PCC
Preventing Colorectal Cancer

CMS Cutbacks on Reimbursement Rates May Effect Colonoscopy Screening Availability

Preventing Colorectal Cancer, a not-for-profit organization, encourages policymakers, health officials, health plan executives and others to support colonoscopies as the Gold Standard colorectal screening method. This issue brief is one in a series of publications aimed at educating the public on concerns surrounding a colorectal cancer colonoscopy screening.

The Issue

The recent Medicare reimbursement reductions for several colonoscopy codes which took effect January 2016 may greatly impact the population that is most at risk for colorectal cancer.

In the United States, colorectal cancer is the second leading cause of cancer related deaths and yet it is one of the cancers that through screening and healthy choices is preventable and treatable. The Gold Standard for colorectal cancer screening is a colonoscopy utilizing propofol.[1] Since the introduction of propofol as an anesthesia agent, studies have shown that actual procedure times have been reduced[2] but the American Gastroenterological Association argues that changes in technology and screening guidelines have increased the time and intensity of the work.[3] The U.S. Center for Medicare and Medicaid Services (CMS) reduced the reimbursement rate for colonoscopy up to 17 percent on the recommendation of the Relative Value Unit Update Committee.[4,5]

Adverse Effects

The 2016 CMS Physician Fee Schedule Final Rule, reduction in reimbursement rates for colonoscopies was initially proposed last summer and went into effect at the beginning of the year. The cuts were opposed by the American Gastroenterological Association, American College of Gastroenterology and American Society of Gastrointestinal Endoscopy and others, who worked with CMS to mitigate the cuts.

Many policy experts and leading providers believe the reduction of reimbursement for colonoscopies may have far reaching effects. Operational costs are substantial and a significant reduction in reimbursement rates will require practices to scrutinize the efficiency of their practice in order to eliminate costs. This could require private practice providers to merge with other practices to share costs. “In essence, solo GIs or small GI practices may eventually be part of a bigger network,” says Dr. Noel Fajardo, of Las Vegas Gastroenterology and The Las Vegas Surgery Center. “That may or may not change the quality of care.”[6]

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The United States Preventative Services Task Force (USPSTF) has recommended preventive screening for colorectal cancer beginning at the age of 50 and continuing until age 75.[7] As our population ages there will be an increased demand for this preventive service and due to reduction of reimbursement rates March Seabrook, MD, FACG, owner of Consultants in Gastroenterology says, "What many Gastroenterologists may have to do is limit the number of Medicare patients that they see. Since the reimbursement has gone down so much, the one that may suffer the most is the Medicare beneficiary who may need the care the most."[8]

In addition to reduced access the cuts may also impact the field of gastroenterology. New physicians may be less incentivized to enter this specialty. To meet the goal of 80% screening by 2018 set by the National Colorectal Cancer Roundtable, "we need to have a workforce available to do those screenings," Dr. Matthew McNeill, a third-year resident in internal medicine New York University School of Medicine, in New York City said.[9]

Beyond CMS Reimbursement Reductions

The reduction in reimbursement is not the only hurdle that may influence a decision whether to take on Medicare patients.

"Basically, if Medicare denies a claim following either a pre-payment or post-payment review, the appeals process is a complex five step process: redetermination by the Medicare Administrative Contractor, reconsideration by an Qualified Independent Contractor, then hearing by an administrative law judge, then an appeal to the U.S. Department of Health and Human Services' Medicare Appeals Board, and then review by the Federal District Court," Kristina Giyaur, partner at Sauchik & Giyaur P.C. says.[10]

This lengthy delay in the Medicare appeals process creates yet another roadblock in a provider's reimbursement.

While the physicians may be re-evaluating their ability to provide services to the Medicare/Medicaid community, the Medicare patient must also be aware of their responsibility for possible co-pays when undergoing a screening colonoscopy that leads to a biopsy or removal of a growth polyp.

"In this case you [the patient] might have to pay 20% of the Medicare-approved amount for the doctor's services, as well as co-pays in a hospital outpatient setting. In this situation, you [the patient] should not have to pay the deductible. But this means that you [the patient] may not know if you [the patient] have a co-pay until after the test is done, and these costs can be over $1,000.00. You [the patient] may want to talk to your doctor and the facility's billing office about this beforehand."[11]

Conclusion

The Preventing Colorectal Cancer strongly encourages RUC and CMS to reconsider the reduced reimbursement rates for colonoscopy as they update the fees for 2017.[12] In addition to reimbursement rates impacting colonoscopies directly, CMS for 2017 already is proposing updated values for the new CPT moderate sedation codes impacting colonoscopies.

By reducing the reimbursement rates and with the complexity of how coverage decisions are made and paid for already, the federal government will effectively reduce the number of Medicare beneficiaries that will get screened for colon cancer. CMS should be investing more not less into this screening procedure.

The benefits of screening for colorectal cancer are evident in the decline of colorectal cancer mortality in the past decade. As the U.S. aging population grows it is important that the ability to receive a preventive screening remains accessible.

It is important that support is given to initiatives like the Supporting Colorectal Examination and

Education Now (SCREEN) Act of 2015.[13] This bill was introduced in April 2015 in the U.S. Senate by Senator Benjamin Carter and in the U.S. House of Representatives by Representative Richard Neal. Two of its aims were to maintain 2015 Medicare reimbursement rates and eliminate Medicare cost-sharing for the removal of polyps or tissue during a colorectal cancer screening test.

A preventive screening for colorectal cancer is far less costly than treatment for colorectal cancer. All 50-75 year olds should have access to the Gold Standard, a colonoscopy screening.

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Headquartered in Annapolis, MD, PCC is a not-for-profit 501(c)6 advocacy organization with the primary mission to educate both public and private stakeholders about the opportunities to reduce the incidence of colorectal cancer through promoting effective screening, prevention and care options for patients. Membership is open to all individuals and groups. For more information, visit *www.preventingcolorectalcancer.org*.

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ENDNOTES

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