CLINICAL UPDATE

Hemorrhoidal Banding and Anesthesia Partnerships as Ancillary Services to Gastroenterology Practices

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G&H Why should gastroenterologists consider adding ancillary services to their practices?

JK Over the past several years, the Centers for Medicare and Medicaid Services (CMS) has made reimbursement cuts to diagnostic colonoscopy and other gastrointestinal (GI) services. The impact from these reimbursement cuts has led gastroenterologists to explore other avenues to lessen expenses, including merging into supergroups, seeking salary-based employment, and retiring early. At the same time, as the US population ages and the demand for GI services increases, a shortage of gastroenterologists creates other challenges. Ancillary services (eg, hemorrhoidal banding and anesthesia partnerships, both of which are offered by CRH Medical; ambulatory surgery centers; pathology; clinical research; diagnostic services; infusion; and nutrition and weight management) offset the reimbursement cuts that have been occurring in GI businesses by providing supplemental income. These services are also beneficial for recruitment, as the additional revenue streams and opportunities within GI practices are attractive to physicians who are finishing their fellowship or are relocating. Furthermore, ancillary services can increase patient satisfaction and equip physicians with an all-in-one practice.

G&H What are the main benefits and limitations regarding adding hemorrhoidal care as an ancillary service?

MG There are typically 3 barriers to adding hemorrhoidal care to a GI practice. The first is what I refer to as the "ick factor," as the thought of taking care of hemorrhoids is not very attractive to many gastroenterologists. However, hemorrhoidal care can be a rewarding part of a GI practice due to the fact that patients requiring this service do so well and provide a lot of positive feedback. In my own experience, the average duration of symptoms prior to treatment has been in excess of 5 years, which may be one of the reasons why patients are so grateful for the care that they receive.

The second obstacle to adding hemorrhoidal care is the fact that most GI fellowship programs do not include relevant material in their training program. However, gastroenterologists can receive the necessary training, including a didactic presentation on anorectal disease, from CRH Medical. A surgeon initially helps guide clinicians through the banding process and remains available to answer questions or provide additional information.

Lastly, there is some concern that a complication might occur during the banding process. However, the

complication rate from the banding procedure is approximately 0.5% to 1%. Pain is the most frequent adverse event and can be treated with topical agents. Bleeding, the second most frequent adverse event, is rarely serious enough to require treatment. If significant bleeding does occur, it can be easily managed with an anoscope or flexible endoscope without the need for a surgical consult. Using the CRH O'Regan System (CRH Medical) and the recommended associated treatment protocols, the treatment success rate is greater than 90%.

The technique itself does not require preparation, sedation, or the use of any special instrumentation. Hemorrhoidal banding can be performed in an ambulatory surgery center or office setting with only examination gloves, lubricant, and a banding kit and takes approximately 60 seconds to complete. The procedure has up to a 99% efficacy rate and is painless. No capital expenditure is required, and the procedure offers favorable reimbursement.

G&H Who is the ideal candidate for hemorrhoidal banding?

MG The ideal candidate is any patient who has recurrent symptoms of any severity (eg, itching, bleeding, swelling, prolapse, leakage, or other "external" symptoms) and who wants to be treated. Patients who have failed other forms of treatment can also undergo hemorrhoidal banding. The vast majority of patients who undergo treatment have Grade II or III internal hemorrhoids.

G&H What is the training process for hemorrhoidal banding?

MG The training that is provided by CRH Medical includes both didactic material as well as a hands-on banding session, led by a surgeon, that utilizes CRH technology. Training can be conducted in an ambulatory surgery center or office setting, and is offered at no cost to the trainee. In order to allow gastroenterologists to feel comfortable with treating the whole gamut of anorectal issues, CRH Medical offers complimentary continuing medical education (CME), which provides access to videos that are available through the American Society for Gastrointestinal Endoscopy. Follow-up, advanced training, and 24-hour consultative service are also offered free of cost.

Nurse practitioners and physician assistants can receive comprehensive anorectal training as well. Because hemorrhoidal banding is translatable into most advanced-practitioner skill sets, training for advanced practitioners is similar to what is given to physician providers. Post-training support is also available at this level. Training advanced practitioners in this procedure allows GI practices to manage the influx of new patients that is created by this ancillary service, increases job satisfaction, and provides additional revenue for the practice.

G&H How does the hemorrhoidal banding procedure work?

MG Prior to hemorrhoidal banding, the patient should undergo a digital examination and an anoscopy. Then, with the patient in the left lateral decubitus position, the ligator (CRH O'Regan System) is inserted into the anal canal past the level at which the band will be deployed. The device is then pulled back until a ridge on the edge of the ligator can be felt at the anal verge. The device is directed toward the hemorrhoid, which is aspirated into the syringe and locked. The syringe is then twisted 180 degrees in both directions to ensure that the patient is not experiencing a cutaneous pinching sensation. If the patient experiences pain or pinching, the band is too close to the dentate line and should be placed more proximally. If no pinch is felt, the band can be deployed and the device removed. The clinician should perform a rectal examination to confirm the proper placement of the band, and readjust it if necessary. Additional hemorrhoidal columns can be treated at subsequent visits spaced 2 to 3 weeks apart. Band ligation of hemorrhoids has demonstrated to be an effective nonsurgical approach to hemorrhoids, with a low complication rate.

G&H What is the financial impact of hemorrhoidal banding?

MG The addition of hemorrhoidal banding can benefit a practice financially, both directly and indirectly. The revenue that is generated by performing the banding procedure is significant, and GI practices have found that offering the procedure attracts a substantial number of new patients, many of whom require colonoscopy and/or other GI care. In 2011, Dr David A. Johnson examined the economics of a GI practice and found that the revenue stream provided by hemorrhoidal banding was higher than the revenue brought in by endoscopic procedures.

G&H What changes have CMS made to GI anesthesia reimbursement, and how do they impact revenue?

JK In July 2017, CMS originally proposed deleting 2 existing Current Procedural Terminology (CPT) codes, which were both valued at 5 base units, and introducing new CPT codes for anesthesia furnished during upper

endoscopic procedures (00731 and 00732) and for anesthesia furnished during lower endoscopic procedures (00811, 00812, and 00813).

The Medicare Physician Fee Schedule Final Rule, which was announced on November 2, 2017 and went into effect on January 1, 2018, confirms the proposal to set the number of base units for codes 00731, 00732, 00811, and 00813 at 5, 6, 4, and 5, respectively. Additionally, the Final Rule reduced the number of base units for code 00812 from 4 to 3. The impact from these changes has been a decrease in anesthesia revenue by approximately 10.5%, which we believe correlates to an income reduction of approximately 18%.

G&H Why should GI practices consider providing anesthesia as an ancillary service?

JK Providing anesthesia as an ancillary service has been shown to be beneficial for patients, physicians, and facilities. Besides overall patient satisfaction, patients undergoing anesthesia have noted an improved quality of life and a reduction in pain. Additionally, patients undergoing anesthesia move less during procedures, which can help physicians. The use of anesthesia also allows physicians to promote predictable recovery times. Facilities are able to increase efficiency and throughput and provide for a standard of care. As previously mentioned, the main reason GI practices should consider offering anesthesia as an ancillary service is that it provides opportunities for supplemental revenue, which can play a role in future physician recruitment.

G&H What are the benefits of approaching anesthesia as a joint venture?

JK Partnering with a company such as CRH Medical for anesthesia services provides several operational and financial benefits. A joint venture allows gastroenterologists to provide high-quality service to their patients while the partnering company manages the overall operation of anesthesia care, including staffing anesthesia providers (such as board-certified anesthesiologists and experienced certified registered nurse anesthetists), training, and credentialing. GI practices can choose from a variety of business models, each of which is tailored to suit the needs of that practice. For example, practices that already provide anesthesia may joint venture their business, thus monetizing a portion of their anesthesia business while retaining ongoing revenue, which is a motivation to grow the practice. Other practices may choose to transition from outsourcing their anesthesia or from using conscious sedation to providing anesthesia in-house. CRH Anesthesia in particular develops, manages, and tracks quality assurance programs and indicators in addition to surveying patient satisfaction and benchmarking performance. Lastly, partnerships allow gastroenterologists to focus on their core business instead of developing or sustaining this business on their own. They no longer have to keep up with the management aspects of the business, some of which include peer review strategies, compliance, and revenue cycle management.

G&H What are the barriers to adopting anesthesia as an ancillary service?

JK Aside from the daily expertise that is necessary to run an anesthesia business, the 2 largest barriers for physicians include staffing and/or recruiting of anesthesia providers and handling an efficient revenue cycle management system.

This column is based on a Product Theater presentation at the 2018 Digestive Disease Week meeting sponsored by CRH Medical Corporation. Mr Kreger serves as president of CRH Anesthesia for CRH Medical Corporation. Dr Guttenplan serves as the medical director for CRH Medical Corporation.

Suggested Reading

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