

Growth Guide

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Upper Gastrointestinal Diseases

Overview

Upper GI diseases* are among the most common conditions treated in the OP setting, with up to 15% of the population experiencing heartburn or regurgitation at least weekly. Proton pump inhibitors, launched in the US in 1990, revolutionized medical management of upper GI disease, but patients now increasingly opt for advanced endoscopic therapies in quest of a definitive cure.

Key Facts

- Sg2 projects 31% OP growth over the decade, with procedural volumes growing 23% to 46%.
- About 10 million OP upper GI endoscopies are performed annually (41% of total endoscopies). GI endoscopies account for about 1 in 4 ASC cases.
- Payments for advanced upper GI endoscopies have jumped; those for diagnostic endoscopies remain flat.
- Despite the premium paid to hospital OP facilities, high device costs for some procedures (eg, BE ablations) make it difficult to break even on these cases.
- Cost pressures increasingly have shifted cases to ASCs, but physician-owned facilities face heightened scrutiny.

Smart Growth Snapshot

Sg2 is focused on smart growth, which includes:

- **Appropriateness Analysis:** Are you growing volumes in clinically appropriate settings across the care continuum?
- **Profitability Analysis:** Are you growing volumes that are financially favorable to your organization?
- **Sustainability Analysis:** Are you growing volumes that are supported by regional demand trends?

Upper GI Services	IP	OP
Appropriateness		
Profitability		
Sustainability		

Scale of Impact Key

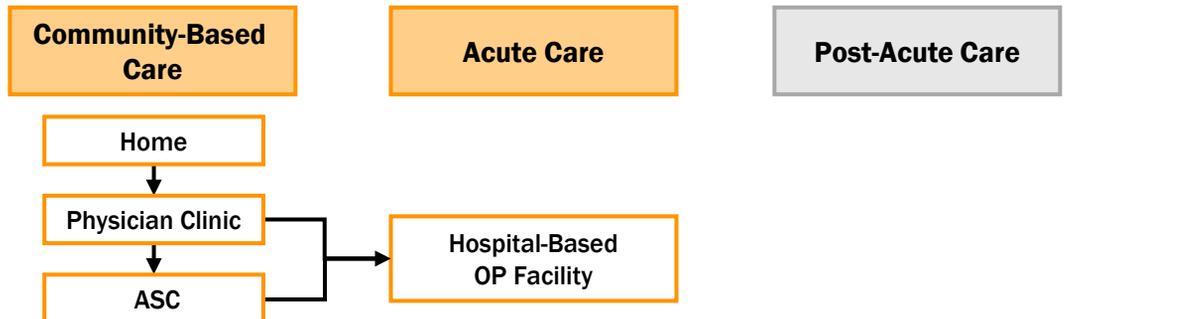
Fully achieves goal

Does not achieve goal



System of CARE Connections

Optimal growth requires connections across your System of CARE. Most upper GI services are provided in the OP setting, with hospital-based OP facilities and comprehensive disease centers reserved for advanced surgical and endoscopic cases.



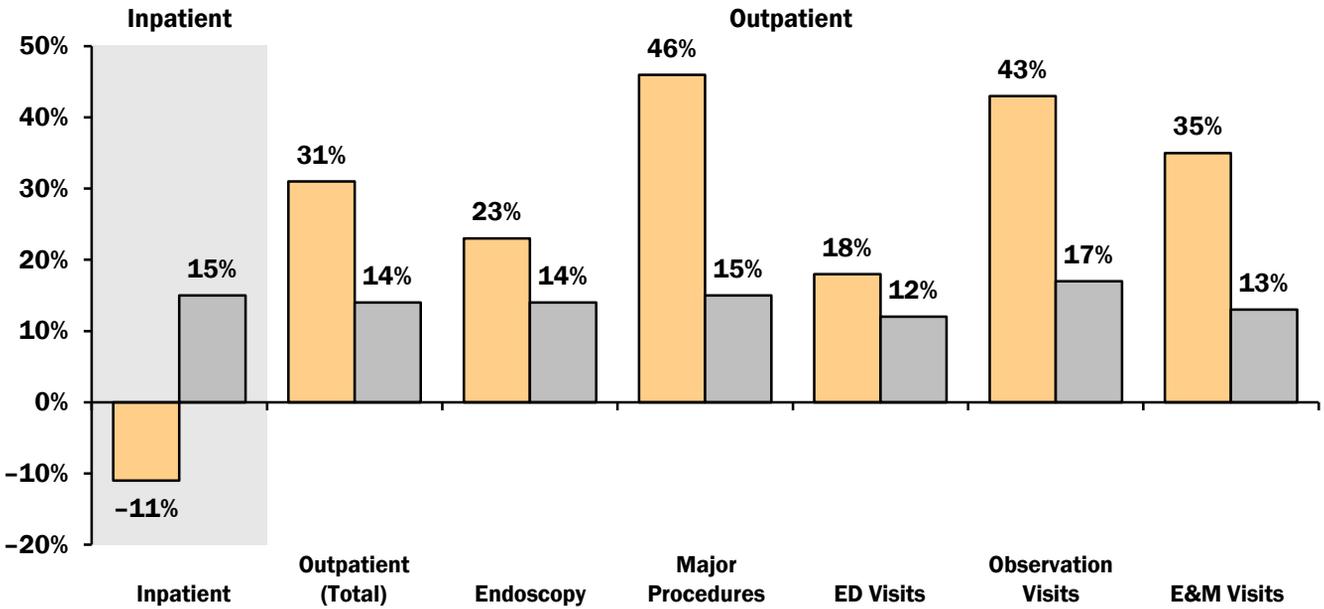
*Includes gastroesophageal reflux disease (GERD), Barrett's esophagus (BE) and gastroduodenal ulcers. ASC = ambulatory surgery center; CARE = Clinical Alignment and Resource Effectiveness; GI = gastrointestinal; IP = inpatient; OP = outpatient.

Impact of Change® Growth Forecast



Esophageal Disease and Gastroduodenal Ulcer Forecast US Adult Market, 2012-2022

■ Sg2 Forecast
■ Population-Based Forecast



2012 Volumes	Inpatient	Outpatient (Total)	Endoscopy	Major Procedures	ED Visits	Observation Visits	E&M Visits
	286K	18M	3.7M	160K	541K	92K	11.5M

2012 Medicare Payments for Hospital-Based and ASC Procedures

APC Code*	Relevant CPT® Codes	Brief Description	Hospital OP		ASC	
			2012 Payment	2011-2012 % Change	2012 Payment	2011-2012 % Change
0141	43200, 43202, 43235, 43239	Diagnostic endoscopy with or without biopsy	\$592	-3%	\$341	-0.9%
0384	43219, 43256	Transendoscopic stent placement, including predilation	\$2,046	+7%	\$1,179	+9.4%
0419	43231, 43232, 43237, 43238, 43259	Endoscopic ultrasound, including ultrasound-guided biopsies	\$887	+45%	\$511	+49%
0422	43216, 43228, 43257	Removal/ablation of tumor(s) or lesions	\$1,819	+58%	\$1,048	+62.2%

*Partial list covering the majority of upper GI procedures. CPT is a registered trademark of the American Medical Association. ED = emergency department; E&M = evaluation and management; APC = Ambulatory Payment Classification; CPT = Current Procedural Terminology.

Impact Summary

Growth Opportunities

Prime growth opportunities include:

- Comprehensive digestive disease services, including bariatric surgery, hepatology and general surgery
- Ancillary revenue sources, such as pathology, anesthesiology and oncology
- Advanced endoscopic procedures, including ablation for BE, esophageal dilation balloons, esophageal stents and endoscopic GERD therapies

Profitability

- Profitability depends on maintaining the right procedure mix and high throughput.
- Downstream revenue can be significant. A 6- to 8-member gastroenterology group annually can generate about \$7.5M in procedural facility fees, \$2M in anesthesia fees, \$1.4M from imaging, \$1.1M from pathology and >250 admissions.
- Increased scrutiny of physician-owned ASCs ultimately may result in payers curtailing payment increases that had enabled the shift to this setting.

Appropriate Utilization

- GERD increases BE risk, which increases the risk for esophageal adenocarcinoma. Yet true incidence of BE and the percent of cases that progress to cancer remain the subject of debate.
- Ongoing research is calling into question the value of screening endoscopies for upper GI conditions.
- AGA's position statement on BE management, updated in March 2011, advises:
 - Only high-risk patients should be screened.
 - High-grade dysplasia should be treated with endoscopic eradication therapy.
 - Such therapy should be an option for patients with confirmed low-grade dysplasia.

Sustainability

- Increasing obesity rates, use of medicine with GI side effects and expanding OP options will drive growth.
- Any move toward global budgets also should drive down use of unproven, costly procedures.
- Although the goal of surgery is a definitive cure for reflux, esophageal disease and GERD likely will remain chronic conditions for the foreseeable future.

Sg2 Position

Upper GI services offer many opportunities for provider systems, ranging from primary care management of epigastric pain to innovative endoscopic diagnostics and therapeutics. The continued high prevalence of GI conditions translates to a strong market opportunity for both community providers and tertiary centers. In certain locales, however, dominant gastroenterology groups may have already captured these volumes. Hospitals seeking to increase their role in this arena should recognize that economic pressure may be reopening some of these markets and seek ways to overcome historical tensions with GI groups to pave avenues for collaboration.

Implementation Considerations

- Offering upper GI care may enable hospitals to expand their ambulatory care footprint. Options include purchasing endoscopy centers, employing gastroenterologists or pursuing joint ventures with key GI groups to maintain and grow volumes as more cases shift to ASCs. Such alignment also helps systems maintain market share for complex procedures that must remain in hospital facilities, especially expanding endoluminal options.
- As evidence for some interventions evolves, care paths that ensure adequate trials of medical therapy and appropriate patient selection for endoscopic and surgical procedures will demonstrate value to stakeholders.
- Programs pursuing advanced endoscopic techniques should participate in research networks, work closely with payers, and support education and training to promote innovation and drive the evidence base for appropriate adoption of endoscopic therapeutics.
- Successful comprehensive digestive disease programs have overcome turf battles with a strong physician champion respected by both gastroenterologists and surgeons, a patient-centered approach to care, and care coordinators to help determine appropriate utilization of surgical and medical services.

AGA = American Gastroenterological Association.

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Strategic Considerations

	Overview	Action Steps
Program Components	Complementary services give programs necessary scale, but a formal program structure may be an essential differentiator in some markets.	<ul style="list-style-type: none"> Combine upper GI services with lower GI, biliary and pancreatic disease services. Where volumes warrant, offer multidisciplinary surgical and medical services for select digestive conditions (eg, obesity, liver disease). Consider developing a comprehensive digestive disease service line to enhance value and decrease overhead if physician relationships are strong enough to support it. Ensure market standing through ASGE recognition for endoscopy care.
Workforce	Optimal care delivery necessitates cross-specialty collaboration and broad team support.	<ul style="list-style-type: none"> Ensure effective interplay among gastroenterologists and general surgeons to optimize care paths. <ul style="list-style-type: none"> Use nurse navigators to appropriately triage patients. Include a pathologist in the care team to ensure accurate diagnosis of dysplasia in patients with BE and to drive ancillary pathology revenue. Commit to established nursing ratios: Suggested minimum is 2 RNs to staff the pre- and postprocedure areas, 1 per procedure room. Plan for additional RNs for complex and pediatric endoscopic procedures. Round out the team with GI techs and anesthesiologists.
Technology	Options for diagnostic endoscopic imaging and endoluminal therapies abound, but payment hinges on appropriate use.	<ul style="list-style-type: none"> Stay abreast of the latest endoscopic technologies and techniques; safety concerns that required some earlier devices to be pulled from the market have dampened innovation. Carefully assess BE ablation devices. Vendors are driving use even while patient selection criteria continue to evolve. Recognize insurance coverage limitations for investigational endoscopic GERD treatments.
Channel Management	Strong referral streams will be key to profitability as competition heats up and payment tightens.	<ul style="list-style-type: none"> Bolster PCP relationships to drive referrals and streamline care. Take a deliberate approach to alignment options with key GI groups. <ul style="list-style-type: none"> Negotiate with an eye toward downstream revenue. Pursue interoperability of electronic health records.

Sg2 Resources

- Customized Intelligence: Future of Freestanding GI Clinics
- Customized Intelligence: Incisionless GERD Surgery
- Customized Intelligence: Increasing Endoscopy Capacity

ASGE = American Society for Gastrointestinal Endoscopy; PCP = primary care physician.

Sources: Society of Gastroenterology Nurses and Associates, Inc. [SGNA Position Statement: Minimum RN Staffing for Patient Care in the Gastrointestinal Endoscopy Unit](#). Revised August 2008; AGA. *Gastroenterology* 2011;140:1084–1091; Fields R. [Which are the most common surgery center specialties?](#) *Becker's ASC Review* October 25, 2011; Callard A. [5 tips for updating a GI center's technology](#). *Becker's ASC Review* October 24, 2011; Physicians Endoscopy. [GI Service Line Integration](#). Accessed November 2011; McMillin DF. *Gastrointest Endosc Clin N Am* 2002;12:285–296; Pace F et al. *Aliment Pharmacol Ther* 2008;27:375–384; Smith MJ et al. Encouraging innovation in endoscopic technology: ASGE seeks to foster advances in endoscopic technology through new "PIVI" initiative. *Gastroenterology & Endoscopy News* 2011;62; Green S et al. *Expert Rev Gastroenterol Hepatol* 2011;5:731–743; Sg2 Interviews and Analysis, 2011.

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