

## MASTER CLASS

**Payment changes drive hysteroscopy to the office****Publish date:** November 22, 2017**By:** Aarathi Cholkeri-Singh, MD

The benefits of integrating hysteroscopy into office practice have been compelling for some time. An in-office approach is patient centered, more efficient, and clinically valuable. It also has had the potential to be economically valuable for practices that are able to perform a mix of diagnostic and therapeutic/operative hysteroscopies.

Dramatic shifts within the Centers for Medicare & Medicaid Services fee schedule in 2017 – and commensurate changes in the private insurance market – have now ramped up this value, making it all the more important that physicians consider investing in equipment and adopting an in-office approach.



Dr. Aarathi Cholkeri-Singh

At the crux of this shift has been a 237% increase, effective at the start of 2017, in the physician office payment for hysteroscopic endometrial biopsy and/or polypectomy (CPT code 58558). According to national payment amounts, performing this procedure in the office earned an average of \$1,382.07 in 2017, compared with \$409.60 in 2016. This reimbursement will hold steady in the 2018 Medicare Physician Fee Schedule [Final Rule <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1676-F.html>](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1676-F.html) published in November.

Central to this increase, in turn, is a significant increase in practice expense reimbursement. CMS has included the costs of equipment, including the costs of the hysteroscopic fluid management system and the hysteroscopic tissue resection system, in recalibrating the practice expense relative value unit.

Clearly, physicians are being encouraged to move hysteroscopic procedures into the office.

**Weighing an investment**

In the Medicare resource-based relative value scale payment system, relative value units (RVUs) are calculated based on three elements: physician work, practice expenses, and malpractice cost. Each component is multiplied by a factor that accounts for geographic cost variations, and each total RVU is multiplied by a dollar amount known as the conversion factor.

This isn't the first year that the payment system – a standard for many other payers in determining compensation – allows for higher reimbursement for some hysteroscopic procedures performed in the office. The practice expense relative units have been higher for some time for certain hysteroscopic procedures – such as diagnostic hysteroscopy (code 58555), removal of a foreign body (58562), endometrial ablation (58353), and biopsy/polypectomy (58558) – when these procedures are performed in the office, compared with the hospital or an ambulatory surgical center.

However, the new increase in physician office payment for 58558 changes the equation significantly and ensures a better return on investment. In 2017, CMS offered a 12% increase in the facility fee paid to hospitals and a 2% increase in the facility fee paid to outpatient surgery centers when a hysteroscopic biopsy/polypectomy is performed in these settings, but the physician reimbursement in these cases declined 11%-19%.

On the flip side, an in-office approach to hysteroscopic biopsy/polypectomy has been rewarded in 2017 through a significantly higher practice expense RVU and a “non-facility” total RVU of 38.51 – a 237% increase over the 2016 practice expense RVU of 11.4. Such dramatic differences between the practice RVUs – and total RVUs – for in-office and out-of-office hysteroscopic procedures will

continue for 2018.

Private insurers are following suit, and some are increasing their reimbursement even more. As of June 2017 in metropolitan Chicago, Blue Cross Blue Shield has been reimbursing in-office hysteroscopic biopsy/polypectomy at approximately \$2,424.00; prior to June, the allowable charge was \$742.81.

Equipment costs for in-office hysteroscopy can range from \$15,000 to \$35,000, based on whether equipment is new or used, the number of trays, and the style of camera and monitor system. Ancillary equipment/disposables cost \$10 or less, and \$40-\$50 or less for diagnostic and many operative procedures, respectively. The prices for handpiece mechanical resection disposables or tissue removal devices vary based on company and blade type, so these costs will need to be accounted for if such equipment is incorporated. Again, the CMS increase in reimbursement for offices accommodates for the inclusion of these disposables as well as fluid management disposable costs.

If diagnostic hysteroscopy (as a separate procedure) is the procedure that you perform most often, the investment will look less favorable. However, if you anticipate performing hysteroscopic biopsies and/or polypectomies as well, the investment will look significantly more favorable now than it has in past years.

Once you have established your in-office system, even those procedures that are weighted equally for the practice setting (non-facility) and hospital/surgery center setting, such as hysteroscopic lysis of adhesions (58559), can be easily incorporated from a financial point of view.

In addition to reimbursement levels, it's important to consider the efficiencies of in-office hysteroscopy. The setup is relatively simple and requires a dedicated exam room, not a surgical suite. You can perform one or two annual exams while the assistant sets up the room and greets each patient, for instance, or see another established patient while the assistant discharges your patient and turns the room over. Hysteroscopy at the hospital, or even at an ambulatory surgical center, involves time driving, changing, and waiting for anesthesia.

For our patients, most importantly, an in-office approach offers less out-of-pocket expense (deductibles), less time away from family/work, avoidance of general anesthesia/intubation, and greater patient comfort from being within a familiar environment. For diagnostic procedures, the patient can be in and out in less than 30 minutes, and for operative procedures, she can be in and out in 1-2 hours, compared with more than 4 hours at the hospital.

## Preparing the office

Physicians in Europe have been performing in-office hysteroscopy for years. But in the United States, it is a newer concept, with most gynecologic surgeons having been taught to perform surgical procedures in the operating room. Undoubtedly, our unfamiliarity with in-office surgery has played a role in the slow uptake of hysteroscopy in our practices.

It requires a culture change. Performing surgery while the patient is awake forces us to be more alert to issues such as the room temperature, the lighting, and the noises that a patient may hear. All of these factors can affect a patient's anxiety level. We need to train ourselves to be acutely aware of the surroundings and to incorporate a "vocal local" approach – a form of nonpharmacologic pain management that involves speaking directly and reassuringly with the patient in order to reduce anxiety and avoid/distract from pain.

Open communication about everything the patient will see hear and feel before, during and after the procedure is important.



*Courtesy Dr. Amy Garcia*

A dedicated exam room, with stirrups attached to the table, a movable light, and video equipment are the basic needs for doing operative procedures in the office.

Focusing on these details can improve your patient's experience and your professional relationship with her.

In an earlier edition of Master Class, I addressed instrumentation and technique, elements of pain control and anesthesia, and the value of a vaginoscopic approach to hysteroscopy. Vaginoscopy avoids the use of a vaginal speculum or cervical tenaculum, and is so tolerable to many patients that I use minimal premedication and only rarely use any local anesthetic and/or sedation, even for biopsies and polypectomies.

Preparing your practice for hysteroscopy is a multifaceted process involving not only the purchase and/or rental of equipment but also compliance with guidelines, regulatory considerations, patient rights, hospital transfer arrangements, and other issues. ACOG's Report of the Presidential Task Force on Patient Safety in the Office Setting is a [valuable resource](#)

<[http://www.scopeforwomenshealth.org/uploads/downloads/Resources/4Report-of-the-Preesidential-Task-Force-on-Patient-Safety\\_FINAL.pdf](http://www.scopeforwomenshealth.org/uploads/downloads/Resources/4Report-of-the-Preesidential-Task-Force-on-Patient-Safety_FINAL.pdf)> for getting started. The report discusses anesthesia levels and the benefits and risks of a contract anesthesiologist, for instance, as well as the role of and processes for credentialing, privileging, and accreditation.

Checklists and drills are important for ensuring a safe practice, and the report discusses each of these elements and provides templates and examples. A sample "Office Surgical Safety Checklist" to be used for each procedure, for instance, has sections with preoperative steps (before anesthesia/analgesia, and before incision), intraoperative steps, postoperative steps, and discharge steps. Similar in format to checklists used in the aviation industry, each step has a box to be checked off to verify completion.

Mock drills help ensure that staff are knowledgeable about their roles and coordinated in their response to potential complications, such as vasovagal episodes, respiratory arrest caused by laryngospasm, and local anesthetic toxicity reactions. And, while not the focus of drills, we also must be prepared to manage cervical strictures and stenosis, cervical laceration, uterine perforation, and other complications.

Outpatient surgery guidelines from organizations such as the American College of Surgeons, the Joint Commission, state regulatory agencies, and professional liability insurers, can also be useful resources. With the use of ACOG's report and other such resources, the set-up and the transition to in-office hysteroscopy need not be daunting. For most gynecologic surgeons, it will all feel comfortable after only a few procedures.

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**Charles E. Miller, MD**

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