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Q&A WITH DR. MEDLAW

Underlying Principles of Payment

The COVID-19 crisis has put many practices under great stress as far as payments as patients lose insurance coverage or cannot cover bills. However, it is essential to remember that the underlying principles in these situations have not changed. Let's look at a few questions that came in before the crisis to reinforce these basic points.

Q: *I converted my family practice to all-cash last year and it has worked out well in most cases - I offer very competitive pricing and the time I don't spend dealing with paperwork I can spend with my patients. However, I have one patient who is always behind, and this has continued even on a $20 per month payment plan. I see him at least every 3 months to follow his diabetes, so this is really backing up. He is actually a great patient otherwise, but this non-payment cannot just continue. Can I terminate him now just for non-payment? Can I make payment a requirement for a new appointment?*

Yes, to your first question but no to your second. The situation in which a patient is under active care that cannot be suddenly discontinued, which would be what most doctors understand to be abandonment, does not apply here. With enough notice, termination is possible. As long as you do not breach your fiduciary duty to not abandon your patient, you may withdraw for any reason. However, keeping him in your practice but refusing to see him until he pays is "internal abandonment"—the patient is kept on the rolls of the practice but gets no care. If you keep him on, he is to be treated as any patient would be, regardless of payment status.

Q: *As a small-town doctor, I have always been lenient on collecting co-pays and dealing with deductibles when patients really cannot afford them. I put a note in the chart of any patient I don't collect on explaining the circumstances. However, I have colleagues who say that it is fraud.*

This can be very risky for you. While AMA Opinion 6.12 says that when the share the patient is responsible for "is a barrier to needed care because of financial hardship, physicians should forgive or waive" it, that is an aspirational ethics statement, and you are still bound by the payor relationships that you have that bind you to collect. If you waive a co-pay, correct your billing to reflect it. There is also the problem of violation of the Anti-Kickback Statute if you do not collect co-pays or apply deductibles to patients in federal healthcare programs. Following the rules with both private and governmental payors should let you keep on helping your patients without risk to yourself.

Q: *How come a hospital can get a patient set up with Medicaid so they can get paid, but I can't pay a premium on a patient's insurance so that it doesn't lapse so that I can get paid?*

You cannot pay for a policy under which you will benefit by the insurer paying you. The hospital, by contrast, is not making a payment and is just assisting the patient to obtain access to what they are eligible for.

This article was written by Dr. Medlaw, a physician and medical malpractice attorney. It originally appeared on SERMO, which retains all rights to it.

Comparing Treatments for Early-Stage Endometrial Cancer With Lymphovascular Space Invasion

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Research indicates that women with early-stage endometrial cancer who have lymphovascular space invasion on their hysterectomy specimen have more aggressive tumors that are more likely to spread to the lymphatics, more likely to recur, and are associated with poor survival. However, consensus is lacking on the optimal treatment for these patients in order to prevent recurrence and improve survival, explains Anna L. Beavis, MD, MPH. "Moreover, more and more data show that a tailored, specific approach to cancer treatment optimizes outcomes," she adds. "Not all endometrial cancers are the same, and with regard to treatment, one size may not fit all."

Comparing Treatment Modalities

For a study published in *Gynecologic Oncology*, Dr. Beavis and colleagues compared progression-free and overall survival in women with stage IA-II endometrial cancer with endometrioid histology with lymphovascular space invasion who were treated with surveillance alone, radiation (external beam and/or vaginal brachytherapy) alone, or systemic chemotherapy with or without radiation. "We were particularly interested in the effect of chemotherapy on recurrence risk in this population," notes Dr. Beavis. "We therefore formed a collaboration between eight institutions, combining data from the prospective endometrial cancer databases of each."

All 478 participants had undergone hysterectomy with or without lymphadenectomy from 2005-2015, had a median age of 64, and were followed for a median of 50.3 months. Following surgery, 30% underwent observation, 48.5% received radiation only, and 21.5% received chemotherapy, 95% of whom also received radiation. Although demographics were similar among the groups, those undergoing observation had lower tumor stage and cancer grade. Risk of recurrence was assessed after controlling for factors known to be associated with recurrence, including age, tumor grade, and cancer stage. "We also tested our hypothesis that chemotherapy would have a different effect on grade III tumors compared with grade I/II tumors by testing for an interaction and looking at the treatment effects in grade III tumors alone," Dr. Beavis explains.

Improved Recurrence Rates

Overall, recurrence occurred in 21% of women. Compared with observation alone, progression-free survival was improved with both chemotherapy with or without radiation (hazard ratio [HR], 0.18) and radiation alone (HR, 0.31). "However, in the total cohort, neither radiation nor chemotherapy with or without radiation was superior to the other," notes Dr. Beavis. "That said, when we looked specifically at grade III tumors—which are known to be more aggressive—we found that the treatment group who received chemotherapy (of whom 95% also had radiation) had lower recurrence rates compared with those who received radiation alone or surveillance. Unfortunately, overall survival did not differ by group, regardless of grade, though we did not have the power to detect a difference in our study."

Additional Research Needed

According to Dr. Beavis, the study findings suggest a potential role for chemotherapy in the adjuvant setting for early-stage, high-grade endometrial cancer with lymphovascular space invasion. "However," she says, "this is only hypothesis-generating data and something that needs further study in a trial before being used to change clinical practice." To that end, Dr. Beavis notes the need for future research focused on individualizing treatment for early-stage endometrial cancer based on tumor and molecular characteristics. "In the United States, we could consider a cooperative group trial evaluating the effect of chemotherapy in grade III tumors with lymphovascular space invasion, in order to better clarify the role chemotherapy may play in adjuvant therapy for early-stage endometrial cancer," she adds.

Table Progression-Free & Overall Survival

Variable	Progression-Free Survival		Overall Survival	
	Hazard Ratio	95% CI	Hazard Ratio	95% CI
Adjuvant therapy				
OBS	Ref		Ref	
RAD	**0.31**	**(0.18-0.54)**	1.20	(0.90-1.60)
CHEMO+/-RAD	**0.18**	**(0.09-0.39)**	1.07	(0.75-1.50)
Age				
<60 years	Ref		Ref	
>60 years	0.99	(0.59-1.67)	0.90	(0.71-1.16)
BMI				
Normal/underweight	Ref		Ref	
Overweight	0.80	(0.39-1.67)	1.48	(1.04-2.11)
Obese	0.86	(0.48-1.55)	1.33	(0.99-1.78)
FIGO Stage				
IA	Ref		Ref	
IB	0.91	(0.43-1.95)	0.87	(0.62-1.23)
II	**2.66**	**(1.09-6.50)**	1.12	(0.71-1.77)
FIGO grading				
Grade 1	Ref		Ref	
Grade 2	0.97	(0.52-1.80)	1.09	(0.84-1.43)
Grade 3	**2.63**	**(1.37-5.03)**	1.18	(0.85-1.64)
DOI				
Inner one-third	Ref		Ref	
Middle one-third	**2.86**	**(1.32-6.21)**	1.03	(0.76-1.39)
Outer one-third	**3.63**	**(1.42-9.29)**	1.05	(0.69-1.59)
Tumor size	1.04	(0.94-1.15)	1.00	(0.94-1.06)

Abbreviations: BMI, body mass index; CHEMO, chemotherapy; DOI, depth of invasion; FIGO, International Federation of Gynecology and Obstetrics; OBS, observation; RAD, radiology.
Bold text indicates the hazard ratio and corresponding confidence interval (CI) are of statistical significance.

Source: Adapted from: Beavis A, et al. *Gynecol Oncol.* 2020;156(3):568-574.

Higher Recurrence & Mortality With MIS?

Minimally invasive surgery for gynecologic cancer has been embraced over the past 2 decades and touted for its efficacy, fewer complications, and reduced recovery time; however, two studies published in *JAMA Oncology* suggest that careful patient selection and surgical skill need to be taken into account when deciding to use this approach.

In systematic review and meta-analysis of observational studies, Roni Nitecki, MD, and colleagues set out to assess the risk of cancer recurrence and all-cause mortality associated with MIS (laparoscopic/robot assisted) compared with open radical hysterectomy in early stage cervical cancer. They culled data from observational studies performed in an academic setting that were optimized to control for confounding. "The pooled hazard of recurrence or death was 71% higher among patients who underwent minimally invasive radical hysterectomy compared with those who underwent open surgery (hazard ratio [HR], 1.71), and the hazard of death was 56% higher (HR, 1.56)," Nitecki and colleagues reported. In drilling down to see if there was a difference between MIS with robot assist, they found no significant difference in the risk of recurrence or death.

Koji Matsuo, MD, PhD, and colleagues conducted an observational study of women with early-stage ovarian cancer undergoing MIS "Among 8,850 women with stage I ovarian cancer, 2,600 women (29.4%) underwent MIS," the study authors wrote. "Use of MIS increased from 19.8% (263 of 1,330) in 2010 to 34.9% (554 of 1589) in 2015 (1.8-fold increase)." Of these, capsule rupture was seen in 22.5%. There was an increase in occurrence over time, from 20.2% in 2010 to 23.9% in 2015. Moreover, there was an independent association between MIS and capsule rupture (adjusted relative risk, 1.17). This was also seen with larger tumor size.

"Women with ruptured tumors were more likely than women with nonruptured tumors to receive chemotherapy," they wrote. "Women with ruptured tumors had lower overall survival compared with those with nonruptured tumors in univariable analysis: 4-year rates, 86.8% for open surgery and ruptured tumors, 88.9% for MIS and ruptured tumors, 90.5% for open surgery and nonruptured tumors, and 91.5% for MIS and nonruptured tumors." MIS with capsule rupture was independently associated with all-cause mortality.

Trends in Brachytherapy for Cervical Cancer

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Evidence shows brachytherapy to be an essential component of definitive treatment for locally advanced cervical cancer (LACC) in combination with external beam radiation and cisplatin-based chemotherapy. The omission of brachytherapy for LACC is associated with inferior survival, even when replaced with an intensity-modulated or stereotactic body radiation therapy boost, according to research findings. Despite the success of brachytherapy, several studies have reported overall declines in brachytherapy use for LACC during the 1990s through the 2010s, while other studies examining privately insured populations during the same period found no declines.

Because of this discrepancy, we analyzed brachytherapy utilization by insurance category in the National Cancer Database from 2004 to 2014, with the hypothesis that the burden of declined brachytherapy use was primarily felt by uninsured patients or those with Medicaid or Medicare. Our analysis, published in *Gynecologic Oncology*, showed that use of brachytherapy declined in the late 2000s and disproportionately affected government-insured patients; however, in the early 2010s, these trends reversed, such that patients of all insurance types experienced overall improved rates of brachytherapy utilization. We believe that contemporaneous publications, press, and awareness raised at national meetings may have been important in reversing this trend. Additionally, the implementation of the Affordable Care Act, which had wide-reaching effects on healthcare—including provisions aimed at strengthening care in underserved areas—may have also positively influenced this trend.

Given the importance of brachytherapy in LACC treatment, it is critical that these gains are solidified and encouraged. With the previous declines in brachytherapy appearing to affect patients with government insurance more severely—despite the encouraging recent trends—it may be prudent to implement additional measures for government-insured patients to buffer against any subsequent declines. Alternative payment models (APMs), which align compensation with high-quality and cost-efficient care, have been proposed in this area. APMs for cervical cancer, however, must be constructed carefully to avoid disincentivizing brachytherapy delivery in a fixed payment system, as brachytherapy is more expensive to providers than external beam boost. Overall, recent trends in brachytherapy use in LACC patients are positive, and hopefully the implementation of well-designed APMs can promote these gains.