EVOLVING PERSPECTIVES FOR SURVIVAL OF GASTROENTEROLOGY PRACTICE:

A Business Plan Assessment for Improved Economic Success

BY DAVID A. JOHNSON, MD, FACG, FASGE
PROFESSOR OF MEDICINE, CHIEF OF GASTROENTEROLOGY
EASTERN VIRGINIA MEDICAL SCHOOL, NORFOLK, VA

Healthcare reform has brought with it a number of changes that have significant economic implications, in particular, for gastroenterology practitioners. The implications of payment reductions coupled with the loss of the CPT consultation codes have ominous financial consequences. The payment reductions related to the loss of consult codes are particularly relevant to gastroenterologists who have an extremely high percentage of new outpatient and initial inpatient contacts. It is estimated that, respectively, 84.9% and 93.2% of these patient encounters are coded as consultations.[1]

Clearly, this is resulting in a significant decline of the reimbursements from Medicare and Medicaid services. Even more worrisome, it is estimated that in the not-too-distant future, this loss in revenue will be in excess of $50,000 per gastroenterologist as third-party payers incorporate policies to parallel CMS. Total practice revenues have already declined in 83% of practices as per a recent survey by the AMA[2]. Further negative economic changes loom with continued reductions in specific CPT codes for gastroenterology services, as well as the ever-looming sustainable growth rate (SGR) deferred reduction. If the SGR is not addressed in 2011, it will trigger approximately a 28% fee reduction in Medicare reimbursements as of January 1, 2012[3].

David A. Johnson, MD, FACG, FASGE

RESPONSE TO THESE LOOMING NEGATIVE ECONOMIC

Practitioners need to have a defined action plan for their respective practices. This would include development of alternative revenue streams, reductions in overhead, increasing efficiency through ancillary providers, and positioning for incentives from CMS (e.g., meaningful use, E-prescribing, maintenance of certification, value-based purchasing, physician quality reporting), and scrutiny of the fiscal structure of their medical practice.

The purpose of this discussion will be to provide an evaluation of practice economics via a specific, time value analysis of direct care related patient interactions in our gastroenterology practice.

EVALUATION AND MANAGEMENT (E&M) CODE ANALYSIS

We evaluated office visit reimbursements by the standard time allocations for CPT coding, which ranged from 15 to 40 minutes for E&M office visits level 1 to level 5 (99211-99215). Standard Medicare reimbursement rates were applied to these unit visits and for comparison, an analysis was provided using our largest third-party payer, Anthem/Well Point.

Further adjustments were made to provide a dollar-per-minute ($/min) analysis for each of these timed visits. Additionally, we included an office-based procedure of hemorrhoid banding (CPT

Table 1: Comparison of specialty coding for consults for outpatient and inpatient services.

Specialty	Percentage of new outpatient codes as consultations	Percentage of initial outpatient codes as consultations
Neurology	89.10%	91.90%
Ophthalmology	71.00%	97.70%
Gastroenterology	84.90%	93.20%
Orthopedics	46.80%	78.80%
Dermatology	31.20%	96.20%
Pulmonary	85.00%	79.00%
Hem/Onc	86.70%	68.70%
Cardiology	82.90%	76.40%
General Surgery	76.40%	81.30%
ENT	58.80%	96.00%

Table 2: Comparative reimbursements for evaluation and management codes (99211-99215) and hemorrhoidal banding (46221) for Medicare and Anthem ($/min).

Office Visit	Time (min)	Medicare	$/min	Anthem	$/min
99211	15	$18.65	$1.24	$28.64	$1.90
99212	15	$38.02	$2.53	$54.47	$3.63
99213	15	$68.89	$4.59	$78.05	$5.20
99214	25	$95.76	$3.83	$115.11	$4.60
99215	40	$129.35	$3.23	$131.95	$3.30
46221	10	$222.01	$22.20	$302.65	$30.26
Less Device Cost			$16.20		$24.27

code 46221), which can be done either in our office or in our office endoscopy suite. For this procedure, we use the CRH O'Regan System™ **(CRH Medical, Vancouver, BC, Canada - http://www.crhsystem.com/md-program.html)**

By the analysis of revenues generated, it was clear the peak $/min reimbursement for E&M codes was for level 3 coding (99213). This was evident both for standard Medicare rates, as well as for the private payer, Anthem. For Medicare, the $/min allowable reimbursements were second highest for a level 4 visit (99214), followed by diminishing amounts for level 5 (99215). Interestingly, there was a higher $/min charge at the level 2 visit (99212) for Anthem reimbursement compared to a more complex level 5 visit (99215).

Across all comparisons, hemorrhoid banding (46221) provided a significant dollar-per-minute reimbursement advantage with a range of 5 to 20 times greater from Medicare, and 5.8 to 15 times greater from Anthem. Even when the device cost of the CRH O'Regan System™ was subtracted from the reimbursement levels, these favorable reimbursement advantages persisted from Medicare at 16.2 $/min and from Anthem at 24.3 $/min compared to the highest reimbursements for E&M visits (99213) at 4.59 $/min and 5.20 $/min, respectively.

OFFICE ENDOSCOPY VERSUS HEMORRHOID BANDING ANALYSIS

As gastroenterologists view endoscopy as their most lucrative reimbursement, we also analyzed the endoscopy reimbursements for our highest volume procedures (endoscopy and colonoscopy) versus hemorrhoid banding. Virginia is a state with a certificate of need (CON) restriction, which for the most part, precludes physician-owned ambulatory surgical centers (ASCs). Accordingly, office endoscopy is performed at negotiated rates (for facility and tray charges) without the advantage of a designated ASC status. It should also be noted that the Medicare reimbursements for office endoscopy do not reimburse separately for a facility fee as is done for ASC or hospital outpatient departments. As such, the Medicare fee for office endoscopy includes both the professional and office expense components.

In our office endoscopy, due to differences in the staffing, we book intervals of 30 or 45 minutes depending on which room is utilized. The analysis was thereby done for both room utilization assessments. Upper endoscopy (CPT 43235) and colonoscopy (CPT 45378) were compared with hemorrhoid banding (CPT 46221).

Of note, hemorrhoid banding reimbursement is somewhat higher if done in an ambulatory surgical center by a margin of approximately $50 to $75, however this was not included in this analysis given the office based location.

As shown in **Table 3**, $/min reimbursements were higher for colonoscopy than for upper endoscopy, but across all comparisons, hemorrhoid banding demonstrated a consistent advantage with an approximate 2 to 4 times increase based on Medicare rates and 0.1 to 2 times increase for the Anthem reimbursements.

When adjusted for the per case endoscopy overhead and hemorrhoid banding costs, the reimbursement advantage of hemorrhoid banding became even more apparent, ranging from 2.5 to 8 times greater from Medicare (dependent on the 30 versus 45 minute room) compared to EGD or colonoscopy. Similarly, this advantage was also evident for the Anthem reimbursements with a value of 0.2 to 2.2 times greater $/min for hemorrhoid banding.

Table 3: Comparative reimbursements for endoscopic procedures and hemorrhoidal banding with adjustments for costs ($/min).

Procedure	Time (min)	Medicare	$/min	Anthem	$/min
43235 (EGD)	30/45	$272.18	$9.07/ $6.05	$680.86	$22.70/ $15.13
45378 (Colo)	30/45	$362.15	$12.97/ $8.04	$800.29	$26.68/ $17.78
46221 (HB)	10	$222.01	$22.20	$302.65	$30.20
Less Cost Endoscopy per case overhead equal to $168.40					
Procedure	**Time (min)**	**Medicare**	**$/min**	**Anthem**	**$/min**
43235 (EGD)	30/45	$272.18	$3.46/ $2.31	$680.86	$17.08/ $11.39
45378 (Colo)	30/45	$362.15	$6.46/ $4.31	$800.29	$21.06/ $14.04
46221 (HB)	10	$222.01	$16.20	$302.65	$24.26

IMPLICATION OF NO-SHOWS

Clinicians would agree that maximal time efficiencies are contingent on an on-time schedule. This is dependent not only on the care provider being on schedule, but also the patient arriving on time to allow adequate intake processing and preparation for the visit or procedure. The financial impact of a "no-show" on the actuarial analysis of our practice revenue revealed some very interesting findings.

Focusing on the evaluation of the E&M codes showed that the greatest $/min reimbursement rates, incorporating the effect of one no show/hr, were greatest for the level 3 visit (99213).

This is evident for both Medicare and Anthem analyses. It should be noted however, that the economic consequences of a no-show for level 5 (99215) are quite striking. Given the time allocation for this visit is 40 minutes, the wide gap in the schedule certainly has a tremendous negative impact on the practice's revenue.

Consistent with the previous analyses, hemorrhoid banding (46221) allocated at 10 minute intervals has remarkable implications for an

Table 4: Comparative reimbursements for evaluation and management codes with effect of one no-show during the hour block ($/hr).

Office Visit	Time (min)	Medicare	1 no show $/hr	Anthem	1 no show $/hr
99211	15	$18.65	$55.95	$28.64	$85.92
99212	15	$38.02	$114.06	$54.47	$163.41
99213	15	$68.89	$206.67	$78.05	$234.15
99214	25	$95.76	$134.06	$115.11	$161.15
99215	40	$129.35	$64.67	$131.95	$65.97
46221	10	$222.01	$1,110.05	$302.65	$1,513.25
Less Device Cost			$810.05		$1,213.25

extremely favorable revenue advantage ranging from 10 to 20 times greater dollar per hour ($/hr) advantage from Medicare and 8 to 22 times greater $/hr advantage from Anthem. Corrected for the expenses of the CRH O'Regan System™, the cost advantage persisted at $810 and $1,213 per hour from Medicare and Anthem reimbursement respectively.

Comparing the procedural codes for endoscopy and colonoscopy and adjusting for room turnover (30 versus 45 minutes), hemorrhoid banding in our endoscopy unit demonstrated a significant advantage. Banding outperformed endoscopy and colonoscopy by 3 to 8 times with respect to $/hr for Medicare reimbursement and was 1.8 to 4 times greater for Anthem reimbursement.

The cost advantage difference was highest when the no-show was in a room with a 45 minute block schedule.

Table 5: Comparative reimbursements for endoscopic procedures and hemorrhoidal banding with effect of one "no-show" during the hour block ($/hr).

Procedure	Time (min)	Medicare	1 no show $/hr	Anthem	1 no show $/hr
43235 (EGD)	30/45	$272.18	$272.20/ $136.10	$680.86	$680.90/ $340.40
45378 (Colo)	30/45	$362.15	$362.10/ 181.10	$800.29	$800.30/ $400.10
46221 (HB)	10	$222.01	$1,110.00	$302.65	$1,513.20

Less Cost
Endoscopy per case overhead equal to $168.40, personnel cost w/o scope $67.36

Procedure	Time (min)	Medicare	1 no show $/hr	Anthem	1 no show $/hr
43235 (EGD)	30/45	$272.18	$36.40/ $18.20	$680.86	$512.50/ $222.50
45378 (Colo)	30/45	$362.15	$126.40/ $63.20	$800.29	$631.90/ $315.90
46221 (HB)	10	$222.01	$870	$302.65	$1,273.25

Adjustment for cost was also performed using similar methods. With this analysis, the endoscopy per case overhead cost was charged if the procedure was done ($168.40). If endoscopy was not done for a no-show case, a personnel and non-utilized room cost of $67.30 per 30 minutes was charged. Again, results showed that the hemorrhoid banding (46221) had consistent and significant cost advantage, consistent with all of the analyses presented thus far.

CONCLUSIONS

The findings from this examination on the economics of a GI practice have significant implications. As physicians evaluate the impact of healthcare reform and the expected declining reimbursements on their practices, a focused look at the specific areas of revenue is of critical importance to identify the specific areas of economic strength and weakness. With healthcare legislation, regulation, and declining reimbursements, gastroenterologists need to better understand the revenues that are derived from each of their services provided. Reviewing above results, it is quite apparent that the perception by gastroenterologists that endoscopy services provide the highest levels of reimbursement is not accurate. In fact, the revenue stream provided through hemorrhoid banding proved to be more advantageous across all presented clinical codes, including evaluation and management codes as well as endoscopy procedures. The benefit became even more apparent when the implications of "no-shows" were considered. Given that no-show occurrence is not unusual in a practice schedule, the missed reimbursement implications need to be factored into an actuarial analysis of practice revenue and expense.

Clearly, the economic pressures on a gastroenterology practice will continue to increase. From a business perspective, a paradigm shift is needed towards a better understanding of how GI practice is conducted on a routine basis. The traditional focus on providing quality services and achieving excellent outcomes will remain a priority for practices; however, to maintain an economic viability, gastroenterologists must hold a more complete understanding of their fiscal strengths and weaknesses and the related implications for sustaining their businesses!

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Dr. David A. Johnson, MD, FACG, FASGE is Professor of Medicine and Chief of Gastroenterology at Eastern Virginia School of Medicine. He has published extensively in the internal medicine/gastroenterology literature contributing over 350 articles/chapters/ abstracts in peer-reviewed journals and authored another 250 invited reviews. He is has been extensively involved in committees of the national GI societies and is a Past President of the American College of Gastroenterology and currently serves on the American Board of Internal Medicine (Gastroenterology) Board of Examiners. He serves as the Gastroenterology Technical Advisory chair for the National Quality Forum (NQF) and as well is steering committee member quality outcomes NQF task force. He is the past co-editor of *Reviews in Gastroenterologic Disorders* and is the current co-editor of *American College of Gastroenterology GI Universe*, co-editor *J Medicine*, GI section editor for *Medscape Gastroenterology, Medscape GI* consultant corner, as well as the esophageal section editor for *Journal Watch Gastroenterology (New England Journal of Medicine).* He is on numerous editorial boards and reviews for 21 medical journals including all of the GI journals as well as a number of prestigious internal medicine journals including: *Annals of Intern Med, Archives of Intern Med, Am J Med, Lancet.* He has recently co-authored the ACS/Multisociety GI task force colon cancer screening guidelines, the ACG CRC screening guidelines as well as ACC/ACG/AHA consensus document on NSAID and antiplatelet issues for cardiology and gastroenterology.