Medicare Coverage of CT Colonography Is Unlikely

BY ALICIA AULT

The Centers for Medicare and Medicaid Services has proposed to refuse coverage of computed tomography colonography for colorectal cancer screening.

"The evidence is inadequate to conclude that CT colonography (CTC) is an appropriate colorectal cancer screening test," the agency said in a posting to its Web site.

The proposal followed a Medicare Evidence Development and Coverage Advisory Committee (MEDCAC) meeting in which a majority of committee members expressed moderate confidence in the technology's ability to determine with adequate specificity and sensitivity the presence of polyps greater than 10 mm, but less confidence in detecting smaller polyps. Committee members expressed even less confidence in the technology's ability to increase overall cancer screening rates. Additionally, they said that it did not appear that CTC had a similar ratio of cost per life-years saved, compared with optical colonoscopy.

At that meeting, representatives of the U.S. Preventive Services Task Force reiterated its position that there is insufficient evidence to assess the benefits and harms of CTC.

When the Centers for Medicare and Medicaid Services (CMS) began its process of considering coverage of the technology in May 2008, it received 100 comments, 79 of which favored adding CTC as a Medicare-covered benefit.

Among those commenting in support of coverage for asymptomatic, average-risk patients over age 50 years were the American Cancer Society, American College of Radiology, American Gastroenterological Association, and the Medical Device Manufacturers Association.

In its comments, the AGA said that it would support coverage only if CMS required providers to meet technology, training, and reporting standards. CTC also should only be covered as part of Medicare's Coverage with Evidence Development process, said the AGA. At the November MEDCAC meeting, AGA reiterated its position.

In its evaluation, CMS said none of the available evidence focuses on "a population more representative of the Medicare population." A younger population likely has a lower polyp prevalence, lower positive rates, and lower rates of referral to optical colonoscopy, the agency said. Further, since Medicare already covers screening tests known to lead to positive health outcomes, a new test should show evidence of increasing overall screening, according to the proposed decision. A new test should not lead to duplicative testing or switching from one test to another, and so far, there's nothing to say that CTC would lead to either of these scenarios, which would increase resource use, said CMS.

Finally, there are no data showing that screening with CTC leads to less cancer, the agency said.

CMS is accepting comments on this proposed decision until mid-March, but it is unlikely to change its direction by the time it makes its final decision shortly thereafter. ■

To view the proposal or to comment, go to http://tinyurl.com/dmpcok.

CMS Limits Bariatric Surgery Coverage for Type 2 Diabetes

BY JOYCE FRIEDEN

The Centers for Medicare and Medicaid Services has made it official: Medicare beneficiaries with type 2 diabetes and a body mass index less than 35 kg/m^2 will not receive coverage for bariatric surgery.

The announcement finalizes a proposed decision memo issued by CMS last November. "While recent medical reports claimed that bariatric surgery may be helpful for these patients, CMS did not find convincing medical evidence that bariatric surgery improved health outcomes for these non-morbidly obese individuals," the agency said in a statement.

In the statement, Dr. Barry Straube, the agency's chief medical officer and director of its Office of Clinical Standards and Quality, said, "Limiting coverage of bariatric surgery in type 2 diabetic patients who are not considered clinically obese is part of Medicare's ongoing commitment to ensure access to the most effective treatment alternatives with good evidence of benefit, while limiting coverage where the current evidence suggests the risks outweigh the benefits."

In its 2006 national coverage decision for bariatric surgery in morbid obesity, CMS said that Medicare would cover three procedures—open and laparoscopic Roux-en-Y gastric bypass surgery, open and laparoscopic biliopancreatic diversion with duodenal switch, and laparoscopic adjustable gastric banding—for beneficiaries who have a BMI over 35, have at least one comorbidity related to obesity, and have been previously unsuccessful with medical treatment for obesity.

Also at that time, the agency asked for comments on whether Medicare should cover various gastric and intestinal bypass procedures. The decision is an outcome of that query, and it clarifies that diabetes is one of the comorbidities included in the criteria. ■

POLICY & PRACTICE

Court Shields Billing Records

An appeals court has ruled against the release of Medicare billing records, which was sought by the group Consumers' Checkbook so that it could grade physicians on quality. The nonprofit had filed a Freedom of Information Act request for all 2004 Medicare claims from physicians in several locations, and the group won in a lower court in 2007. But the Department of Health and Human Services, joined by the American Medical Association, appealed, and the U.S. Circuit Court of Appeals for the District of Columbia ruled that HHS does not have to release the information. Disclosure of the requested data would constitute an invasion of physicians' privacy, the appeals court said. The AMA praised the decision. "The court clearly found that the release of personal physician payment data does not meet the standard of the Freedom of Information Act, which is to provide the public with information on how the government operates," Dr. Jeremy Lazarus, AMA board member, said in a statement.

IOM Report: HIPAA Is Inadequate

The government's main health-privacy rule doesn't adequately protect people's health information, yet it hinders important health research, a report from the Institute of Medicine concluded. The privacy rule, stemming from the Health Insurance Portability and Accountability Act (HIPAA), is difficult to reconcile with other federal regulations governing research and personal information, the IOM report said. In addition, organizations that collect and use health data vary greatly in how they interpret and follow HIPAA, leading to potential privacy problems, the report said. Congress should create an entirely new approach to protecting personal health information in research, separate from the HIPAA rule, an IOM panel recommended. "We believe there is synergy between the goals of safeguarding privacy and enhancing health research," said panel chairman Lawrence Gostin, a professor of health law at Georgetown University, Washington.

Many People Go Without Drugs

More children and working-age adults are failing to take needed prescription medications because of cost concerns, according to a national study by the Center for Studying Health System Change. In 2007, 1 in 7 Americans under age 65 years reported not filling a prescription in the previous year because they couldn't afford the medication, up from 1 in 10 in 2003. Rising prescription drug costs and less-generous drug coverage probably contributed to the change, the report said. Uninsured, working-age Americans saw the biggest jump in unmet prescription needs between 2003 and 2007, with the proportion going without medications rising from 26% to almost 35% in that time, the report said. However, a growing proportion of working-age Americans with employer-sponsored health insurance also reported going without prescription medications.

FDA on 'High-Risk' List

The Food and Drug Administration faces significant challenges that compromise its ability to protect Americans from unsafe and ineffective products, the Government Accountability Office said in adding the FDA to its biennial "high-risk" list. The GAO gives that label to government programs or agencies that need to address internal mismanagement. In its 2009 report, the GAO said the FDA needs to beef up its foreign-drug inspection program, better manage its reviews of companies' promotional materials, and ensure that drug makers properly present clinical data.

Poll: Affordability Is Tops

Making health insurance more affordable trumps improving quality and expanding coverage among the public's priorities for health care reform, according to a new poll. The survey from the Kaiser Family Foundation and the Harvard School of Public Health found that most people believe that action on health care is important to help the nation out of recession. But when respondents were asked to choose between coverage expansion, cost reduction, and delivery-system change, 4 in 10 named affordability as most important, followed by 3 in 10 who said that expanding coverage is the top priority. Roughly 2 in 10 picked improving the quality and cost-effectiveness of the health care delivery system. Two-thirds of those surveyed favored requiring all individuals to have health insurance, but when told that some people may then have to buy health insurance they consider too expensive or don't want, support for the mandate dropped to 19%.

Humana Supports ID Cards

Humana has become the first health insurer to publicly support the Medical Group Management Association's drive to get standardized, machine-readable insurance cards into people's wallets by next January. "Our goal is to continue working with MGMA and the industry to eliminate waste, create efficiencies, and reduce the hassle factor for providers," Humana Senior Vice President Bruce Perkins said in a statement. Adopting readable cards is part of an overall drive by the company to simplify health insurance administration, he said. MGMA estimates that machine-readable insurance cards could save physician offices and hospitals as much as $1 billion a year by reducing paperwork and avoiding denial of many claims.

—Jane Anderson