Colonoscopy Bundled Payment Model

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Why Colonoscopy?

Clear “beginning” and “end” of episode
◦ Predictable range of expected services helps to limit variability in costs for both payors and providers

Opportunities for cost inflection and quality improvement
◦ Significant opportunity for high quality care at a lower cost
Colonoscopy Bundle Opportunity

Comprehensive prospective bundled payment model to more effectively manage patients who require colonoscopy for:

- As a **preventive** service for a patient with an absence of signs or symptoms who is being screened for CRC
- As a **diagnostic** service for a patient who has undergone CRC screening (e.g. stool, blood, flex sig, CT colonography) and found to have an abnormality that warrants referral for colonoscopy
- As a **surveillance** service for a patient who has previously undergone CRC screening and is now returning for follow-up colonoscopy in accordance with the Multi-Society Task Force (MSTF) specialty society recommendations
- And other diagnostic purposes
Population Exclusions

Patients undergoing therapeutic colonoscopy
  ◦ E.g. control of bleeding, place stent, dilate stricture, remove foreign body, ablate lesion, EMR, EUS, decompress volvulus

Pediatric, age < 18 years

Asymptomatic patients with history of certain pre-malignant conditions:
  ◦ Lynch syndrome (hereditary non-polyposis colon cancer)
  ◦ Familial adenomatous polyposis
  ◦ Peutz-Jeghers syndrome
  ◦ Inflammatory bowel disease requiring four-quadrant biopsies every 10 cm
  ◦ Other defined high-risk conditions
Colonoscopy Bundle

- Pre-op Eval (as required)
- Prep
- Lab Tests
- Antibiotics

- Anatomic Path
- Anesthesia
- Endoscopist

- Facility

- Post-op Eval (as required)

Post-procedure coverage:
- Inadequate prep
- Post-polypectomy bleed
- Incomplete exam

- Pre-op Interval: 3 Days
- Colonoscopy: 1 Day
- Post-procedure Period
Post-Procedural Interval

Post-procedure evaluation/management follow-up

Repeat colonoscopy due to:
- Poor prep/inadequate visualization of lumen
- Incomplete procedure
- Post-polypectomy bleeding (occurring within 14 days of procedure)
- Use of alternative technology (CT colonography, Barium Enema, colon capsule) due to incomplete procedure

\(^1\)Performed by same or different endoscopist within 1 year of procedure
\(^2\)Performed by same or different endoscopist
## Incenting Cost-Efficient Care

<table>
<thead>
<tr>
<th><strong>Fee-for-Service</strong></th>
<th><strong>Bundled Payment</strong></th>
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<tbody>
<tr>
<td>Treat patient in most convenient location of care (e.g., HOPD)</td>
<td>Treat patient in cost-efficient, high-quality facilities (e.g., ASC)</td>
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<td>Compensated for repeat colonoscopies due to poor prep or incomplete procedure</td>
<td>Held accountable for providing high quality, complete examination</td>
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<td>Encouraged to perform surveillance colonoscopies when not clinically warranted</td>
<td>Encouraged to perform surveillance colonoscopies consistent with specialty society recommendations</td>
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<tr>
<td>Population</td>
<td>Adults aged 50 to 75 y</td>
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<tr>
<td>Recommendation</td>
<td>Screen for colorectal cancer starting at age 50 y. Grade: A</td>
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<tr>
<th>Risk Assessment</th>
<th>For the vast majority of adults, the most important risk factor for colorectal cancer is older age. Other associated risk factors include family history of colorectal cancer, male sex, and black race.</th>
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<tbody>
<tr>
<td>Screening Tests</td>
<td>There are numerous screening tests to detect early-stage colorectal cancer, including stool-based tests (gFOBT, FIT, and FIT-DNA), direct visualization tests (flexible sigmoidoscopy, alone or combined with FIT; colonoscopy; and CT colonography), and serology tests (SEPT9 DNA test). The USPSTF found no head-to-head studies demonstrating that any of these screening strategies are more effective than others, although they have varying levels of evidence supporting their effectiveness, as well as different strengths and limitations.</td>
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<td>Starting and Stopping Ages</td>
<td>The USPSTF concluded that the evidence best supports a starting age of 50 y for the general population. The age at which the balance of benefits and harms of colorectal cancer screening becomes less favorable varies based on a patient’s life expectancy, health status, comorbid conditions, and prior screening status. The USPSTF does not recommend routine screening for colorectal cancer in adults 86 y and older.</td>
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<tr>
<td>Treatment and Interventions</td>
<td>Treatment of early-stage colorectal cancer generally consists of local excision or simple polypectomy for tumors limited to the colonic mucosa or surgical resection (via laparoscopy or open approach) with anastomosis for larger, localized lesions.</td>
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<td>Balance of Benefits and Harms</td>
<td>The USPSTF concludes with high certainty that the net benefit of screening for colorectal cancer is substantial. The USPSTF concludes with moderate certainty that the net benefit of screening for colorectal cancer in adults aged 76 to 85 y who have been previously screened is small. Adults who have never been screened are more likely to benefit. Screening is most appropriate for those healthy enough to undergo treatment and those without comorbid conditions that significantly limit their life expectancy.</td>
</tr>
<tr>
<td>Other Relevant USPSTF Recommendations</td>
<td>The USPSTF has made a recommendation on aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in average-risk adults. This recommendation is available on the USPSTF website (<a href="http://www.uspreventiveservicestaskforce.org">http://www.uspreventiveservicestaskforce.org</a>).</td>
</tr>
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</table>

For a summary of the evidence systematically reviewed in making this recommendation, the full recommendation statement, and supporting documents, please go to http://www.uspreventiveservicestaskforce.org.
Definition of CRC Screening Tests

The Affordable Care Act waives any Part B coinsurance that would otherwise apply for certain recommended preventive services, including screening colonoscopies.

Effective January 1, 2015: expenses incurred for a screening colonoscopy, and the anesthesia services furnished in conjunction with such tests, will not be subject to the Part B deductible and will not count toward meeting that deductible.
Preparing and E/M visit covered for Screening Colonoscopy


The following are now covered without patient financial responsibility when provided as part of screening colonoscopy:

- Pre-procedure E/M
- Pathology

Because the Departments' prior guidance may reasonably have been interpreted in good faith as not requiring coverage without cost sharing when performed in connection with a colonoscopy screening procedure, the Departments will apply this clarifying guidance for plan years (or, in the individual market, policy years) beginning on or after the date that is 60 days after publication of these FAQs (e.g. December 23, 2015).

Guidance does not apply to Medicare.
Patient responsibility when a CRC screening becomes a procedure

Section 1834(d)(3)(D) of the Act states that, “[i]f during the course of such a screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under this part shall not be made for the screening colonoscopy but shall be made for the procedure classified as a colonoscopy with such biopsy or removal.”

As a result, when an anticipated screening colonoscopy ends up involving a biopsy or polyp removal, Medicare cannot pay for this procedure as a screening colonoscopy.

- Medicare pays 80 percent of the diagnostic colonoscopy procedure and the beneficiary is responsible for paying Part B coinsurance.
- Similarly, the beneficiary is responsible for paying Part B coinsurance for any covered anesthesia.
A colonoscopy bundle can:

Align
- Patient expectations about waiver of cost-share for preventive services when patient undergoes initial screening service then referral for colonoscopy
- Healthcare professionals to perform high quality, cost-effective, patient centered services

Support transparency initiatives around colonoscopy quality
- Complete exam rate
- Prep adequacy rate
- Screening Adenoma Detection Rate (ADR)
- Complication rate

Recommended interval for next CRC screening / surveillance procedure
- Scope and non-scope tests