC Mortality

By Monica J. Smith

San Diego—A randomized controlled trial (RCT) of fecal occult blood test (FOBT) screening for colorectal cancer (CRC) has demonstrated dramatic reductions in mortality. The results are highly durable and persistent, and also support the role of polypectomy.

Results of the Minnesota Colon Cancer Control Study, which included more than 46,000 participants, aged 50 to 80 years, who were randomized to receive annual or biennial CRC screening with FOBT, or no screening, showed a relative risk for CRC-related mortality of 0.68 in the annual screening arm and 0.78 in the biennial screening arm through 30 years of follow-up. This translated into risk reductions of 32% with annual screening and 22% with biennial screening.

The Minnesota study confirms the findings of two RCTs of biennial CRC screening with FOBT carried out in the United Kingdom and Denmark

see FOBT, page 18

OPINION

Colonoscopy— Facts *The New York Times* Omitted

Farid Naffah, MD, MS
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If you happened to come across *The New York Times* article "The $2.7 Trillion Medical Bill: Colonoscopies Explain Why U.S. Leads The World in Health Expenditures" (by Elisabeth Rosenthal, June 2, 2013), you undoubtedly felt outraged by what you read, perhaps even betrayed. Outraged to learn about the exorbitant cost of colonoscopy and the profit-mongering schemes of those who provide the service. Betrayed by the insight that the entire thing may have been a fraud: Your colonoscopy may not have even been medically necessary.

On the other hand, if you were a patient at any one of the 5,300 physician-owned and operated ambulatory surgery centers (ASCs) across the country, you may have felt perplexed, even confused. You could not easily dismiss the

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INSIDE

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By Gary H. Hoffman, MD and Stephen Yoo, MD ....page 51

CLINICAL REVIEW
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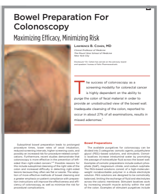
Bowel Preparation for Colonoscopy: Maximizing Efficacy, Minimizing Risks
By Lawrence B. Cohen, MD



PRODUCT ANNOUNCEMENT
see page 59 for product information
Medivators' Jet Prep Flushing Device
for cleansing of GI mucosa during endoscopic procedures

FROM THE BENCH TO THE BEDSIDE
see pages 10-11
Solesta for the Treatment of Fecal Incontinence
Mitchell A. Bernstein, MD, FACS, FASCRS

Separation of Medicine and State

Re: "Dear Professor Flexner: Medicine Is a Business, as Well as a Public Trust," by Nicholas V. Costrini, MD, PhD, MBA. *Gastroenterology & Endoscopy News* January 2014;65:6.

Once again, Dr. Costrini provided a well-written essay that was a pleasure to read regarding medicine being a business.

Many years ago, one of our best medical residents went into private practice and took on a partner who was not a physician, but an MBA. At the time I thought this was rather unusual. He subsequently developed a very successful urgent care center.

Although I agree with Dr. Costrini that health care is a business, I do not believe that medicine should be thought of as a business. I do agree that for some MDs, an added MBA would be very beneficial, as well as for the future of a well-managed health care system—but for most MDs, I believe this would be a disservice.

Our purpose as physicians should be to make our patients feel well in an efficient health care delivery system. Gastroenterologists frequently have comforted our patients by freeing them of anxieties while performing endoscopies and communicating test results. In fact, spending extra time talking to our patients may accomplish the same thing.

What we need is a health care system that values the time we spend with our patients, and spends less time focused on our business practices. The business should be left to the MBAs, and perhaps the few among us with an MD and an MBA.

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The Lowdown on Burnout in Medicine
Resolutions for Mitigating Stress and Avoiding Burnout in 2014
New Oral HCV Drugs Show Lasting Efficacy
'Disclose-and-Investigate' Approach To Malpractice Claims Pays Off

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profusion of tales, quotes, figures and anecdotes carefully compiled by *The New York Times*. Yet you could not wrap your mind around the story, simply because the story did not reflect your own experience. Indeed, no one at the vast majority of ASCs ever sees the astronomical bills cited by *The New York Times*, and few, if any, of our patients perceive us as profligate moneymakers.

So why the discrepancy? Could "all the news that's fit to print" have omitted a few facts fundamental to the understanding of health care cost and delivery, but perhaps cumbersome to their message?

Ms. Rosenthal Opts for Sensationalism: Price Is Not a Reflection of Quality

In *The New York Times* article, Ms. Rosenthal tells a compelling story of four patients who were dismayed after undergoing a screening colonoscopy when they faced the whopping charges they incurred, totaling $6,385, $7,563.56, $9,142.84 and $19,438, respectively. Although they all enjoyed insurance coverage and had no out-of-pocket outlays, and although the actual payment on each of those charges was only on the order of $3,500, that amount is still shocking. We agree.

What Americans pay for colonoscopy varies widely, and as Ms. Rosenthal correctly pointed out, the price is in no way a reflection of quality. Indeed, variations in price should arouse suspicion in a society that has increasingly regarded medical services as commodities. The very notion of quality has eluded our payors, government-funded programs (i.e., Medicare and Medicaid) and private insurers alike. A consultation, for example, is valued by its "level of complexity," a seemingly reasonable estimate of merit but in effect a ludicrous appraisal of worth. Complexity is measured by the amount of data gathering, no matter how irrelevant or unnecessary the time spent on the task. Neither diagnostic accuracy nor appropriateness of therapy even enters the picture. Our system derides efficiency and correctness in favor of verbosity. In fact, the pay-for-performance rules enacted in conjunction with the Affordable Care Act, and exalted as a way to promote quality, do little to improve it. The so-called "quality measures" are at best marginal to the management of disease and their impact is insidious. Readily achieved, they create a collectivist standard of valuation, which sidesteps the essence of medical practice and makes a mockery of clinical excellence.

> **The so-called 'quality measures' are at best marginal to the management of disease and their impact is insidious. Readily achieved, they create a collectivist standard of valuation, which sidesteps the essence of medical practice and makes a mockery of clinical excellence.**

How are we then to expect that the price of colonoscopy would bear any relationship to the preeminence of care?

Payments to Hospitals Far Higher Than ASCs

Commercial insurance carriers compensate hospital outpatient departments generously for colonoscopy, as they do for other services, with the tendered sum frequently exceeding $2,500. ASCs owned by hospitals and considered part of the hospital outpatient department are paid a similar amount. Physician-owned ASCs, on the other hand, are a different entity altogether, but Ms. Rosenthal fails to establish that distinction with clarity. Reimbursement to ASCs for colonoscopies, as well as other procedures, is but a small fraction of what is paid to hospitals. According to a survey conducted by the Ohio Association of Ambulatory Surgery Centers, the average ASC reimbursement for a colonoscopy by commercial insurance carriers in 2012 was only $787.

Medicare reimbursement is even lower. In our area, screening colonoscopy is reimbursed at $523, which includes the professional fee of $215.42 and the facility fee of $307.53. If anesthesia is used, which is optional, it generates an additional payment averaging $124, bringing the total to $646.95.

With payments so modest, what is the explanation for the startling charges exposed by Ms. Rosenthal in her *New York Times* article? The story remains untold, leaving the reader with indignation over the unconscionable abuses that have riddled our system. Well, perhaps portions of our system.

The Disparity Between Charges and Payments

Charges that appear on a patient's bill often seem excessive, but payments commonly amount to a thin slice of the charge. Medicare payments are fixed for physician-owned ASCs, whereas commercial insurance settles an amount predetermined by contractual agreement. Conversely, hospital compensation follows a different calculation. Medicare pays hospitals a base facility fee equal to 178% of the total fee paid to an ASC, and itemized charges follow, making for a bloated total.

see Colonoscopy, page 8

Editor's note—*Dr. Naffah's article was originally published online at www.avamargastro.com/PDF/Colonoscopy-Facts_the_NY_Times_Omitted.pdf. It is reprinted here with his permission. Also see the related article, "The U.S. Trillion-Dollar Medical Bill: 99.6% Is Not Related to Colonoscopy," by Victoria Stern.* Gastroenterology & Endoscopy News *December 2013;64:1,8,10,13-14,27,34.*

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Commercial insurance payments to hospitals are even higher, but the payment formula is typically prearranged.

Why then do hospitals and physicians maintain artificially high charges? Ms. Rosenthal states that they constitute a starting point for negotiations. Negotiations between hospitals and insurance companies are impervious to public scrutiny. When it comes to physicians, however, reimbursement is mostly set by the insurer, with minimal bargaining room for the provider. Indeed, the offer to join an insurer's provider panel entails acceptance of that insurer's fee schedule. When a provider is excluded from a certain panel because the insurance plan chooses to funnel patients to other providers, or when proposed payments are unacceptably low, that provider may still bill the insurance plan on behalf of enrollees who seek his services, provided the plan includes out-of-network benefits. Inflated charges then become pertinent because payment is calculated as a percentage of the charge. Depending on the market, that stance may eventually pressure the insurance company to contract with the provider or the enrollee to change insurance plans. Although those instances are few and in no way typical of the industry at large, the high charges are sure to raise eyebrows when the underlying dynamics are misconstrued. It is an unfortunate state of affairs that has resulted from the inequity of insurance contracts.

Ms. Rosenthal describes the move from office endoscopy to ASCs as a 'lucrative migration for physicians,' who started cashing in on the abundant new demand for the service—the coronation of their lobbying efforts!

Rosenthal's Attack on Physician-Owned ASCs Unfounded

Colonoscopy was largely an office procedure, Ms. Rosenthal states, when it was approved by Congress as a screening test for colon cancer. She suggests that the anticipation of a substantial increase in the number of colonoscopies spurred gastroenterologists' interest in ASCs for financial gain. There is only one fee for an office procedure—the professional fee—but in an ASC, gastroenterologists would benefit from a supplemental facility fee. She describes the move from office endoscopy to ASCs as a "lucrative migration for physicians" who started cashing in on the abundant new demand for the service—the coronation of their lobbying efforts!

Not only is that characterization demeaning to physicians, it is unfounded. In 1998, when colonoscopy was approved as a screening procedure, the vast majority (75%) of endoscopies were performed in hospitals, and ASCs already were growing in robust numbers. Office-based endoscopy already had given way to ASCs, as physicians, patients and regulators alike understood the many advantages. ASCs provide a safer environment, convenience and easy accessibility, as well as a high level of expertise provided by the availability of trained personnel. Other benefits include responsive, nonbureaucratic environments tailored to patients' needs, more convenient locations, ease in scheduling and shorter waiting times. According to a 2009 report from KNG Health Consulting, 70% of ASC volume growth between 2000 and 2007 was due to migration from hospitals to less costly ASCs.

Besides, the economic reality of office-based endoscopy compared with ASCs is not what Ms. Rosenthal's article suggests. In our area, for example, office-based screening colonoscopy is reimbursed by Medicare at $388.21, whereas the professional fee for the same procedure performed at an ASC is only $215. Of course, an ASC entails a facility fee of $307.53, bringing the total payment to $523. The difference in cost between screening colonoscopy at an office and an ASC is therefore only $135, an amount largely offset by the expense of maintaining, staffing and operating the facility, with the myriad of regulations that govern it. We believe that safety alone, not to mention comfort and the other amenities, is well worth the small price increase. Surely, those who indulge in spending billions on green energy to "save the environment" will warmly embrace that trifling surcharge, as they must cherish human life.

ASCs Provide 40% in Savings to Medicare, 50% to Patients

The large majority of services performed at ASCs, including colonoscopy, are offered at a cost far lower than that at hospitals. Not only do ASCs produce approximately 40% in annual savings to the Medicare program, but the savings translate to an estimated 50% in out-of-pocket costs for patients. As Nancy-Ann DeParle, former administrator for the Centers for Medicare & Medicaid Services observed, physicians have no reason to apologize for their investments in ASCs but instead should be proud of the contribution they have made in holding down the cost of ambulatory surgery; no other group would have come forward and put up their own money to accomplish this.

The difference in cost between screening colonoscopy at an office and an ASC is therefore only $135, an amount largely offset by the expense of maintaining, staffing and operating the facility, with the myriad of regulations that govern it.

No Evidence of Overutilization, According to OIG

In 2009, Ms. Rosenthal asserts, gastroenterologists who bought into a surgery center performed 27% more procedures. If the insinuation is that unnecessary procedures were being performed, it is without substance. The Ambulatory Surgery Center Advocacy Committee has examined similar claims and misconceptions. According to Andrew Hayek, chair of the committee, the increase in the number of surgical procedures performed in ASCs is due to a variety of positive factors, including the transition of procedures and services from outpatient facilities to the less costly ASC setting, as well as patient preference and cost savings. In the case of screening colonoscopy, public awareness of the test continues to grow, driving up the numbers, although screening rates are still considerably lower than recommended. Regarding overutilization, even the Office of Inspector General, the federal agency charged with prosecuting fraud, recognized the benefits of physician-owned ASCs: It stated that the risks for improper payment for referrals were relatively low.

The move away from office-based endoscopy was primarily motivated by the desire for better service, patient acceptance and safety concerns, particularly during a period that witnessed the largest proliferation of malpractice lawsuits in the history of medicine. It is an aberration to recriminate gastroenterologists because they are hardworking. Working hard when you own a business, as when a physician owns his practice, is typical of any industry. It should be commended and rewarded. Sadly, the inexorable escalation of regulations, coupled with declining reimbursement, is now forcing physicians to trade their practices for hospital employment. It is an unfortunate trend, quickly leading to higher costs for medical services, notwithstanding the erosion of access, efficiency and quality. With the loss of their practices, physicians also lose enthusiasm and dedication, and their productivity dwindles.

Propofol: Benefit or Superfluous Expense?

Ms. Rosenthal takes issue with the use of propofol as a sedative for colonoscopy, contending that it increases cost but is unnecessary. Propofol may result in respiratory depression, and most states mandate that it be administered by anesthesia personnel to ensure expertise in resuscitation techniques. Nurse anesthetists are usually entreated with that task, rather than anesthesiologists, whose charges may be considerably higher. In either case, however, Medicare reimbursement is fixed for ASCs, with commercial insurance generally paying somewhat more.

The introduction of propofol as a sedative for colonoscopy was initially met with resistance because of its added expense, but has gradually gained acceptance and is now in great demand, attesting to the added value it brings. Its detractors continue to argue that it is an extravagance fomented by anesthesiologists, with the complicity of gastroenterologists, conspiring to gouge an unsuspecting public. Ironically, it turns out that propofol was exactly what the public wanted. It provides restful sleep and a refreshed feeling upon awakening. Patients familiar with it invariably prefer it to older sedatives, which left them groggy, unsteady and confused. Endoscopists favor it for its capacity to provide deeper sedation at safe doses, without agitation, thus enhancing the quality of the procedure as it relates to polyp detection and removal, particularly when the procedure is lengthy and technically difficult.

Ms. Rosenthal argues that economies of scale should have reduced the cost of colonoscopy, which is being performed in greater numbers. Indeed they have, at least with respect to ASCs. The facility fee has dropped by approximately 25% since 2008. Hospital reimbursement, on the other hand, has not.

Ms. Rosenthal Confuses Screening and Surveillance

Ms. Rosenthal seems to accuse physicians of tacking on unneeded colonoscopies, presumably for the purpose of enriching themselves. She tells the story of a patient

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who was advised by his physician to have a follow-up colonoscopy 19 months after the finding of a polyp, then goes on to denounce that physician because "medical guidelines do not recommend such frequent screening." Clearly, she does not understand the difference between screening and surveillance.

She quotes James Goodwin, MD, a geriatrician at the University of Texas Medical Branch, Galveston, who estimates that one-fourth of Medicare patients undergo the screening test more often than recommended. However, Dr. Goodwin's analysis assumes screening when that code is not actually used and underestimates poor cleansing as a reason for shorter examination intervals. And studies have shown that the rate of inadequate cleansing during the referenced period may have been as high as 26%. Interestingly, Dr. Goodwin's analysis found that extra colonoscopies were more likely to occur in the office setting than in hospitals or ASCs.

Physician owners of ASCs favor price transparency, but as Ms. Rosenthal points out, hospital charges often are shrouded. Sometimes, they are opaque to the point that even physicians who refer their patients for certain procedures cannot get an accurate quote of their costs.

Situations abound in clinical medicine where conventional guidelines and available resources fall short of individual expectations, but physicians usually are left to bear the burden of that responsibility. We care for patients, not collectives. Although abuse admittedly occurs, as in any other trade, Medicare does not cover screening colonoscopies unless performed at appropriate intervals.

Is Colonoscopy in the United States Overpriced?

Ms. Rosenthal labels colonoscopy as the most expensive screening test that healthy Americans undergo, but even that is debatable. A screening colonoscopy is performed only every 10 years in average-risk individuals, generally costing less than $1,000 in an ASC, whereas mammography, with a price tag in excess of $270, is recommended yearly.

She concludes that colonoscopy, along with other medical procedures, accounts for the astronomical cost of health care in the United States and illustrates that point by way of comparison with other countries. Direct cost comparisons between countries are misleading, in that different societal considerations apply to different markets. The Sunday edition of *The New York Times* sells for $5, whereas *The Sunday Times* and *The Guardian* are priced at 2.5 pounds (approximately $3.80) and the Sunday edition of Spain's *El País* goes for a mere €2.2 (approximately $2.86). Is it then fair to say, using Ms. Rosenthal's own words, that "that chasm in price helps explain why the U.S. is far and away the world leader in spending" for news reporting? Have studies concluded that Americans get better news?

She refers to Cesare Hassan, MD, an Italian gastroenterologist who is chair of the Guidelines Committee of the European Society of Gastrointestinal Endoscopy. According to Dr. Hassan, studies in Europe estimated the cost of colonoscopy to range from $400 to $800. Does it follow that pricing in the United States should be modeled accordingly?

Any discussion of the comparative cost of health care without discussion of its legal context and the bureaucracies that surround it is profoundly naive or fundamentally dishonest. In Europe, malpractice lawsuits are few and rarely, if ever, lead to the staggering awards that have become well rooted in U.S. society. Sweden deals with damages under a no-fault patient insurance scheme. Britain, like most of Europe, has a loser-pay-all system: A plaintiff who loses carries the burden of defraying all costs, including those of the defense. By contrast, the perversion of our legal system and its flagrant exploitation causes physicians to fear the prospect of bankruptcy every day of their lives. The fear of lawsuits is indomitable and has created an industry of burdensome tasks and activities, suffused in litanies of senseless verbiage. They are costly, onerous and very time-consuming. Regardless, malpractice insurance premiums have continued to rise.

Furthermore, our bureaucracy is shackling, and snowballing regulations continue to create inefficiencies. If the Brits, the Swedes and the Greeks had a mere caricature of our regulatory and legal environment, their systems would quickly collapse. It is therefore remarkable that our ASCs are able to provide screening colonoscopy at a cost comparable to that of our European counterparts.

Physician owners of ASCs favor price transparency, but as Ms. Rosenthal points out, hospital charges often are shrouded. Sometimes, they are opaque to the point that even physicians who refer their patients for certain procedures cannot get an accurate quote of their costs.

Ms. Rosenthal Hints Colonoscopy May Be Unnecessary

What is most disturbing about *The New York Times* article, however, is that it seeks to cast doubt on colonoscopy as the preferred screening method for colon cancer. It is a question that has been carefully examined and thoroughly researched. Would Ms. Rosenthal opt for fecal occult blood testing or flexible sigmoidoscopy for herself and members of her family? Is she perturbed by the fact that colonoscopy, as other procedures, is a source of income for private physicians? Or is her analysis meant to serve as preparation for the rationing of medical services anticipated under the new health care law?

That colonoscopy is superior to flexible sigmoidoscopy is not just a matter of intuitive sense, as Ms. Rosenthal suggests; it is a matter of common sense. No one would think of doing mammography on a single breast! A town that harbors criminals must be patrolled in its entirety. Keeping watch on the south side allows crime to foster elsewhere. The argument that early lesions may have been hard to detect in some parts of the colon has led to the development of better cleansing solutions, enhanced optics and improved techniques. Colonoscopy has made major strides since its inception. Negating technological advances retrenches it, as it would other inventions, to its early stages of development. Rather than embracing its many advances, the critics of colonoscopy continue to disparage its early limitations. By the same token, the Wright brothers may have seen their efforts thwarted, and transatlantic flights would still be a fairy tale. More people should be encouraged to undergo colonoscopy. It is lifesaving. Fifteen years ago, the case for screening colonoscopy prevailed. Today, that victory would be even more resounding. ■

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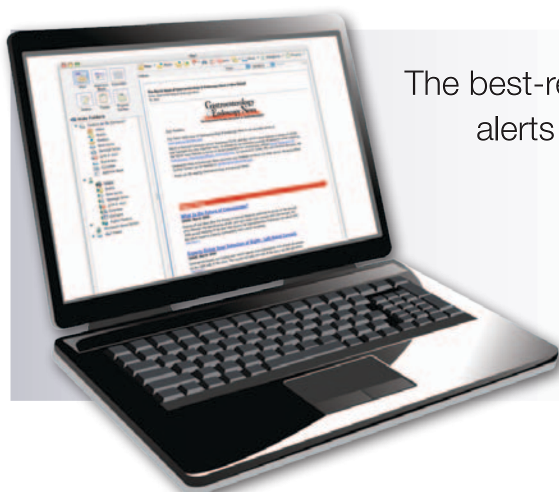

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