ABSTRACT

Objective: Abnormal uterine bleeding (AUB) is an increasingly common reason for hysterectomy in gynecologic outpatient procedures. Polyps and sub-mucosal fibroids, a common etiology of AUB, can be removed during office hysteroscopy (OH) with a minimally invasive hysteroscopic tissue removal device (TRUCLEAR System, Smith & Nephew.) (HTR) allowing increased patient convenience, safety, and at least equal effectiveness compared to current treatments performed in hospitals or ambulatory surgery centers (ASCs). But because current procedural coding does not allow offices to bill patients for new technology HTRD. Thus they are sufficiently reimbursed and lose money on the procedure. We sought a coverage and payment method to equitably share value between Blue Cross Blue Shield of North Carolina (BCBSNC), the office and the patient. The advantages of OH using a HTRD include that patients are seen and treated during a single office visit, experience a shorter procedure time, may avoid preliminary medications and general anesthesia, and return to activity sooner. Expenses for patients and payers could be reduced because overhead costs of an office procedure should be lower than those performed at traditional procedure sites. Methods: A mutually beneficial OH fee schedule for patients, offices, and BCBSNC was determined. A global procedure fee was calculated estimating how often the HTRD device would be used during OH. The higher overhead charges of hospitals or ASCs for staff, operating and recovery room fees, plus avoidance of general anesthesia, allowed an increase in office reimbursement sufficient to offset HTRD cost while allowing a net reduction in overall BCBSNC payments. Results: In 2011 we did 48 OH for BCBSNC patients. In 2011 exclusion criteria for treatment in OH vs hospital/ASC would have included patient preference, medical comorbidities, and likelihood for need use of a HTRD. From October 2 of 2013 (when the pilot program was initiated), until December 31, 2014, 20 patients received in-office hysteroscopies (polypectomy 15; myomectomy 5) using the HTRD in BCBSNC patients. This resulted in lower insurance deductibles equaling a savings of $500 to $3,000 per procedure for patients, and $1,000 to $6,500 in savings per case for BCBSNC. Conclusions: Patients experience convenience and lower deductible costs for receiving at least equally safe and effective treatment during a single office visit compared to scheduling a follow-up treatment at a more costly site of care.

METHODS AND ACTIONS

Evidence review:

The Practice and BCBSNC met to review clinical evidence and stakeholder economics describing the benefits of shifting indicated patients to office treatment.

Cost assessment:

Office procedure costs (facility, staff, equipment, disposables and payment method) were assessed. The higher overhead charges of hospitals or ASCs for staff, operating and recovery room fees, plus avoidance of general anesthesia, allowed an increase in office reimbursement sufficient to offset HTRD costs while allowing a net reduction in overall BCBSNC payments. Results: In 2011 we did 48 OH for BCBSNC patients. In 2011 exclusion criteria for treatment in OH vs hospital/ASC would have included patient preference, medical comorbidities, and likelihood for need use of a HTRD. From October 2 of 2013 (when the pilot program was initiated), until December 31, 2014, 20 patients received in-office hysteroscopies (polypectomy 15; myomectomy 5) using the HTRD in BCBSNC patients. This resulted in lower insurance deductibles equaling a savings of $500 to $3,000 per procedure for patients, and $1,000 to $6,500 in savings per case for BCBSNC. Conclusions: Patients experience convenience and lower deductible costs for receiving at least equally safe and effective treatment during a single office visit compared to scheduling a follow-up treatment at a more costly site of care.

Background:

Hysteroscopic removal of indicated polyps and fibroids in office appears as safe and effective as done in a hospital or ASC1-4 Measurable patient benefit is increased patient convenience, safety, and lower deductible costs for receiving at least equally safe and effective treatment during a single office visit compared to scheduling a follow-up treatment at a more costly site of care. Results: In 2011 we did 48 OH for BCBSNC patients. In 2011 exclusion criteria for treatment in OH vs hospital/ASC would have included patient preference, medical comorbidities, and likelihood for need use of a HTRD. From October 2 of 2013 (when the pilot program was initiated), until December 31, 2014, 20 patients received in-office hysteroscopies (polypectomy 15; myomectomy 5) using the HTRD in BCBSNC patients. This resulted in lower insurance deductibles equaling a savings of $500 to $3,000 per procedure for patients, and $1,000 to $6,500 in savings per case for BCBSNC. Conclusions: Patients experience convenience and lower deductible costs for receiving at least equally safe and effective treatment during a single office visit compared to scheduling a follow-up treatment at a more costly site of care. Results: In 2011 we did 48 OH for BCBSNC patients. In 2011 exclusion criteria for treatment in OH vs hospital/ASC would have included patient preference, medical comorbidities, and likelihood for need use of a HTRD. From October 2 of 2013 (when the pilot program was initiated), until December 31, 2014, 20 patients received in-office hysteroscopies (polypectomy 15; myomectomy 5) using the HTRD in BCBSNC patients. This resulted in lower insurance deductibles equaling a savings of $500 to $3,000 per procedure for patients, and $1,000 to $6,500 in savings per case for BCBSNC. Conclusions: Patients experience convenience and lower deductible costs for receiving at least equally safe and effective treatment during a single office visit compared to scheduling a follow-up treatment at a more costly site of care.

Figure 3. Pilot program average allowed payments

Table: Pilot program average allowed payments

<table>
<thead>
<tr>
<th>Facility</th>
<th>Physician</th>
<th>Office</th>
<th>Hospital</th>
<th>ASC</th>
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<tbody>
<tr>
<td>HTRD-NC Average</td>
<td>$2,926</td>
<td>$7,560</td>
<td>$8,956</td>
<td>$5,858</td>
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<tr>
<td>Allowed Payment</td>
<td>$14,500</td>
<td>$9,125</td>
<td>$3,100</td>
<td>$6,760</td>
</tr>
<tr>
<td>Case</td>
<td></td>
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</tbody>
</table>

SUMMARY & CONCLUSIONS

Alignment of reimbursement incentives between an office-based practice and BCBSNC resulted in savings of $1,000 to $6,500 per case for BCBSNC and, depending on the benefit plan, patient savings of $500 to $3,000 per case. Because there could not be a separate diagnostic and treatment professional fee reimbursement for the office, offices records from the review period were matched to the BCBSNC claims database to determine what percent of all patients receiving diagnostic hysteroscopy in the office would have a qualifying indication for hysterotonic tissue removal to be performed in association with the foster. This was the basis of the weighted average reimbursement payment negotiated for patients treated in the office.

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