JOURNAL OF THE KMA
KENTUCKY MEDICAL ASSOCIATION
Physicians Caring for Kentucky

MARCH 2011/VOL 109/NO 3

Special Articles

March is National Colorectal Cancer Awareness Month

54 Introductory Letter
Kentucky Colon Cancer Screening Program Advisory Committee

55 Barriers to Colon Cancer Screening in Kentucky
John M. Bennett, MD, MPH; Sarojini Kanotra, PhD, MPH; Jennifer Redmond, DrPH; Susan Reffett, RN, BSN; Sue Thomas-Cox, RN, BS

63 The Effect of Insurance on Stage at Diagnosis for Colorectal Cancer Patients in Kentucky
Thomas C. Tucker, PhD, MPH; Bin Huang, DrPH; John M. Bennett, MD, MPH; Eric B. Durbin, MS; Whitney F. Jones, MD

Editorial

75 Unintentional Consequences
Daniel W. Varga, MD

Cancer Comments

70 Colorectal Cancer Screening Tip Sheet
Colon Cancer Prevention Project

72 Snapshot of Colon Cancer
Kentucky Cancer Consortium

Association

52 KMA Annual Meeting
86 Medicare Coding Tip for Colorectal Screening Tests
77 Member-Get-A-Member Campaign
83 People

Departments

50 President's Page
86 Advertisers' Guide
80 Alliance Page
78 Letter to the Editor

Copyright 2011 Kentucky Medical Association

The *Journal of the Kentucky Medical Association* (ISSN 2155-661X) is published monthly by the Kentucky Medical Association, 4965 US Hwy 42, Suite 2000, Louisville, KY 40222, under the direction of the Board of Trustees.

The *Journal*, its editors, and the Kentucky Medical Association do not assume responsibility for the opinions and statements of its contributors and advertisers. The Journal reserves the right to make the final decision on all content and advertisements.

March Madness or Springtime Sanity?

The March Madness we love is basketball tournament frenzies, which ends with cutting down nets and trophies for proud victors. The March Madness we loathe is state and national legislative charades of purchased special-interest bills, neglected substantive legislation, and trivial partisanship, which ends with tearing down of public confidence and leaves trophies of unmet public needs. I write this at half-time (the state legislature is in mid-session). They still have choices between the madness of a wayward, trivialized session or the sanity of solid accomplishments for our Commonwealth's citizens. Which will prevail?

...residency program funding caps sharply exacerbated rural physician workforce shortages

Once again, this legislative session features scope-of-practice expansion bills sought by non-physician practitioners, who cite physician shortages as reason for their own practice expansions. This is not new. Ninety years ago, the AMA came to aid the KMA's lion of public health, J.N. McCormack, MD, in defeating a popular 1922 bill proposing independent practice licenses for minimally trained practitioners in counties with physician shortages. In recent years, the madness of residency program funding caps sharply exacerbated rural physician workforce shortages. Rather than sanely lifting caps and expanding rural primary care residencies, lawmakers chose to allow independent medical practice by non-physicians who have only a fraction of the education and training hours for a fully trained physician. In some cases, non-physician provider programs with bachelors or masters degree level hours have been upgraded somewhat, and the title "doctor" inserted into the degree, but without the program approaching the hours or intensity of a physician's training. Thus, the public is misled by seeing the word "doctor" and expecting skills only a physician can provide. Analysis of competency for complex judgments and skills suggests at least ten thousand hours are necessary for optimal performance.

Education content data gathered by the AMA compares education and training after undergraduate degrees and before practice licensure between different medical disciplines. Required patient care training hours plus combined graduate and residency-fellowship years for physicians are 12,000-16,000 hours and 7-11 years; Nurse Practitioners receive 500-720 hours and 2-4 years; Naturopaths receive 720-1200 hours and 4 years; and optometrists receive clinical hours over 1 year and 4 graduate years. Moreover, non-physician curricula are often directed toward skills that do not contribute to the practice of medicine, although they are legitimate for other disciplines.

An enormous flaw of these bills is intentionally not placing medical scope-of-practice expansions under the Board of Medical Licensure for public protection. Rather, current non-physician scope-of-practice bills place regulation under boards composed of the same non-physician practitioners, who

have flagrant conflicts-of-interest. This is one of the most inappropriate features of the 2011 Optometry Surgery Bill (S.B. 110) that has been rushed through the Kentucky Senate and House with record speed amidst disclosures of exceptional levels of campaign contributions.

Many non-physician practices are set in malls or supermarkets near retail pharmacies. Last year, the KMA achieved regulation of retail clinic practices, which helps substantially. Still, these clinics provide episodic encounters, rather than the continuity of care necessary for optimal chronic disease management, today's major quality and cost issue.

...our citizens deserve optimally educated caregivers serving in appropriate roles

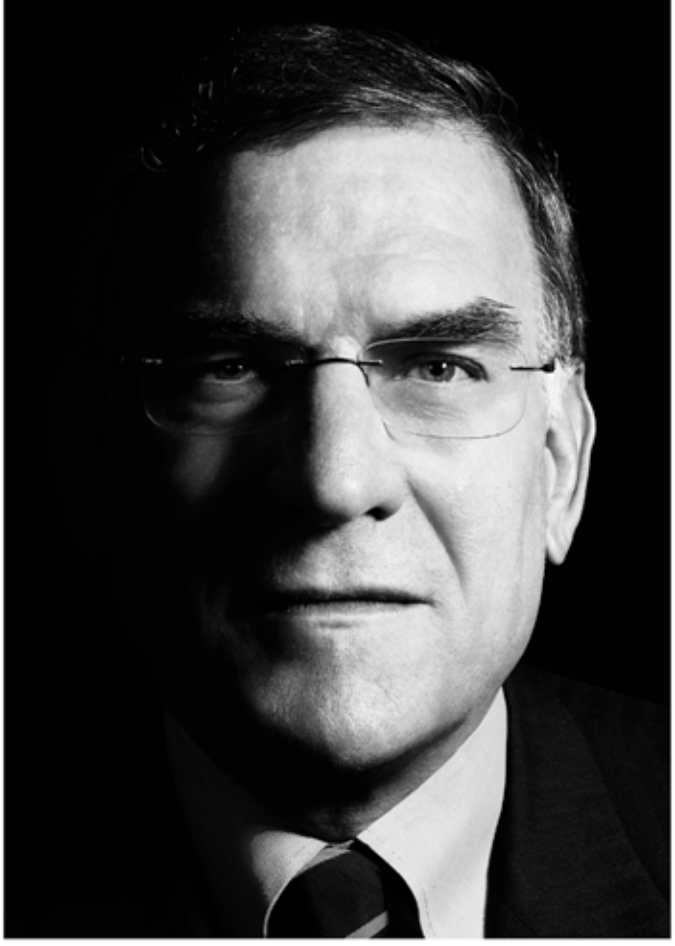
The following steps toward sanity are in order:

- First, all non-physician medical scope-of-practice determinations should be placed under regulation by the Board of Medical Licensure. Allowing non-physician boards to self-regulate their own practices allows self-interest to trample public protection.
- Secondly, the public should be given a straightforward and immediately visible distinction between physician and non-physician providers. The American Medical Association has developed just such a strategy titled "Truth in Advertising." This can be accessed for review through the AMA Advocacy Resource Center. Currently, the Kentucky Medical Association has commissioned focus groups to determine if the AMA's recommendations can be modified for better understanding by Kentucky patients. Also, federal legislation has been introduced by Representatives John Sullivan (R, Oklahoma) and David Scott (D, Georgia) that requires anyone advertising health care services to state in each advertisement the specific license that authorizes them to provide the stated services. Moreover, it makes it unlawful to mislead patients into believing that the practitioners have training or qualifications that they lack. This legislation has the backing of several physician organizations including the American Medical Association, the American Osteopathic Association, and the American Society of Anesthesiologists. In 2010, the same measure died in committee after the American Nurses Association opposed the bill, citing "unprecedented and unnecessary imposition of federal trade law on health care practices," and voicing their concerns that the bill would limit nurses' scope of practice. The AMA is currently drafting even stronger patient disclosure legislation.
- Thirdly, the maldistribution and rural shortages in the physician workforce must be solved. Rural physician shortages are repeatedly cited by sponsors to justify non-physician scope-of-practice expansion. Two sets of initiatives are needed to address this fundamental issue: 1) Improved economic incentives for practice in underserved regions. Higher payments for primary care and selected specialties contained in the Affordable Care Act of 2010 will certainly help, if sustained through judicial and legislative challenge. Also, we need a better-designed and more generous program for education debt repayment for practice in critical rural shortage areas. 2) The second initiative is funding and replication of rural residency primary care programs that select applicants most likely to choose rural practice.
- Finally, programs should be designed and tested that provide long-term wellness and disease management by physician-led medical teams, which use non-physician professionals as physician extenders in roles appropriate to their training. This strategy is especially urgent in light of the rapidly upcoming influx of new patients to practices from the ranks of the previously uninsured brought by the Affordable Care Act of 2010. These patients will arrive long before any expansions of residencies can provide new physicians in adequate numbers.

These are some suggestions to address physician shortages and meet the public's need for quality care. We must not roll back the education standards achieved over the 100 years since the AMA-Abraham Flexner collaboration brought public protection from inadequately educated practitioners. In the 21st century, our citizens deserve optimally educated caregivers serving in appropriate roles. Kentucky legislators have choices before them. When the clock runs out at this session's end, will the scoreboard show sane solutions or more madness?

Gordon R. Tobin, MD
President

Save the Date
2011 KMA Annual Meeting



Richard E. Anderson, MD, FACP
Chairman and CEO, The Doctors Company

We proudly announce that American Physicians and The Doctors Company have united.

Together, we set a higher standard. We aggressively defend your name. We protect good medicine. We reward doctors for their loyalty. We ensure members benefit from our combined strength. We are not just any insurer. We are the largest national insurer of physician and surgeon medical liability.

On October 22, 2010, The Doctors Company and American Physicians officially joined forces. With the addition of American Physicians, we have grown in numbers, talent, and perspective—strengthening our ability to relentlessly defend, protect, and reward our nearly 55,000 members nationwide. To learn more about how we can protect your livelihood and reputation with our medical professional liability program, call (800) 748-0465, or visit us at www.thedoctors.com.

We relentlessly defend, protect, and reward the practice of good medicine.

THE DOCTORS COMPANY
American Physicians

www.thedoctors.com

CHAIR
John M. Bennett, MD, MPH
VAMC Lexington

CO-CHAIR
Thomas C. Tucker, PhD, MPH
Kentucky Cancer Registry

MEMBERS
Rep. Rocky Adkins
Kentucky House of Representatives

Whitney F. Jones, MD
University of Louisville

Claire Albright, JD
Colon Cancer Prevention Project Director

Debra Armstrong, MSW, MPA
Kentucky Cancer Program

William F. Beam
Colon Cancer Survivor

Virginia Bradford, RN
Kentucky African Americans Against Cancer

Sen. Tom Buford
Kentucky Senate

Rep. Tom Burch
Kentucky House of Representatives

Mary Coleman, RN
Kentucky Dept. for Medicaid Services

Steve Davis, MD
Kentucky Dept. for Public Health

Kim Dees, RN, MSN, MBA/HCM
Kentucky Hospital Association

Mark Evers, MD
Markey Cancer Center

Fran Feltner, MSN, RN
Kentucky Homeplace

Paul Hopkins
Pike Co. Public Health Director

Don Miller, MD, PhD
Brown Cancer Center

Jennifer Redmond, DrPH, MPH
Kentucky Cancer Consortium

Ellen Schroeder
American Cancer Society

Connie Sorrell, MPH
Kentucky Cancer Program

Alan Stein
Lexington Legends

Connie White, MD
Kentucky Dept. for Public Health

Kentucky Colon Cancer Screening Program Advisory Committee

Kentucky Department for Public Health, 275 Main Street, HS2WE, Frankfort, KY 40621

Phone: (502) 564-7996 • Fax: (502) 564-4667 • Email: Susan.Reffett@ky.gov

January 25, 2011

To the Editor,

Colon cancer is a significant health problem in Kentucky – it is the second leading cause of cancer death, and for a decade, the Commonwealth led the nation in both incidence and deaths from colon cancer. Each year, about 2,500 Kentuckians are diagnosed with colon cancer and more than 900 die from this disease. According to data from the Kentucky Cancer Registry, many of these cases are invasive late stage cancers, which are expensive to treat, often without success. Up to 90% of colon cancer deaths could be prevented by following screening guidelines and removing colon polyps before they become cancerous.

To address this public health problem, the Kentucky General Assembly passed legislation that called for the development of a colon cancer screening program within the Kentucky Department for Public Health in 2008. The Kentucky Colon Cancer Screening Program (KCCSP) was established to provide outreach and education throughout the state to increase the rates of colon cancer screening and to provide for screening of the disadvantaged and uninsured.

Despite the lack of resources, KCCSP is working with several local health departments to establish pilot colon cancer screening programs. During the 2010 legislative session, $200,000 of Coal Severance funds were designated to support colon cancer prevention efforts in four rural counties that have struggled with high incidence and mortality rates.

Recent Behavioral Risk Factor Surveillance Survey data indicates that Kentucky has made remarkable progress over the past several years toward increased screening for colon cancer; however, the primary reasons that Kentuckians cite for not being screened are that their primary care provider did not recommend it and that they did not think it was necessary if they were not experiencing symptoms. Continued education and outreach to at-risk individuals is vital.

During the month of March and beyond, I hope the members of the Kentucky Medical Association will join us in our efforts to increase awareness about the importance of colon cancer screening and ensure their patients make well-informed decisions about their preventive care.

Together we can maintain the momentum achieved and reduce the impact of colon cancer on families throughout the Commonwealth.

Respectfully,

John M. Bennett, MD, MPH
Chair, KCCSP Advisory Committee

Enacted by KRS 214.540 – KRS 214.544

Barriers to Colon Cancer Screening in Kentucky

John M. Bennett, MD, MPH; Sarojini Kanotra, PhD, MPH; Jennifer Redmond, DrPH; Susan Reffett, RN, BSN; Sue Thomas-Cox, RN, BS

Primary care providers (physicians, APRNs, PAs) play a critical role in the delivery of colon cancer screening in Kentucky. This article addresses barriers to colon cancer screening as identified by respondents to the most recent Behavioral Risk Factor Surveillance System (BRFSS) survey in which colon cancer screening questions were asked.

METHODS*: Data from the 2008 Kentucky BRFSS survey were used to compare colon cancer screening rates for respondents aged more than 50 years in Kentucky and the United States. A state-added question in the 2008 BRFSS Questionnaire was used to determine respondents' perception of barriers to screening across Kentucky's fifteen Area Development Districts.*

RESULTS*: Approximately four of ten respondents report never being screened for colon cancer by either a flexible sigmoidoscopy or colonoscopy. Of that group, 27% reported that they had no symptoms or family history, and 27% reported that it was not recommended by their provider.*

CONCLUSIONS*: Identifying geographic regions that would benefit from provider-specific education and regions that would benefit from improved patient medical knowledge would help to use limited resources to improve the overall screening rate of colon cancer and to reduce or remove existing barriers. Given the range of responses regarding barriers to colon cancer screening, the education and support of primary care providers regarding colon cancer screening recommendations and practice is vital to continued improvement in the prevention and detection of colon cancer.*

Dr Bennett is Medical Director, Berea Community Based Outpatient Clinic; Dr Kanotra is BRFSS Program Director/Epidemiologist III, Ms Reffett is Comprehensive Cancer Program Manager, and Ms Thomas-Cox is Branch Manager Chronic Disease Prevention, at the Kentucky Department for Public Health; and Dr Redmond is Program Director, Kentucky Cancer Consortium.

Corresponding author: John M. Bennett, MD, MPH, Medical Director, Berea Community Based Outpatient Clinic, Lexington VAMC, 209 Pauline Drive, Berea, KY 40403; Phone: 859-233-4511, Ext. 7447; Fax: 859-986-1289; e-mail: John.Bennett4@va.gov

INTRODUCTION

Colon cancer is the second most common cause of cancer-related mortality in men and women combined in Kentucky, as well as the nation. Over 2600 cases of colon cancer are diagnosed in Kentucky each year.[1, 2]

In Kentucky, there are more than 2500 primary care providers including physicians, advanced practice registered nurses (APRNs), and physician assistants to serve a geographically diverse patient population.[3] These providers not only deliver primary care, but also a host of other services to the patient including recommendations regarding screening for colon cancer.[4] Of the six American Cancer Society recommended colon cancer screens,

four of the tests find polyps and cancer: flexible sigmoidoscopy every 5 years, colonoscopy every 10 years, double-contrast barium enema every 5 years, or CT virtual colonoscopy every 5 years (although not yet approved for reimbursement on a regular basis by many insurers). Two of the tests primarily find cancer: annual fecal occult blood test (FOBT), or annual fecal immunochemical test (FIT).[5] Promising on the horizon (but not yet recommended) is the stool DNA test (sDNA).

Patients with an ongoing relationship with a primary care provider show an increase in pursuing risk factor reductions and are more likely to follow through on the screening and lifestyle recommendations of their provider, including colon cancer screening.[6] A broad assessment of current colon cancer screening rates and recommendations of primary care providers can be made using the Behavioral Risk Factor Surveillance System (BRFSS). This survey provides consistent questions over time and across cultural and geographic areas.

METHODS

The Behavioral Risk Factor Surveillance System is the world's largest, ongoing telephone health survey system, tracking health conditions and risk behaviors in the United States yearly since 1984. The colorectal cancer screening question is part of the core questionnaire and is asked in even years of respondents over the age of fifty across the US. The most recent survey for which results are available (2008) includes the number of Kentuckians reporting that they have been screened with colonoscopy and sigmoidoscopy. This number has steadily increased over the past decade. Kentucky moved from 48th in the nation for colon cancer screening in 1997, to 23rd in 2008 with, currently, 63.7% of the over 50 population reporting being screened compared to a national average of 62.2%.[7]

A Kentucky Public Health Leadership Institute change master project team and the Kentucky Department for Public Health identified that critical information regarding

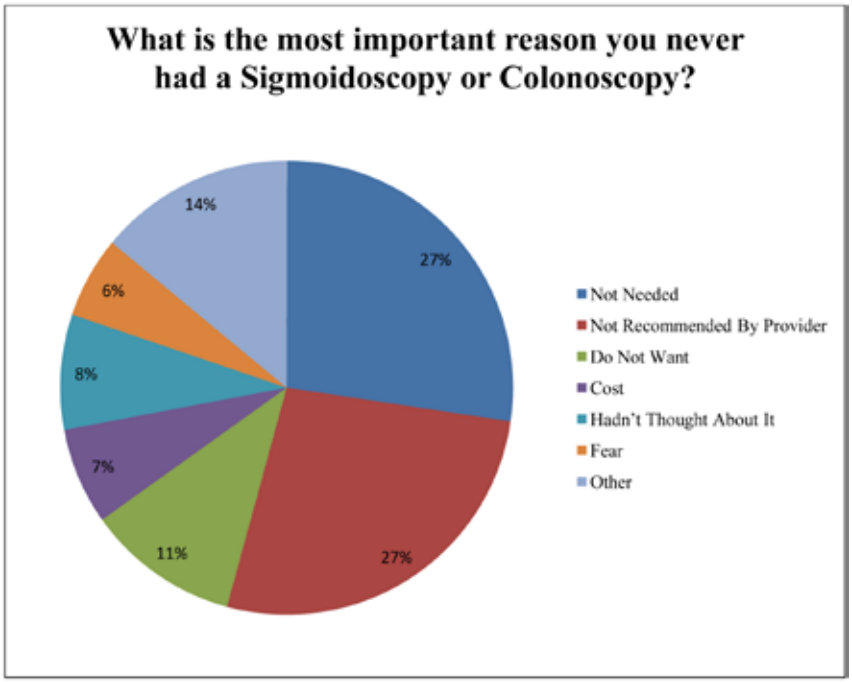


Figure 1. Graph showing survey responses

screening for colon cancer could be obtained with the addition of a state-specific question to the 2008 Kentucky BRFSS.[8] This question was intended to identify barriers to colon cancer screening and further define responses from persons 50 and over who had never been screened for colorectal or colon cancer by sigmoidoscopy or colonoscopy. The data was analyzed using SPSS version 17. Prevalence was estimated using weighted data. Chi square tests were performed to test for differences in responses by Area Development Region (ADD). Further Cramer's V coefficient test was performed to measure the strength of association.[9]

The responses for the entire state of Kentucky in descending order were: test not needed/no symptoms/no family history (27%); not recommended by provider (27%); no desire for procedure (11%); not considered by patient (8%); cost not covered by insurance (7%); concerns about procedure or fear of procedure (6%). The remaining answers accounted for 14% of the respondents' replies. They were in descending order: no time, lazy, no regular doctor, embarrassing, services not available, afraid of results, too old, test doesn't work, too young, and other.

Table 1. *Characteristics of Respondents Who Answered the Colon Cancer Screening Question.*

Characteristics	Ever Had Sigmoidoscopy/Colonoscopy		P- value
	Yes (N=3109)	No (N=1930)	
Sex			
Male	44.4%	48.1%	
Female	55.6%	51.9%	0.009
Education			
Less than high school	11.6%	20.3%	
High school or GED	33.5%	37.9%	
Some post high school	24.9%	22.8%	
College Graduate	30.0%	19.1%	<0.001
Income			
Less than $15,000	8.9%	15.8%	
$15,000 to less than $25,000	17.0%	22.8%	
$25,000 to less than $35,000	14.6%	14.4%	
$35,000 to less than $50,000	15.1%	16.5%	
$50,000 or more	44.4%	30.5%	<0.001
Have Health Care Coverage			
Yes	95.1%	4.9%	
No	87.5%	12.5%	<0.001
Ever Had Blood Stool Test Using Home Kit	76.5%	56.2%	<0.001
Activity Limitation due to Health Problems			
Yes	36.2%	29.4%	
No	63.6%	70.3%	<0.001

BRFSS also provides information regarding respondents. Table 1 shows the characteristics of the respondents who have undergone colon cancer screening with sigmoidoscopy or colonoscopy versus those who have not been screened by either method. This information can be utilized to tailor more detailed interventions in primary care practices and within targeted communities.

Respondents who were screened for colon cancer were more likely to be females, more likely to be college graduates, more likely to earn greater than $50,000 a year, and more likely to have health coverage. Respondents who did not get screened for colon cancer were more likely to have less than a high school education and earn less than $15,000. They were less likely to have health care

Table 2. *Frequency of Responses for Barriers by Area Development Districts**

ADD Region	BARRIERS				
	Not needed/ No symptoms/ No family history of cancer (N=548)	Not recommended by doctor (N=495)	Doesn't want to have one (N=199)	Cost/Not covered by insurance (N=139)	Other (N=225)
Purchase	4.2%	6.1%	3.0%	7.2%	2.2%
Pennyrile	8.6%	**9.1%**	8.5%	4.3%	5.8%
Green River	7.5%	6.5%	6.0%	5.8%	4.9%
Barren River	8.6%	8.7%	6.0%	4.3%	7.6%
Lincoln Trail	5.8%	5.3%	4.5%	5.0%	4.0%
KIPDA	5.8%	7.5%	10.1%	4.3%	**14.7%**
Northern Kentucky	3.5%	4.0%	7.5%	3.6%	5.8%
Buffalo Trace	7.5%	6.9%	9.5%	5.0%	7.6%
Gateway	**10.9%**	6.1%	7.0%	10.8%	5.8%
FIVCO	8.4%	5.3%	4.5%	11.5%	8.4%
Big Sandy	3.8%	6.5%	6.0%	5.0%	7.6%
KY River	5.8%	7.9%	9.0%	6.5%	5.3%
Cumberland Valley	6.8%	4.4%	3.0%	**14.4%**	5.3%
Lake Cumberland	7.7%	8.1%	4.5%	5.0%	9.3%
Bluegrass	4.7%	7.9%	**10.6%**	7.2%	5.8%

**The top five identified barriers are highlighted within the 15 ADDs*

coverage as compared to those who had colon cancer screening done. The differences between these two categories of respondents are significant according to chi-square tests. The table shows weighted estimates.

The Commonwealth of Kentucky can be subdivided into 15 Area Development Districts (ADDs) which are: Purchase, Pennyrile, Green River, Barren River, Lincoln Trail, KIPDA, Northern Kentucky, Buffalo Trace, Gateway, FIVCO, Big Sandy, Kentucky River, Cumberland Valley, Lake Cumberland, and Bluegrass. Table 2 shows the distribution of the frequency of the top five barriers by ADDs. The numbers in bold suggest that the frequency of this barrier was highest in the ADD cited, for example cost was a barrier cited with the highest frequency in Cumberland Valley (14.4% of 139 respondents).

In order to see if the responses were distributed identically across ADDs, a test for association (Cramer's V) between the independent variable (ADD) and the dependent variable (response) was done. The result was 0.114, which indicates that there is an association between the geographic location and the barrier cited by the respondent, albeit small.

CONCLUSION/ RECOMMENDATIONS

The recent results of the BRFSS added state-specific question suggest that there is room for improvement within the regular screening practices of providers, both as a state and in specific geographic areas. From a resource utilization standpoint these geographic differences might be an ideal target for educational outreach or provider education. We have identified four ADDs that may benefit from targeted interventions at the level of the providers, third-party payers, or even population-based education. These are: For cost/Not covered by insurance (Cumberland Valley), No symptoms (Gateway), Not recommended by provider (Pennyrile), and does not want one (Bluegrass). Planned interventions can now look at the prevalence of a barrier and address the barrier at a specific ADD.

An approach to the two most common responses (Not needed due to family history or lack of symptoms, and not recommended by provider) could include provider education regarding the message that is delivered to patients about the importance of colon cancer screening. With limited statewide resources and geographic differences identified with BRFSS, focused use of assets and working in local collaborative partnerships with such organizations as hospitals, local health departments, Federally Qualified Health Centers, faith-based organizations, the Kentucky Cancer Program, and assistance from state level organizations such as the Kentucky Department for Public Health should be considered.

Addressing the need for colon cancer screening in the medical office and within the community should reduce the number of patients/respondents who do not think of being screened or who are resistant to screening.

The Affordable Care Act of 2010 specifically addresses prevention and screening for many cancers, including colon. Medicare has enhanced the prevention and screening package, and as new private insurance policies are issued, eligible patients should expect that their concerns about copays and insurance coverage to be resolved.[10]

Providers and their practices establish a culture of caring; in primary care this translates into a system that is designed to address many tasks. In designing provider or practice-based interventions, it becomes important to recognize this culture and system of caring, if any benefit from an office change model is to be expected. System change models should be designed to be self-sustaining and supportive of the model that underlies each primary care practice. Some of the techniques aimed at changing how a provider or practice screens for cancer have met with success. The most successful are those tailored to the specific needs of each practice. Tailoring changes increases buy-in by the primary care provider and support personnel. Another successful method to improve the adherence to current prevention standards is working with the office personnel to develop a specific protocol for addressing the particular topic; ie, colon cancer screen-

ing. Specific resources that can be tailored for these system changes can be found in the guide known as *How to Increase Colorectal Cancer Screening Rates in Practice: A Primary Care Clinician's Evidence-Based Toolbox and Guide*.[11] This toolbox and guide provides specific examples of how to implement the evidence-based approaches highlighted in the Guide to Community Preventive Services, such as provider assessment and feedback and provider reminder systems.[12] Little benefit has been shown for patient education materials or handouts unless they are coordinated with community level education, social marketing, or a multimedia campaign.[13]

In 2008, the Kentucky legislature passed a bill to establish a colon cancer screening program in Kentucky for the uninsured and to provide outreach and education for all age-eligible Kentuckians in order to increase the colon cancer screening rates in Kentucky. To this end, the Kentucky Colon Cancer Screening Advisory Committee was established, as required by statute, to serve as an advisory group to the program and at the same time, the Kentucky Colon Cancer Prevention Committee was established to work collaboratively on barriers and issues as described by respondents to the BRFSS survey.

The results of this BRFSS added state-specific question should be compared temporally and against other geographically separate entities to better determine if there are practice or provider changes that can be made that will ultimately increase the number of patients screened for colon cancer. This information, if used judiciously, could be used to identify and reduce barriers to appropriate colon cancer screening.

REFERENCES

1. American Cancer Society. Cancer Facts and Figures 2010. http://www.cancer.org/Research/CancerFactsFigures/CancerFactsFigures/cancer-facts-and-figures-2010. Accessed January 10, 2011.
2. Kentucky Cancer Consortium. *A KCC Snapshot of Colon Cancer*. July 2010.
3. American Medical Association. *Physician Characteristics and Distribution in the US*. 2010.
4. Klabunde CN, Ambs A, Keating NL, et al. The role of primary care physicians in cancer care. *J Gen Intern Med*. Sep 2009;24(9):1029-1036.
5. Levin B, Lieberman DA, McFarland B, et al. Screening and surveillance for the early detection of colorectal cancer and adenomatous polyps, 2008: a joint guideline from the American Cancer Society, the US Multi-Society Task Force on Colorectal Cancer, and the American College of Radiology. *Gastroenterology*. May 2008;134(5):1570-1595.
6. Zarychanski R, Chen Y, Bernstein CN, Hebert PC. Frequency of colorectal cancer screening and the impact of family physicians on screening behaviour. *CMAJ*. Sep 11 2007;177(6):593-597.
7. Kentucky Department of Public Health. Kentucky BRFSS 2008 Data Set. 2010.
8. DuMaurier J, Champion A, Centers I, Young AL, Redmond J. Colon Cancer—Motivating At Risk Kentuckians to Screening. 2008; http://www.mc.uky.edu/kphli/masterprojects2008.html. Accessed January 26, 2011, 2011.
9. Changing Minds. Cramer's V. 2011; http://changing-minds.org/explanations/research/analysis/cramers_v.htm. Accessed January 26, 2011.
10. Cassidy A. *Preventive Services Without Cost Sharing, New Private Health Plans Must Pay for Screenings and Other Preventive Services. Will the Benefits Outweigh the Costs?* Health Affairs/RWJF Health Policy Brief Series 2010. Accessed December 29, 2010.
11. Sarfaty M, Feng S. Choice of screening modality in a colorectal cancer education and screening program for the uninsured. *J Cancer Educ*. Spring 2006;21(1):43-49.
12. Guide to Community Preventive Services. Cancer Prevention & Control: Provider-Oriented Screening Interventions. 2011; http://www.thecommunityguide.org/cancer/screening/provider-oriented/index.html Accessed January 11, 2011.
13. Bennett JM. *Improving Compliance for Colon Cancer Screening Through Educational Outreach and a Practice Based Intervention.* Lexington, Kentucky: College of Public Health, University of Kentucky; 2004.

ACHIEVEMENT:

GETTING YOUR REVENUE CYCLE TO FOLLOW DOCTOR'S ORDERS

PNC ADVANTAGE FOR HEALTHCARE PROFESSIONALS offers CFO: Cash Flow Options, a comprehensive suite of products and services delivered through a specialized team of healthcare business bankers. We work closely with you to custom fit integrated solutions that can accelerate the collection of receivables, improve the way you make payments and help ensure access to cash. And we'll examine every opportunity to improve your revenue cycle, so that you have more time and energy to focus on your practice. To learn more about all the ways we can make your cash flow healthier, go to *pnc.com/hcprofessionals*, or call:

CHAD NEELY 859-281-5280

JERE FRITTS 502-648-6728

JOHN ALLEN 502-581-6386

PNC BANK | *for the* ACHIEVER *in us all*℠

PNC | CFO
Cash Flow Options

Bank lending and deposit products and services provided by PNC Bank, National Association. **Member FDIC.** BBK-4898 ©2011 The PNC Financial Services Group, Inc. All rights reserved.

Recovery Isn't Simply a Goal, It's Our Mission.

Kindred Healthcare understands that when people are discharged from a traditional hospital, they often need continued care in order to recover completely. That's where we come in.

Kindred offers services including aggressive, medically complex care, intensive care and short-term rehabilitation.

Dedicated to Hope, Healing and Recovery

Doctors, case managers, social workers and family members don't stop caring simply because their loved one or patient has changed location. Neither do we.

Come see how we care at www.continuethecare.com.

Kindred Healthcare

CONTINUE THE CARE

LONG-TERM ACUTE CARE HOSPITALS • NURSING AND REHABILITATION CENTERS • ASSISTED LIVING CENTERS

The Effect of Insurance on Stage at Diagnosis for Colorectal Cancer Patients in Kentucky

Thomas C. Tucker, PhD, MPH; Bin Huang, DrPH; John M. Bennett, MD, MPH; Eric B. Durbin, MS and Whitney F. Jones, MD

The association between insurance and stage at diagnosis for Kentucky colorectal cancer patients was examined while controlling for age, race, gender, smoking, metro/non-metro residence, and Appalachian/non-Appalachian residence. The study utilized information from the records of 9876 colorectal cancer patients in the Kentucky Cancer Registry who were diagnosed between 2004 and 2008. A chi square test was used to evaluate the bivariate relationship between stage at diagnosis and each of the predictor variables. Multivariate logistic regression models were constructed to evaluate the association between insurance and stage at diagnosis while controlling for other covariates. More than 71% of the patients who did not have insurance and 64% of the patients with Medicaid were diagnosed with late stage colorectal cancer compared to just over 50% for patients with private insurance or Medicare. Patients who lacked insurance had more than twice the odds (OR = 2.2) of being diagnosed with advanced colorectal cancer and patients with Medicaid had more than a 60% increase in the odds (OR = 1.62) of being diagnosed with late stage disease compared to patients with private insurance while controlling for other factors. These findings suggest that funding needs to be available for screening-age-eligible individuals in Kentucky who do not have insurance. The findings also suggest that age-eligible individuals who have Medicaid should be strongly encouraged to have a colonoscopy exam.

Dr Tucker is Director, Dr Huang is Director of Population-based Studies, and Mr Durbin is Director for Cancer Informatics, at the Kentucky Cancer Registry, University of Kentucky College of Medicine. Dr Bennett is in Primary Care Service at the Lexington VAMC, and Dr Jones is Clinical Professor of Medicine at the University of Louisville and Founder, Colon Cancer Prevention Project.

Corresponding author: Thomas C. Tucker, PhD, MPH, Associate Director, Cancer Prevention and Control Program, Markey Cancer Center; Associate Professor, Department of Epidemiology, College of Public Health; and Director, Kentucky Cancer Registry, University of Kentucky, 2365 Harrodsburg Road, Suite A230, Lexington, Kentucky 40504; Phone 859-219-0773, Ext. 225; Fax 859-219-0557; e-mail tct@kcr.uky.edu

BACKGROUND

The value of screening for colorectal cancer has been clearly demonstrated.[1,2] Screening can prevent colorectal cancer from occurring by finding pre-cancerous polyps that can be removed before they become cancer. Screening can also reduce deaths from colorectal cancer by finding the disease at an early stage when treatment is more effective. A recent large randomized clinical trial in Europe comparing fecal occult blood test (FOBT) to sigmoidoscopy showed that screening for colorectal cancer using sigmoidoscopy resulted in finding the disease at an earlier stage and could reduce the mortality rate by as much as 40%.[3]

A number of studies have shown that age, race, and socioeconomic factors are associated with the stage at diagnosis for colorectal cancer patients.[4,5] Halpren and his colleagues used records from a large number of hospital cancer registries to study the effect of insurance on stage at diagnosis for twelve cancer sites. They found that patients who did not

have insurance and patients with Medicaid were significantly more likely to be diagnosed with advanced disease compared to patients with private insurance or Medicare.[6] However, the association between not having insurance and being diagnosed with late stage colorectal cancer has only been partially examined because most population-based cancer surveillance programs do not routinely collect information on health insurance. The Kentucky Cancer Registry is one of the few population-based cancer surveillance programs that systematically collect information about the health insurance of each newly diagnosed cancer patient.

The Kentucky Cancer Registry is the official population-based cancer surveillance program for the state. Established by state law in 1990, the Kentucky Cancer Registry is part of both the National Cancer Institute's Surveillance Epidemiology and End Results (SEER) program and the Centers for Disease Control and Prevention's National Program of Cancer Registries (NPCR).

Using data from the Kentucky Cancer Registry, this study examines the relationship between having, or not having, health insurance and stage at diagnosis for colorectal cancer patients in Kentucky while controlling for age, gender, race, smoking, urban/rural residence at diagnosis (metro status), and Appalachian/non-Appalachian residence at diagnosis.

METHODOLOGY

Records of patients diagnosed with colorectal cancer during the five year period from January 1, 2004, through December 31, 2008, were selected from the Kentucky Cancer Registry. Only patients who were residents of Kentucky and 20 years of age or older at the time of diagnosis were included in the study. Any patients with more than one primary cancer and any patients with missing information for stage at diagnosis were excluded from the study. Because Kentucky does not have a diverse population by race or ethnicity, only patients identified in the Registry as white or black were included. The study utilized information from 9876 colorectal cancer patients who met the criteria for inclusion in the analysis.

The independent or predictor variables included in this study were defined as follows:

Insurance (primary payer) = Not Insured, Medicaid, Medicare (with or without supplement), Military Type, and Private Insurance

Age = <50, 50-64, 65-74, and 75+

Race = White or Black

Gender = Male or Female

Smoking = Smoked or Never Smoked

Metro/non-Metro Residence at Diagnosis = Beale codes 1-3(Urban) or Beale codes 4-9 (Rural)[7]

Appalachian/non-Appalachian Residence at Diagnosis = Any patient living in one of the 54 Kentucky counties designated as Appalachian by the Appalachian Regional Commission (ARC) at the time of diagnosis or any patient living in one of the 66 Kentucky counties not designated as Appalachian by the ARC.

The outcome of interest, stage at diagnosis, was defined as early stage or late stage where early stage included all cases with a SEER summary stage of in situ or local and late stage included all cases with a SEER summary stage of regional or distant metastases at diagnosis.

A chi square model of independence was used to assess the association between stage at diagnosis and each of the predictor variables. Multivariate logistic regression models were constructed to evaluate the association between insurance and stage at diagnosis while controlling for other covariates. The final model included only covariates with a significance level of 0.05 or less. All statistical tests were two sided and all analyses were done using SAS Statistical software version 9.1.

RESULTS

The bivariate relationship between stage at diagnosis and each of the independent (predictor) variables is shown in Table 1.

Table 1. *Bivariate Analysis: Risk Factors associated with stage at diagnosis for Kentucky colorectal cancer patients (2004 – 2008).*

		Late Stage (%)	*Early Stage (%)*	*p-value*
Insurance				**<.0001**
	Not Insured	**257 (71.2)**	**104 (28.8)**	
	Medicaid	**321 (64.2)**	**179 (35.8)**	
	Medicare	2966 (52.3)	2708 (47.7)	
	Military Type	85 (40.9)	123 (59.1)	
	Private	1611 (51.4)	1522 (48.6)	
Age				**<.0001**
	< 50	**667 (60.0)**	**444 (40.0)**	
	50 - 64	1696 (52.8)	1516 (47.2)	
	65 - 74	1346 (51.6)	1262 (48.4)	
	75 +	1531 (52.0)	1414 (48.0)	
Race				0.6851
	Black	352 (53.8)	302 (46.2)	
	White	4888 (53.0)	4334 (47.0)	
Gender				0.5118
	Female	2545 (53.4)	2221 (46.6)	
	Male	2695 (52.7)	2415 (47.3)	
Smoking				**<.0001**
	Non-Smoker	1620 (53.5)	1410 (46.5)	
	Smoker	**993 (58.7)**	**699 (41.3)**	
	Unknown	2627 (51.0)	2527 (49.0)	
Metro Status				**0.0061**
	Metro	2698 (51.8)	2515 (48.2	
	Non-Metro	**2542 (54.5)**	**2121 (45.5)**	
Appalachian Status				0.0533
	Appalachian	1654 (54.5)	1380 (45.5)	
	Non-Appalachian	3586 (52.4)	3256 (47.6)	

Source of Data: Kentucky Cancer Registry

There is a strong association between not having health insurance and being diagnosed with late stage colorectal cancer. For colorectal cancer patients who did not have health insurance, 71.2% were diagnosed with late stage colorectal cancer compared to just over 50% of those patients that had private insurance or Medicare. Colorectal cancer patients with Medicaid were also significantly more likely to be diagnosed with advanced disease compared to patients with private insurance, Medicare, or military type insurance. Colorectal cancer patients with military type insurance were the least likely to be diagnosed with late stage disease. Patients who were diagnosed before age 50, smokers, and

those who lived in non-metro (rural) areas at the time of diagnosis were also significantly more likely to be diagnosed with late stage colorectal cancer. Race, gender, and living in an Appalachian or non-Appalachian area of the state at the time of diagnosis were not significantly associated with stage at diagnosis. However, the relationship between living in an Appalachian area at the time of diagnosis and being diagnosed with late stage at disease was approaching significance (p = 0.0533).

The results of the multivariate logistic regression analysis modeling risk factors that contribute to the diagnosis of late stage disease among colorectal cancer patients in Kentucky are shown in Table 2. Because race, gender, and Appalachian residence status were not significant factors in the initial logistic regression model, they were removed from the analysis.

Having or not having health insurance is closely associated with stage at diagnosis (p<0.0001) while controlling for age, smoking status, and metro/non-metro residence at diagnosis. Patients without health insurance had more than twice the odds (OR= 2.2) of being diagnosed with advanced (late stage) disease compared to those with private insurance while controlling for other factors in the model. Patients with Medicaid had more than a 60% increase in the odds (OR = 1.62) of being diagnosed with late stage colorectal cancer compared to those with private insurance while controlling for other covariates. Patients under the age of 50 at the time of diagnosis, patients who were smokers and patients who lived in non-metro (rural) areas of the state also had increased odds of being

Table 2. *Logistic Regression Analysis: Risk Factors contributing to the diagnosis of late stage disease among Kentucky colorectal cancer patients (2004 – 2008).*

		Odds Ratio	*95% Confidence Interval Limits*		p-value
Insurance					<.0001
	Private Insurance	*Reference*			
	Not Insured	**2.200**	**1.731**	**2.797**	
	Medicaid	**1.622**	**1.331**	**1.976**	
	Medicare	1.125	0.977	1.296	
	Military Type	**0.712**	**0.534**	**0.951**	
Age					0.0079
	50 – 64	*Reference*			
	< 50	**1.251**	**1.087**	**1.441**	
	65 – 74	0.937	0.810	1.085	
	75 +	0.969	0.834	1.125	
Smoking					<.0001
	Non-Smoker	*Reference*			
	Smoker	**1.203**	**1.064**	**1.360**	
	Unknown	0.912	0.832	0.998	
Metro Status					0.0249
	Metro	*Reference*			
	Non-Metro	**1.096**	**1.012**	**1.188**	

Source of Data: Kentucky Cancer Registry

diagnosed with late stage colorectal cancer while controlling for the other predictor variables.

DISCUSSION

This study demonstrates a strong relationship between the lack of health insurance and being diagnosed with late stage colorectal cancer in Kentucky while controlling for other factors associated with stage at diagnosis. It is reasonable to assume that people without health insurance are less likely to be able to pay for colorectal cancer screening and thus, people without health insurance are less likely to be screened for colorectal cancer. The lack of screening has consequences (ie, when a population has less than adequate screening, more patients are diagnosed with advanced disease).[1] Even though Medicaid will pay for colorectal screening for age-eligible individuals, those patients whose health insurance was Medicaid were also significantly more likely to be diagnosed with advanced disease compared to patients with private insurance while controlling for other factors. This is consistent with the findings from previous studies.[6] One possible explanation is that Medicaid provides health coverage for the very poorest people in the population. These individuals often have many competing demands in their lives, they may lack knowledge about the importance of colorectal cancer screening, and they may lack other essential resources such as transportation. It is important to note that patients with Medicaid are also younger. Many are under the age of 50, and current screening guidelines do not recommend colorectal cancer screening for asymptomatic people under the age of 50.[2] In contrast, patients with military-type insurance were less likely to be diagnosed with late stage disease. However, the number of colorectal cancer patients with this type of insurance is very small and the estimates should be interpreted with caution.

In this study, patients diagnosed with colorectal cancer under the age of 50 were significantly more likely to be diagnosed with late stage disease. Again, this is consistent with previous findings.[4] There are two potential factors that may be contributing to this finding. First, patients diagnosed with colorectal cancer at a younger age are more likely to have a genetic predisposition for colorectal cancer and these cancers tend to be more aggressive,[8] and second, the guidelines for colorectal cancer screening do not recommend the procedure for asymptomatic patients under the age of 50.[2]

Colorectal cancer patients who were smokers were also more likely to be diagnosed with advanced disease compared to non-smokers or patients for whom the smoking status was unknown. It is not clear if there is a biological explanation for this finding, or if patients who smoke also tend to be uninsured or have health behaviors that are inconsistent with screening recommendations.

Finally, patients living in non-metro (rural) areas of the state were more likely to be diagnosed with late stage colorectal cancer. There is evidence that cancer patients living in rural areas or areas more distant from screening facilities are less likely to be diagnosed with early stage disease and it is possible that a similar scenario is contributing to late stage diagnosis for Kentucky colorectal cancer patients.[9]

The association between living in the Appalachian area of Kentucky and late stage diagnosis for colorectal cancer was approaching significance in the bivariate analysis. However, Appalachian residence at diagnosis was not significant in the multivariate model. One possible explanation is that much of Appalachian Kentucky is rural and the urban/rural (metro/non-metro) variable was simply a more powerful predictor of late stage diagnosis. Because of the well documented health disparities, the Appalachian area of Kentucky remains a high priority for colorectal cancer screening.

There are several limitations associated with this study. The data on insurance type represents only the primary payer at the time of diagnosis. Information on secondary or supplemental insurance is not routinely collected by the Kentucky Cancer Registry. Patients who are uninsured at the time of diagnosis may be able to obtain Medicaid later in their treatment, and this information is also not routinely collected by the Registry.

However, the primary objective of this study was to explore the relationship between having, or not having, insurance and the stage at diagnosis for colorectal cancer patients in Kentucky. Therefore, this is not considered to be a severe limitation.

A second limitation is the fact that the Registry does not routinely collect information on screening practices among colorectal cancer patients. Thus, it is not possible to directly link a patient's experience with screening and their stage at diagnosis. However, there is considerable evidence that screening for colorectal cancer increases the likelihood that the disease will be detected at an early stage.[1] Therefore, this, too, is not considered to be a severe limitation. Finally, information on poverty and literacy were not included in this analysis. A number of studies have documented the association between these two variables and stage at diagnosis.[4,5] This information is not generally available in the medical records and, therefore, the Registry is unable to routinely collect the information. It is important, however, that these two variables be included in future studies if at all possible.

The findings from this study do suggest several actions that will be essential if Kentucky is to make further significant improvements in earlier diagnosis of colorectal cancer. First, funding needs to be available for screening-age-eligible individuals in Kentucky who do not have health insurance. A Bill to provide colorectal cancer screening for uninsured individuals aged 50 or older (KRS 214.540) was passed by the Kentucky General Assembly and enacted into law on July 15, 2008. Unfortunately, this program remains unfunded. Second, age-eligible individuals who have Medicaid should be strongly encouraged to have a colonoscopy exam. These two actions have the potential to both save lives by finding more colorectal cancers at an early stage when treatment is more effective, and also save money by finding the disease when it is less expensive to treat.[10]

REFERENCES

1. Liebermann D. Screening for colorectal cancer. *N Engl J Med*. 2009 Sept 17;361:1179-1187.
2. Winawer S, Fletcher R, Rex D, et al. Colorectal cancer screening and surveillance: clinical guidelines and rationale—update based on new evidence. *Gastroenterology*. 2003 Feb;124(2):544-560.
3. Atkin WS, Edwards R, Kralj-Hans I, et al. Once-only flexible sigmoidoscopy screening in prevention of colorectal cancer: a multicenter randomized controlled trial. *Lancet*. 2010 May 8;375 (9726):1624-1633.
4. Mandelblatt J, Andrews H, Kao R, Wallace R, Kerner J. The late-stage diagnosis of colorectal cancer: demographic and socioeconomic factors. *Am J Public Health*. 1996 Dec;86(12):1794-1797.
5. Seeff LC, Nadel MR, Klabunde CN, et al. Patterns and predictors of colorectal cancer test use in the adult U.S. population. *Cancer*. 2004 May 15;100 (10):2093-2103.
6. Halpren MT, Ward EM, Pavluck AL, Schrag NM, Bian J, Chen AY. Association of insurance status and ethnicity with cancer stage at diagnosis for 12 cancer sites: a retrospective analysis. *Lancet Oncol*. 2008 Mar;9(3): 222-231.
7. US Department of Agriculture, Economic Research Service. ERS/USDA Briefing Room—Measuring Rurality: Urban-Rural Continuum Codes. Washington, DC: 2003, available at http://www.ers.usda.gov/briefing/rurality/RuralUrbCon/.
8. Lynch HT, de la Chapelle A. Hereditary colorectal cancer. *N Engl J Med*. 2003 Mar 6;348(10):919-932.
9. Rushton G, Peleg I, Banerjee A, West M. Analyzing geographic patterns of disease incidence: rates of late-stage colorectal cancer in Iowa. *J Med Syst*. 2004 Jun;28(3):223-236.
10. Frazier AL, Colditz GA, Fuchs CS, Kuntz, KM. Cost-effectiveness of screening for colorectal cancer in the general population. *JAMA*. 2000 Oct 18;284(15): 1954-1961.

"As physicians, we have so many unknowns coming our way...

One thing I am certain about is my malpractice protection."

Medicine is feeling the effects of regulatory and legislative changes, increasing risk, and profitability demands—all contributing to an atmosphere of uncertainty and lack of control.

What we do control as physicians:
our choice of a liability partner.

I selected ProAssurance because they stand behind my good medicine and understand my business decisions. In spite of the maelstrom of change, I am protected, respected, and heard.

I believe in fair treatment—
and I get it.

Professional Liability Insurance & Risk Management Services

ProAssurance Group is rated **A (Excellent)** by A.M. Best.
For individual company ratings, visit **www.ProAssurance.com.**

502.423.7201

Colorectal Cancer
Screening Tip Sheet

Risk	Average	High		
Definition or Diagnosis	No risk factors other than ≥ age 50 and ≥ age 45 for African Americans	HNPCC: Hereditary Nonpolyposis Colorectal Cancer or Family or personal history of early (< age 50) ovarian, endometrial or colorectal cancers	Family history of FAP (familial polyposis) in a first degree relative (parent, sibling, or child)	Ulcerative colitis (UC) or Crohn's colitis (CC)
Begin Screening	Age 50 or age 45 for African Americans	By age 20-25	At puberty	Personal history of pan ulcerative colitis ≥ 8 years, left sided colitis ≥ 15 years, or longstanding CC
Preferred Screening Strategy	Colonoscopy every 10 years	Colonoscopy every 2 years, genetic testing and referral to a specialist	Flexible sigmoidoscopy or colonoscopy, genetic testing, and referral to a specialist	Colonoscopy every 1-2 years
Alternative Screening Strategies from the American Cancer Society	• Flexible sigmoidoscopy every 5 years • Double contrast barium enema every 5 years • CT colonography (virtual colonoscopy) every 5 years • Fecal occult blood test annually • Fecal immunochemical test annually • Stool DNA test (sDNA), interval uncertain	No alternative screening strategy for higher risk individuals other than colonoscopy		

Note: Kentucky and Indiana mandate coverage of colorectal cancer screening tests recognized by the American Cancer Society.

Recommendations for Individuals with Family History of CRC or Adenomatous Polyp

Relationship	Screening Recommendations	Surveillance
First-degree relative[s] with colorectal cancer diagnosed at age < 60 years	Colonoscopy at age 40 or 10 years younger than affected relative, whichever is younger	If normal, repeat every 3-5 years
First-degree relative[s] with colorectal cancer diagnosed at ≥ 60 years	Colonoscopy at age 40	If normal, repeat every 10 years
First-degree relative[s] with adenomatous polyp < 60 years	Colonoscopy at age 40 or 10 years younger than affected relative, whichever is younger	If normal, repeat every 5 years
First-degree relative[s] with adenomatous polyp > 60 years	Colonoscopy for screening age individualized	If normal, same as average risk
Second or third-degree relative with cancer or polyps	Colonoscopy as average risk individuals	If normal, same as average risk

See reverse page ⇨

General Recommendations for Surveillance (Complete colonoscopy is the only recommended procedure for surveillance.)

Colonoscopic Findings	Recommendations*
1 or 2 tubular adenomas, <1 cm, low grade dysplasia	Next colonoscopy in 5 years
≥ 3 adenomas or Adenoma ≥ 1 cm or Villous histology or high grade dysplasia	Next colonoscopy in 3 years
> 10 adenomas on colonoscopic exam or inadequate colon preparation	Next colonoscopy in < 3 years
Colon cancer, resected	Clearance of remainder of the colon at or around time of resection, followed by colonoscopy at 1 year, then at 3 years and then at 5 year intervals if results are normal
Rectal cancer, resected	Clearance of remainder of the colon at or around time of resection, followed by colonoscopy at 1 year, then at 4 years and then at 5 year intervals if results are normal
Pan ulcerative colitis >8 years, Left-sided ulcerative colitis ≥15 years, Longstanding Crohn's colitis	Colonoscopy every 1-2 years with systematic Biopsies to detect dysplasia
Sessile adenomas that are removed piecemeal	Follow-up colonoscopy in 2-6 months to verify complete removal of adenomas

*All recommendations are based on the assumption that colonoscopy was completed with adequate bowel prep and that the exam reached the cecum. A repeat examination may be warranted for incomplete bowel prep or if the colonoscopy was not completed to the cecum.

Comprehensive Colonoscopy Documentation to be sent to primary care physician

- ✓ Pre-procedure risk assessment
- ✓ Depth of insertion (i.e. to cecum or other landmark)
- ✓ Quality of the bowel prep
- ✓ Duration of colonoscopic exam
- ✓ Recommendation for follow-up
- ✓ Complete description of polyp(s) found:
  1. Location
  2. Size
  3. Number
  4. Gross Morphology

For more information or laminated copies of this document, please contact:

Colon Cancer Prevention Project
PO Box 4039, Louisville, KY 40204
(502)290-0288 or (800)841-6399
www.ColonCancerPreventionProject.org

The Colon Cancer Prevention Project is a nonprofit dedicated to eliminating preventable colon cancer death and suffering by increasing screening rates through education, advocacy, and health systems improvement in Kentucky and surrounding communities.

This screening and surveillance tip sheet is distributed in conjunction with the Kentucky Medical Association.

These recommendations are based upon the following: (1) U.S. Preventive Services Task Force (http://www.ahrq.gov/clinic/uspstf08/colocancer/colors.htm) and (2) Levin B, Lieberman DA, McFarland, et al. Screening and Surveillance for the Early Detection of Colorectal Cancer and Adenomatous Polyps, 2008: A Joint Guideline from the American Cancer Society, the US Multi-Society Task Force on Colorectal Cancer, and the American College of Radiology. *CA Cancer J Clin.* 2008;58.

Revised April 2009

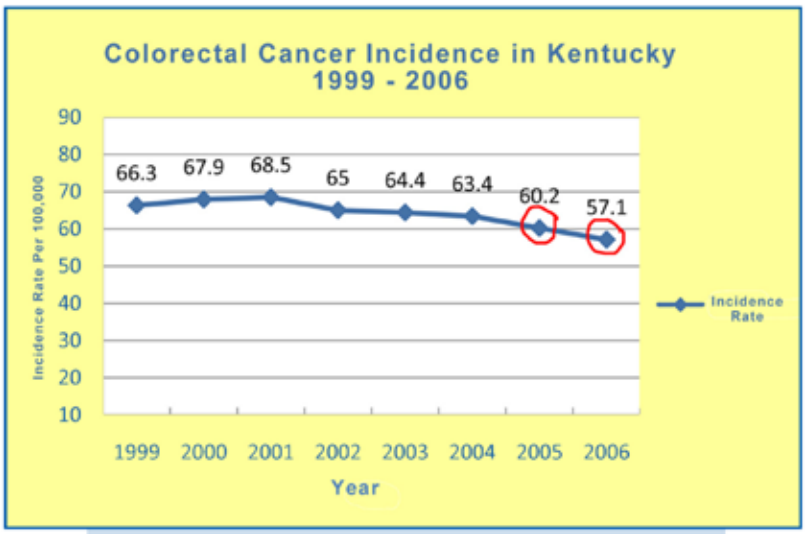
A KCC SNAPSHOT OF COLON CANCER

July 2010

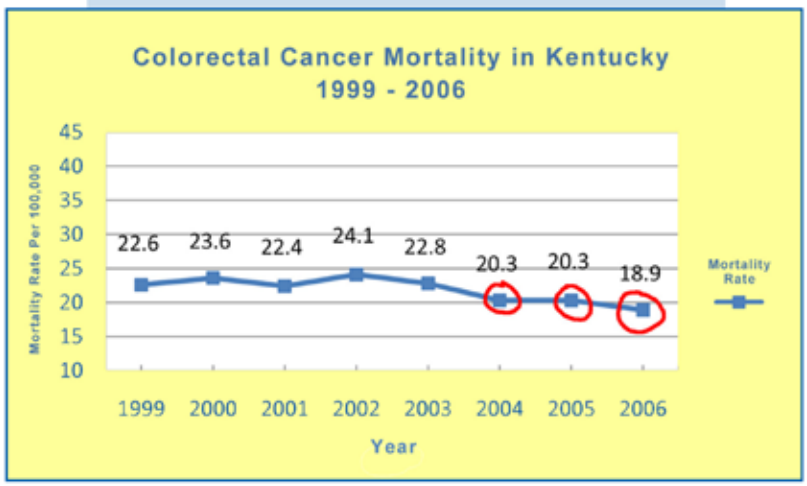
Colon cancer is the second most common cause of cancer death (mortality) in men and women combined in Kentucky, as well as the United States. Over 2,600 cases of colon cancer are diagnosed in Kentucky each year, with more than half of those cases diagnosed at a late stage.

When detected early, the 5-year survival rate for colon cancer is more than 90%. At least 60% of colon cancer deaths could be prevented altogether with regular screenings.

Kentucky has seen a significant decline in new cases and deaths from colon cancer since exploring the data in depth in 2001. This may be attributed in part to the effort of dozens of organizations working together to promote colon cancer screening across the state in committees such as the Kentucky Cancer Consortium's Colon Cancer Prevention Committee.



The red circles indicate a statistically significant decline at the p=0.05 level.



Kentucky Cancer Action Plan: How Are We Doing?

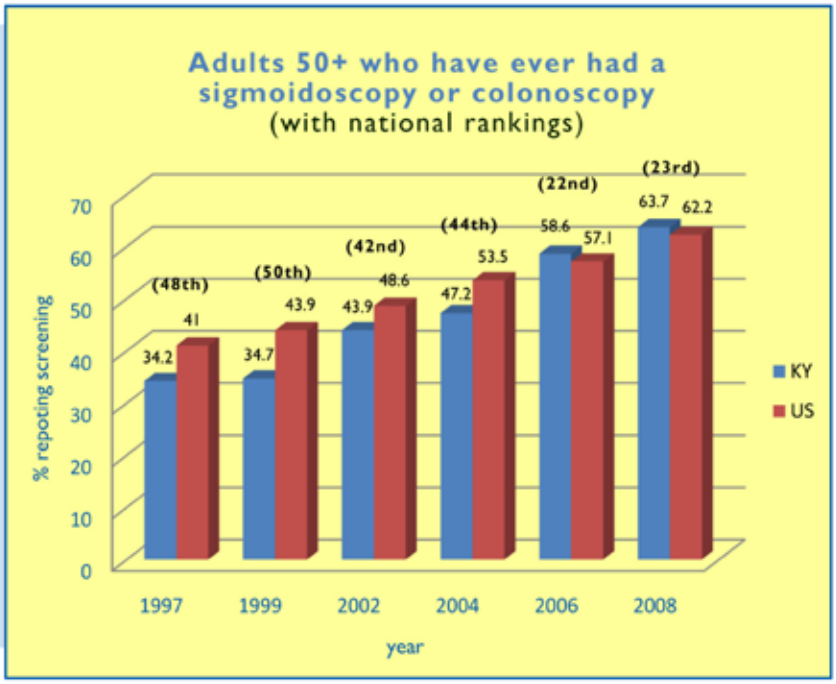
GOAL 7: Reduce incidence and mortality from colon cancer through prevention and early detection. (See graphs above.)

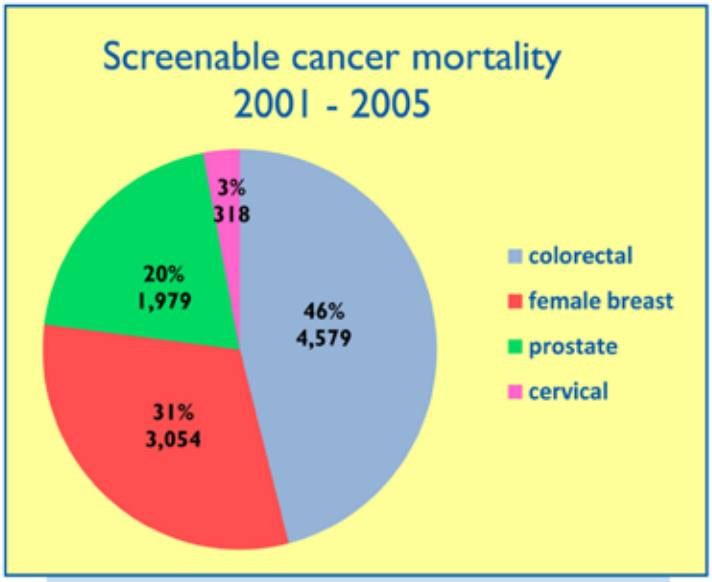
Objective 7.1: Increase colon cancer screening among adults ages 50 and older to 75% by 2012. Baseline (2006): 58.6%. Current (2008): 63.7%.

Objective 7.2: Increase percentage of Kentuckians diagnosed at an early stage of colon cancer to 60% by 2012. Baseline (2005): 50.2%. Current (2007): 48.2%.

A KCC SNAPSHOT OF COLON CANCER

Increases in colon cancer screening are highly associated with decreases in the number of cases diagnosed at late stage, leading to better health outcomes. The number of Kentuckians reporting screening with colonoscopy and sigmoidoscopy has increased steadily over the past decade. Kentucky moved from 48th in the nation for colon cancer screening in 1997 to 23rd in 2008. Kentuckians with low educational attainment and low income have the lowest rates of screening.





"Screenable" refers to those cancer sites that have early detection methods recommended by the American Cancer Society. Some of these cancers may be prevented or detected early enough to reduce a person's chance of dying from the cancer.

Source of data: for charts: Behavioral Risk Factor Surveillance System (1997-2008), Kentucky Cancer Registry (accessed April 2010), American Cancer Society Facts & Figures 2009, Centers for Disease Control and Prevention, Screen for Life Fact Sheet (2009), and National Cancer Institute (2010).

To view the entire Kentucky Cancer Action Plan, which includes strategies for colon cancer outreach in the community (provider-oriented utilizing advocacy, workplace and wellness, and utilizing insurers), visit **www.kycancerc.org/cancer-action-plan.**

To learn more about the Kentucky Cancer Consortium's efforts to reduce colon cancer in our state, and how you can be part of the Colon Cancer Prevention Committee, visit **www.kycancerc.org/colon-committee.**

KCC Snapshots can be found online at **www.kycancerc.org.**

Kentucky Cancer Consortium
July 2010

Kentucky Physicians

*20 year level term policy on Woodford R. Long, Premium: N/A

Does your ordinary level term life insurance look like this?

Year 1-20: $940
Year 21: $28,280*

Like me, most of our clients will either need or want to keep their life insurance longer than planned.

Many will not be able to requalify or renew their ordinary term insurance policies.

The Kentucky Physicians term life plan is guaranteed renewable to age 75. Available in 10, 20, and yearly renewable plans, the Kentucky Physicians plan is built to protect your future, not terminate at the level period end, or lapse with prohibitive renewal premiums. Plan for the future with the Kentucky Physicians Life Plan.
www.niai.com

- Woody Long, CLU

NATIONAL INSURANCE AGENCY Inc.

Professional Association & Affinity Insurance Services

www.niai.com • Phone: 502 425-3232 • wrl@niai.com

Dan W. Varga, MD

Unintended Consequences

"We're gonna spite the nose right off of our faces."

- John Prine
In Spite of Ourselves

The art and practice of medicine is, and has always been, at its core a delicately balanced and intricately interwoven consideration of risk and benefit. Preoperative informed consent, exam room discussions of potential harm attendant to a new medication, and second opinions from colleagues comprise both the ethical and practical hallmarks of a physician's daily work. In their most elegantly applied form, these considerations expand far beyond the variables impacting the first node in a decision making algorithm, and encompass ever widening divisions of possible consequences resulting from the initial decision. This art and practice differentiates us and elevates us as a profession. At its best, it informs not only our interactions with our patients, but also guides our decision making on behalf of our community and our profession.

It seems strange, therefore, that we should today find ourselves forced to confront so many situations wrought by self-inflicted shots to the feet. Cases in point involve a bill regarding mandatory reporting of hospital infections that appeared in Frankfort before the House Committee on Health and Welfare and the recently passed bill expanding scope of practice for optometrists. Both bills arose, in large part, as a result of the unintended consequences of decisions made by our profession locally and nationally. The public reporting bill resurfaces almost annually in response to a public demand for increased transparency and accountability regarding the performance of doctors and hospitals. Physician and hospital intransigence regarding the adoption of consensus clinical accountability tools is a major reason why performance transparency is not the norm already, and is the reason that structurally flawed bills like the one filed this year inevitably reappear.

The rationale for that intransigence lies in the argument that we did not have perfect measurement systems; that there was no reliable way to risk adjust patient populations from doctor to doctor or hospital to hospital; that it was impossible to attribute accountability reliably; etc, etc, etc. While there are legitimate issues raised in each of these and other arguments, they have always been simply problems to be solved, not reasons for abandoning the work. Because we too often opted to kick this can down the road, others with less knowledge and a more focused personal or organizational agenda have taken up the work, built their own momentum, and very frequently make us look defensive, uninformed, and self-serving in our response. As doctors and hospitals rush to catch up with this train, they are amazingly acknowledging that the methodological problems noted above can be remedied without having to stop and reverse the rotation of the Earth. We may catch this train, but it is going to cost us dearly in credibility, a cost that was completely avoidable.

We may catch this train, but it is going to cost us dearly in credibility

The optometry bill reflects a similar lack of understanding on our part. The practice of medicine in this state is nebulously defined

and left to the licensure board to interpret and regulate. Because the statute does not specifically define what medicine is, the board has had the latitude to endorse expansions of services provided by physicians in response to community need, emergence of new technology (like telehealth), and economic opportunity. Usually, these expansions have served the public good. Because the statute does not define what medicine ***is not***, other disciplines have relentlessly driven to expand their scope of practice into this ill-defined landscape. Given the physician shortage and maldistribution in the state, it has become the KMA's unfortunate task to argue against expansion of scope of practice by nonphysicians without a ready physician-oriented solution to address the lack of services in many communities. Legislators and the public have grown tired of this defense, and, because there is nothing prohibitive in statute, they have embraced other options. Thus, we see the expansions such as prescriptive authority for nonphysicians and the recent optometry bill.

...other disciplines have relentlessly driven to expand their scope of practice into this ill-defined landscape

There are countless other examples to which we have been a party, but they resonate similarly. When we have not as a profession worked our way down the decision tree with the appropriate diligence, we have lived to regret it. We know how to avoid this trap. We do it every day for and with our patients. We should now know that no one else will do it for us, so we better figure out how to do it for ourselves.

Daniel W. Varga, MD

The views expressed in this editorial are those of the individual editor and do not necessarily reflect the opinion of the full Editorial Board or the KMA Board of Trustees. The Journal of the Kentucky Medical Association *wishes to foster the free exchange of ideas and opinions regarding articles that appear in these pages. If you wish to submit a Letter to the Editor, it should be written in clear, concise language, and the length should not exceed approximately two typed, double-spaced pages. Letters will be published in part, or in their entirety, at the discretion of the Editorial Board.*

2011 MEMBER-GET-A-MEMBER CAMPAIGN

Begin Recruiting Non-Members and Earn Awards for New Active KMA Members Recruited by March 1, 2011.

1-3 members	Gift Certificate
4-6 members	Wii Game System
7-9 members	iPad
10+ members	Notebook Computer ($1000 value)

Dear Editor:

Teaching after Death

As a premedical student, I had a strong desire to learn as much as I could about the medical profession prior to matriculating at medical school. I wanted clinical experience and hoped I could find a position where I could observe and interact with patients. I felt very fortunate when I actually was able to obtain such a position at a regional medical clinic near where I lived.

During one of my visits to this clinic, an oncologist asked if I would like to assist with the examination of a patient. I, the enthusiastic student, jumped at the opportunity to actually be involved in an exam. Mr C was a 61-year-old lymphoma patient, and he had such an ease about him, that despite my nervousness and confusion, I soon found myself absorbed in the history of his illness and listening intently about the course of his treatments. Mr C was very knowledgeable and articulate, and he freely encouraged me to ask questions. During his physical exam, Mr C offered to let me palpate his liver which the doctors felt was enlarged because of his disease. He was a natural teacher, and during his clinic visit, I learned so much. He was such a kind and thoughtful man—and so tolerant of my inexperience. Mr C seemed to take special care to make certain I understood every aspect of his illness and treatment, and I was grateful to have a patient who was so understanding of my awkward questions and clumsy hands. He knew I wanted to become a doctor, and he wanted to teach. He said it was important to learn something new every day, and I promised him that I would try.

When I came to the clinic the following week, a pathologist asked me if I would like to see an autopsy. I had never seen an autopsy, so I, the eager student, again jumped at the opportunity. I was determined to act professionally even though I did not have the slightest idea what to do or what to expect. When I entered the hospital morgue, the patient was on the autopsy table and to my great astonishment, it was Mr C. I have never fainted in my life, but at that moment, my knees buckled, and I stepped forward to grasp the table to support myself. What had happened? Only a few days had passed since we talked. A flood of thoughts and emotions poured over and through me. I felt weak, and despite my vow to remain professional, I was afraid I might actually faint. The pathologist asked me if I was all right, and I managed an affirmative nod. I wanted to leave, but I knew I had to stay, because all I could hear was Mr C telling me to learn something new every day, and my promise to him that I would.

The pathologist introduced Mr C's case as an unusual form of lymphoma. I watched in amazement as she gently and respectfully began her examination—first exploring the body, and then carefully making incisions. Though still in somewhat of a daze, I realized I was learning just by listening to her descriptions of her observations and findings. I had never seen a real human heart or touched an actual lobe of a lung, but I had mental preconceptions of how these organs might appear. Who, however, imagines what cancer looks like? Mr C's body was riddled with it. There were nodules and masses on or within almost every organ in his body—almost every organ, except the liver. I remembered palpating Mr C's liver in the exam room. His doctors had thought his liver was involved, but the pathologist carefully and painstakingly breaded the liver, and no gross evidence of lymphoma was noted. This finding was a surprise. As the pathologist speculated regarding this discovery, it occurred to me that Mr C was continuing to teach.

By the time the autopsy finally concluded, I had seen and learned so much. The pathologist had conducted the entire proceedings with such respect and reverence that I felt it was an honor to have been allowed in the room. As I left the morgue, I could not help but appreciate how Mr C—this kind and thoughtful gentleman—had continued to educate me even after his death. He will never know how much and how deeply his teachings have impacted and inspired me.

Many months have passed since Mr C's autopsy. I did become a medical student, and

I have kept my promise to him. I have tried to learn something new every day. I have learned, for example, that autopsies have long been recognized as having significant merit for determining the cause and manner of death, for comparing premortem and postmortem findings, for identifying new diseases and conditions, for monitoring public health, and for evaluating the effectiveness and quality of the medical care provided.[1] They can clarify a family's health problems and confirm or relieve fears regarding specific diseases. Often, by providing a specific determination for the cause of death, autopsies also can ease relatives' anguish and provide families with closure.

Learning these benefits, I assumed as my medical education and clinical experiences progressed that I would see many autopsies and have many more learning opportunities like the one I had experienced, but I am beginning to believe this may not be the case. From several of my fellow students in medical schools in different states, I have learned that many have never seen any autopsies. This was a surprise to me, but it probably should not have been; there has been a dramatic decline in the number of autopsies being conducted across the whole country.

In the United States, autopsy rates have declined "from approximately 50% in the 1960s to a low of about 5% of all patients who die in our hospitals under our care."[2] Many medical, social, legal, and economic reasons have been given for this decline,[1,2] but one of my fellow students told me that he believes autopsy rates have simply declined because, with the advances in modern diagnostic tools, they are just not needed as much anymore. I realize the decline in autopsies is likely due to a combination of many reasons, but I disagree that they are not needed anymore.

I believe autopsies are a powerful tool for advancing medical students' knowledge. They are an important part of learning about anatomy and disease. They help students learn firsthand if clinical diagnoses were correct. They provide actual evidence of patients' diseases and causes of death, and they reveal this pathologic evidence in the most direct manner I can imagine. The word autopsy, I learned, means "seeing with your own eyes" or "seeing for oneself." I can think of no greater learning tool than one that lets students see for themselves what happened to a patient. Autopsies can help students assess the quality of care their patients received and help them to plan improved care for future patients. They can also teach students about respect for the deceased and the power patients have to teach even after death.

The distinguished physician and professor, Sir William Osler, fully recognized the usefulness of autopsies in medical education and often used postmortem specimens to teach medical students.[3] In a 1903 address delivered at the New York Academy of Medicine, Osler stated that " . . . the best teaching is that taught by the patient himself."[4] It is unfortunate with the current decline in autopsy rates that an integral part of medical education is being discarded and a valuable teaching tool is being lost. I know I will forever be grateful for what Mr C taught me—in life, and after his death.

Logan Mark Skelley, BS
University of Kentucky College of Medicine
Email Address: logan.skelley@uky.edu

REFERENCES:

1. Lundberg GD. Low-tech autopsies in the era of high-tech medicine: continued value for quality assurance and patient safety. *JAMA*. 1998;280(14):1273-1274.
2. Burton EC. The autopsy: a professional responsibility in assuring quality of care. *Am J Med Qual*. 2002; 17(2):56-60.
3. Rodin AE. Osler's autopsies: their nature and utilization. *Med Hist*. 1973;17(1):37-48.
4. Osler W. The hospital as a college. In: Hinohara S and Niki H, eds. *Osler's "A Way of Life" and Other Addresses, With Commentary and Annotations, Sir William Osler*. Durham, NC: Duke University Press; 2001:277-285.

Kim Moser

Annual KMAA Spring Meeting

It is that time of year already, where the Spring Meeting Committee has been busy nailing down details of what is sure to be a wonderful Annual Spring Meeting! The dates to hold are April 18th and 19th. The events will be held in Northern Kentucky this year, my home town area. We invite all physicians, Alliance members, and future members of the Alliance to attend the Spring Meeting.

We invite all physicians, Alliance members, and future members ...to attend the Spring Meeting

After checking into the Commonwealth Hilton in Florence on Monday night, guests will be welcomed by Drs Brett Coldiron and Lana Long for a reception in their beautiful Covington home, overlooking the Ohio River and Cincinnati city skyline. This is an event not to be missed and is remembered as very special by previous KMAA guests! A stay at the Hilton is sure to delight, with a hospitality suite and lots of KMAA camaraderie!

The next morning, we will be greeted and treated to a tour of the historic Willis-Graves Bed and Breakfast Inn in Burlington, owned by Dr Bob and Mrs Nancy Swartzel, where we will enjoy coffee and light breakfast. Immediately following, we will stroll to the Tousey House Restaurant in historic Burlington for our meeting. Nationally distinguished antiques aficionado Ray Mongenas will entertain and educate with our own version of the "Traveling Antiques Roadshow"! Bring your old family heirloom or garage sale find, if it's small enough to carry, and see if it is what you think it is! This will be followed by a wonderful luncheon and fun visiting.

Hotel reservations should be secured by April 1 to get the group rate of $109 per room (normally $189). Visit the website at www.kmaalliance.org for registration information.

I also want to give a shout out to all Kentucky physicians in observance of Doctor's Day on March 30. Around the state, Alliance members join with others in their communities to celebrate you and the amazing profession you have chosen. We appreciate all that you do for the people of our Commonwealth!

Kimberly Moser, President
KMA Alliance

stability matters.

If there is one thing to learn from the recent financial turmoil, knowing who to trust is paramount.

Medical Protective, a proud member of Warren Buffett's Berkshire Hathaway, has always believed that to provide our healthcare providers the best defense in the nation, our financial stability needs to be *rock-solid*, stronger than any other company.

Stability even in the worst of times.

Medical Protective is the only medical professional liability insurance company to protect their healthcare providers through all the business and economic cycles of the last 110 years, including the tough economic times of *the Great Depression*. We are also proud to have provided unmatched defense and stability during all the medmal crises.

We have received higher ratings from A.M. Best and S&P than any other carrier in the healthcare liability industry.

Trust Stability. Trust Medical Protective.

MEDICAL PROTECTIVE

Strength. Defense. Solutions. Since 1899.

a Berkshire Hathaway Company

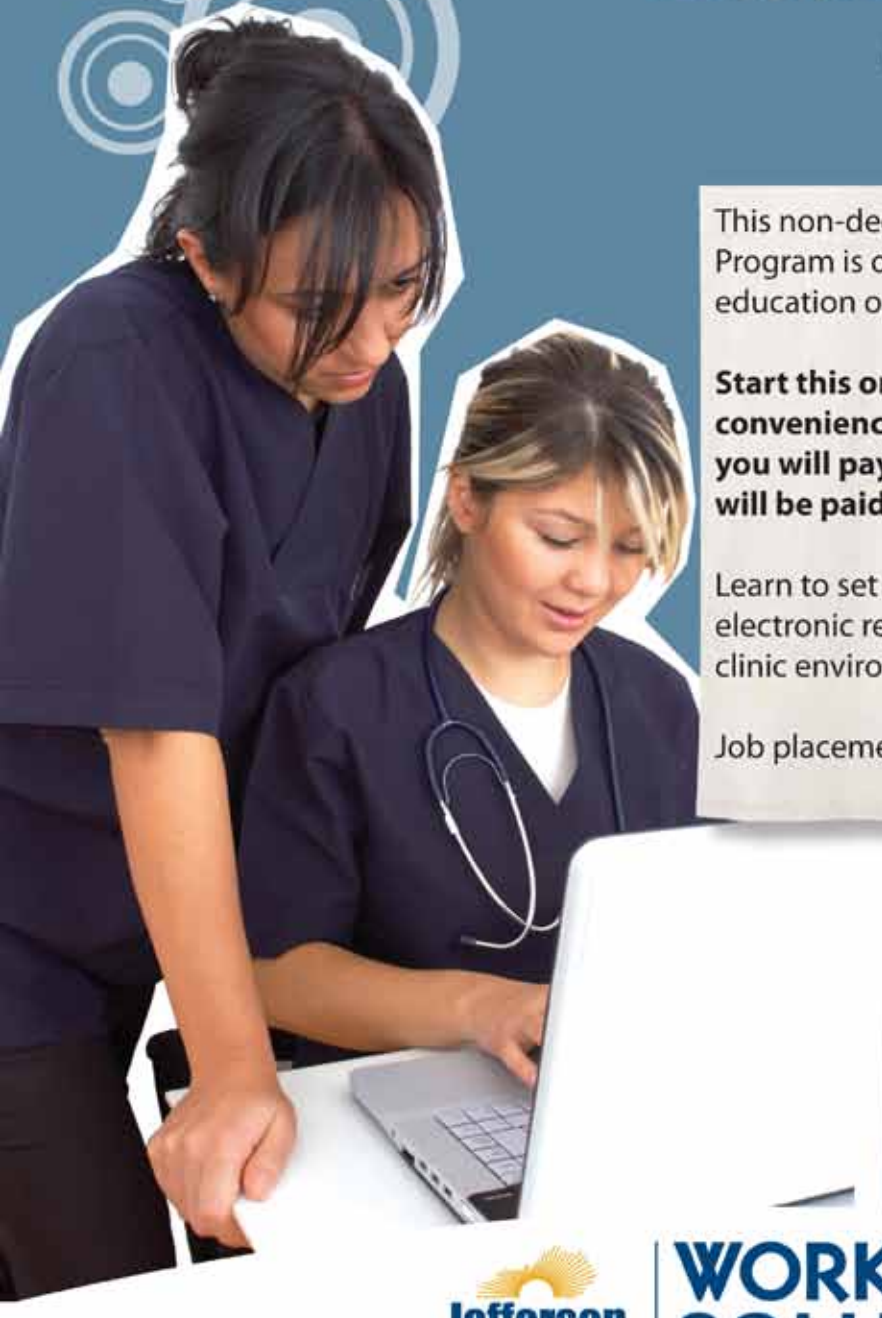
Serving Kentucky doctors since 1922. Contact Debbie Lopez today for your FREE no-obligation quote.

- Call: 800-4MEDPRO ext. 3939
- Email: experts@medpro.com
- Visit: www.medpro.com
- Contact your local Medical Protective agent

All products are underwritten by either The Medical Protective Company® or National Fire and Marine Insurance Company,® both Berkshire Hathaway businesses. Product availability varies based upon business and regulatory approval and may be offered on an admitted or non-admitted basis. ©2011 The Medical Protective Company.® All Rights Reserved.

New federal law requires all medical records to be electronic by 2015

You may qualify for a free 6-month, on-line training program to develop the Electronic Health Record for doctor's offices and hospitals



This non-degree Health Information Technology Training Program is open to people with medical or computer education or backgrounds.

Start this on-line program at any time, at your convenience. If you complete the program in 6-months, you will pay only a $50 registration fee; the $490 tuition will be paid.

Learn to set up Electronic Health Records, coordinate electronic records for a hospital, physician's office or other clinic environment, or learn to train others.

Job placement assistance is provided to graduates.

Apply today!
(502) 213-2605
Jefferson.KCTCS.edu
(Workforce Solutions)

Jefferson Community & Technical College | WORKFORCE SOLUTIONS
CUSTOMIZED EMPLOYEE TRAINING

KENTUCKY COMMUNITY & TECHNICAL COLLEGE SYSTEM

Life Members

The Kentucky Medical Association would like to recognize physicians who have recently become Life Members of the Association.

CAMPBELL

Roger A. Haas, MD
Fort Thomas KY

JEFFERSON

Joseph R. Bowling, MD
Louisville KY
David L. Douglas, MD
Prospect KY
James I. Harty, MD
Louisville KY
Mohammed Hussain, MD
Jeffersonville IN
Ronald E. Podoll, MD
Louisville KY
Glenn R. Stoutt, MD
Louisville KY
Richard J. Wiesemann, MD
Louisville KY
Nathan Zimmerman, MD
Louisville KY

KENTON

Thomas M. Mayer, MD
Lakeside Park KY

PULASKI

Randall Clark, MD
Sanibel FL

New Members

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members of these organizations.

BARREN

Donna M. Warren, MD **PD**
Glasgow
2004, U of Louisville

BOYD

Bonnie Laudenbach, MD **OBG**
Ashland
1978, Michigan State U

BOYLE

Ginny L. Gottschalk, MD **FM**
Danville
2007, U of Kentucky

FAYETTE

R. Carter Cassidy, MD **ORS**
Lexington
2000, Northeastern Ohio U
Leonard R. Durrett, MD **AN**
Lexington
1982, U of Texas Med Branch
Jonathan Hundley, MD **S**
Lexington
2000, U of Louisville
Steven J. Lawrence, MD **ORS**
Lexington
1987, Jefferson Med Coll
of Thomas Jefferson
James Y. Liau, MD **PS**
Lexington
2003, U of Kentucky
Kirit Patel, MD **PTH**
Tampa
1968, U of Baroda
Denise W Phillips, MD **HOS**
Lexington
2001, U of Louisville
Akaluck Thatayatikom, MD **A**
Lexington
1989, Chiangmai U

JEFFERSON

Rakesh Gopinathannair, MD **C**
Louisville
2000, U of Kerala, Trivandrum
Mohammad Ali Haider, DO **OPH**
Louisville
2005, Lake Erie Coll of Osteopathic Med
Thomas Kelly, MD **PMR**
Louisville
2004, U of Cincinnati
Michael Eli Pendleton, MD **FM**
Louisville
2005, U of Kentucky

Mitra Shams, MD **IM**
Prospect
1994, U of Vienna

PERRY

Gary W. Turner, MD **FM**
Jackson
2005, St. Matthew's U Grand Cayman

PIKE

Leslieann Dotson, DO **PD**
Paintsville
2007, U of Kentucky

IN TRAINING

FAYETTE

Carrie Reschke, MD **PM**
Shivan Tekwani, MD **OPH**

Obituaries

Jerry D. Fraim, MD
Paintsville, KY
1931-2011

Jerry D. Fraim, MD, a retired family physician, died January 6, 2011. Dr Fraim graduated from the University of Tennessee Science Center College of Medicine in 1962 and was a Life member of KMA.

Edgar B. Morgan Sr, MD
Louisville, KY
1918-2011

Edgar B. Morgan Sr, MD, a retired family physician, died February 7, 2011. Dr Morgan graduated from the University of Louisville School of Medicine in 1950, and he was a Life member of KMA.

Garnett J. Sweeney, MD
Liberty, KY
1914-2011

Garnett J. Sweeney, MD, a retired family physician, died February 9, 2011. Dr Sweeney graduated from the University of Louisville School of Medicine in 1939, and he served the Casey County and surrounding areas for 56 years before retiring in 1996 at the age of 82. Dr Garnett served on the Board of Trustees of the Kentucky Medical Association, going on to serve as the KMA Board Chair. In 1979 he received the KMA Distinguished Service Award. He was a Life member of KMA.

Newsmakers

Louisville researcher receives NIH grant

Roberto Bolli, MD, has been awarded $9.5 million over five years to form a multi-center network to study "cardioprotective therapies." The grant was awarded by the National Heart, Lung and Blood Institute, part of the National Institutes of Health, and it is reported to be the first time the NIH has funded a network of laboratories to test cardioprotective therapies at the preclinical level.

Dr Bolli is Director of the Institute of Molecular Cardiology and Chief of the Division of Cardiovascular Medicine at the University of Louisville Health Sciences Center. He is also principal investigator of the CAESAR Project. Dr Bolli will oversee a consortium of laboratories at U of L, Johns Hopkins University in Baltimore, Emory University in Atlanta, and Virginia Commonwealth University in Richmond.

The network's data will be shared with scientists across the nation in an effort to translate basic research into clinical therapies for patients with acute myocardial infarction.

Keep talking to your patients about colon cancer screening.
So you won't have to talk to them about colon cancer.

©2005 American Cancer Society, Inc.

If everyone who's 50 and older would get screened for colorectal cancer, the death rate could be cut in half*. You play a critical role in your patients' decisions to get tested. So make it a priority to talk to your patients about getting screened. For some helpful tools, call us at 1-800-ACS-2345 or visit www.cancer.org/colonmd. This is how we can work together to prevent colorectal cancer. This is the American Cancer Society.

*Source: http://prg.ncl.nih.gov/colorectal/

Hope.Progress.Answers.® / 1.800.ACS.2345 / www.cancer.org/colonmd

American Cancer Society®

Medicare Coding Tip

March is National Colorectal Cancer Awareness Month

Medicare Coding Tip for Colorectal Screening Tests – When to Use the *New* "PT" Modifier

The question of how to code a screening colonoscopy that becomes diagnostic during the course of the procedure and whether the patient's deductible applies has caused some gastrointestinal distress to physician practices over the years.

This problem has been solved with the implementation of a new modifier for use in cases where a screening flexible sigmoidoscopy, screening colonoscopy, or barium enema is initiated as a colorectal cancer screening service, but clinical findings lead to a diagnostic colonoscopy on the same date of service.

Effective January 1, 2011, the modifier PT will be appended to the diagnostic procedure code (range 10000 to 69999), and the claims processing system will process the service as part of the screening benefit allowing the deductible to be waived.

Reference: MLN Matters: MM7012

For complete guidelines on Medicare coverage for Colorectal Cancer Screening please visit: http://www.cms.gov/ColorectalCancerScreening/

Thanks to our advertisers!

American Cancer Society 85

Jefferson Community and Technical College . . .82

Kindred Healthcare.. 62

Medical Protective 81

National Insurance Agency 74

PNC Bank. 61

ProAssurance 69

The Doctors Company 53

For complete advertising information, visit our website at
www.kyma.org **or contact:**
Sharon Heckel, Managing Editor
502.426.6200
heckel@kyma.org