2013 Reimbursement Changes for Gastroenterology

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Chair, Practice Mgt. Comm.
American Society for Gastrointestinal Endoscopy

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Change this? AAPC instead?
Braswell, Megan, 12/12/2012
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Is this Glenn's LLC?
Braswell, Megan, 12/12/2012
Agenda

• Introduction
• 2013 Key GI Code Changes--Additions, Deletions, Replacements
  – ICD-9 Codes
  – ICD-10 Update and Implications
  – HCPCS/CPT® Codes*
  – C-codes
• Summary of Medicare Payment Changes for GI Procedures for 2013
  • Outpatient Hospital: Changes for 2013
  • Inpatient Hospital: Changes for 2013
  • Ambulatory Surgery Center (ASC): Changes for 2013
  • Physician: Changes for 2013
• Health Care Reform Proposals: Update for Gastroenterology
• A few polling questions along the way: What are YOU doing?
• Discussion / Questions

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Polling Question

• Just what are you?
  - (1) ASC-based nurse/manager
  - (2) Office Practice-based nurse/manager/administrator
  - (3) HOPD nurse/manager/administrator
  - (4) Coder
  - (5) Physician
  - (6) “Other”
2013 Key GI Code Changes
Additions, Deletions, Replacements
2013 ICD-9 Diagnosis Code Changes

NO CHANGES FOR 2013
(Freeze with 2014 ICD-10 coming)

If you would like more information or would like to review 2010 and 2011 updates:
http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm
It’s Coming.....ICD-10 Update

• US implementation date was pushed off to October 1, 2014, although ICD-11 becoming the world standard (electronic)

• ICD-10-PCS is the new **PROCEDURE** coding system that is being developed as a replacement for ICD-9-CM, Volume 3
  – Physician services: Continue using CPT

• ICD-10-CM is the new **DIAGNOSIS** coding system that is being developed as a replacement for ICD-9-CM, Volumes 1 & 2

• For Information on ICD-10:
Procedure is CM?
Braswell, Megan, 12/12/2012
Implications of ICD-10

• Granularity, “space”, “logic”

• Major strain/work for billing professionals
  – Training for coders & then the rest of us

• Payer’s claims edits need to use the same crosswalks
  – Clear and transparent crosswalks needed early

• Impact on payment for inpatient procedures
  – Mapping from ICD-9 to ICD-10 to understand impact on MS-DRG

• 2012: 5010 data standards allow for transmitting ICD10
ICD9, ICD10...tweedlenine & tweedleton?
Examples of ICD-10

- **V80.8** Animal-rider or occupant of animal-drawn vehicle injured in collision with fixed or stationary object

- **V80.81** Animal-rider injured in collision with fixed or stationary object

- **V80.82** Occupant of animal-drawn vehicle injured in collision with fixed or stationary object
Got a headache yet?

T39 Poisoning by, adverse effect of and underdosing of nonopioid analgesics, antipyretics and antirheumatics

The appropriate 7th character is to be added to each code from category T39
A initial encounter
D subsequent encounter
S sequela

T39.0 Poisoning by, adverse effect of and underdosing of salicylates
T39.01 Poisoning by, adverse effect of and underdosing of aspirin
   Poisoning by, adverse effect of and underdosing of acetylsalicylic acid
T39.011 Poisoning by aspirin, accidental (unintentional)
T39.012 Poisoning by aspirin, intentional self-harm
T39.013 Poisoning by aspirin, assault
T39.014 Poisoning by aspirin, undetermined
T39.015 Adverse effect of aspirin
T39.016 Underdosing of aspirin
Examples of ICD-10

MOSTLY 1:1 changes, BUT
- 28 Crohn’s codes
- 34 Ulcerative colitis codes
- 24 diverticulosis/diverticulitis

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>530.85</td>
<td>Barrett’s esophagus</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD-10</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>K2270</td>
<td>Barrett’s esophagus without dysplasia</td>
</tr>
<tr>
<td>K22710</td>
<td>Barrett’s esophagus with low grade dysplasia</td>
</tr>
<tr>
<td>K22711</td>
<td>Barrett’s esophagus with high grade dysplasia</td>
</tr>
<tr>
<td>K22719</td>
<td>Barrett’s esophagus with dysplasia, unspecified</td>
</tr>
</tbody>
</table>
More examples

Signs/Symptoms
  R14.0 Abdominal distension (gaseous)
  R14.1 Gas pain
  R14.2 Eructation
  R14.3 Flatulence

Abdominal Pain
  R10.11 RUQ pain
  R10.12 LUQ pain
  R10.13 Epigastric pain

Anemia
  D50.0 Iron deficiency anemia secondary to blood loss (chronic)

Inflammatory Bowel Disease
  K50.00 Crohn's disease of small intestine without complications
  K50.011 Crohn's disease of small intestine w bleeding
  K50.012 Crohn's disease of small intestine w intestinal obstruction

Large Intestine/Rectum
  K58.0 Irritable bowel syndrome with diarrhea
  K58.9 Irritable bowel syndrome without diarrhea
43206: Esophagoscopy, rigid or flexible; with optical endomicroscopy

43252: Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with optical endomicroscopy

**APC for HOPD: 419;** $927 Medicare national average facility fee

Physician fee “contractor determined” 2013. Likely to be on fee schedule for 2014
New 2013 Gastroenterology CPT® Codes

• **44705**: Preparation of fecal microbiota for instillation, including assessment of donor specimen <for C difficile colitis>
  - CMS: rejected RUC value; created G0455 code “fecal microbiota preparation & instillation”
  - Work RVU 0.97
  - Physician Medicare fee approximately $90

• **91112**: (replaces cat.III 0242T) GI transit & pressure measurement, stomach through colon, wireless capsule, with interpretation and report
  - TC Medicare fee approximately $730-912
  - PC Medicare fee approximately $75-88
GI codes in the hot seat

CMS requires re-survey of all GI code families
Any new code in a family → resurvey entire family

Ouch!
CPT / RUC Cycle

CPT Editorial Panel → Level of Interest

Medicare Payment Schedule

CMS

The RUC

Survey

Specialty RVS Committee
## Endoscopy Code Family Survey Calendar

<table>
<thead>
<tr>
<th>Procedure Family</th>
<th>Code Range</th>
<th># of Codes in Family</th>
<th>When Surveyed?</th>
<th>Present to RUC</th>
<th>Medicare Fee Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Esophagoscopy</td>
<td>43200-43234</td>
<td>16</td>
<td>Summer 2012</td>
<td>October 2012</td>
<td>2014</td>
</tr>
<tr>
<td>Dilation</td>
<td>43450-43458</td>
<td>4</td>
<td>Summer 2012</td>
<td>October 2012</td>
<td>2014</td>
</tr>
<tr>
<td>EGD</td>
<td>43235-43259</td>
<td>22</td>
<td>Fall 2012</td>
<td>January 2013</td>
<td>2014</td>
</tr>
<tr>
<td>ERCP</td>
<td>43260-43273</td>
<td>12</td>
<td>Winter 2013</td>
<td>April 2013</td>
<td>2014</td>
</tr>
<tr>
<td>Enteroscopy</td>
<td>44360-44373</td>
<td>10</td>
<td>Winter 2013</td>
<td>April 2013</td>
<td>2014</td>
</tr>
<tr>
<td>Enteroscopy to Ileum</td>
<td>44376-44382</td>
<td>4</td>
<td>Winter 2013</td>
<td>April 2013</td>
<td>2014</td>
</tr>
<tr>
<td>Procedure Family</td>
<td>Code Range</td>
<td># of Codes in Family</td>
<td>When Survey?</td>
<td>Present to RUC</td>
<td>Medicare Fee Schedule</td>
</tr>
<tr>
<td>-------------------------------</td>
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<td>--------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Ileoscopy</td>
<td>44380-44386</td>
<td>5</td>
<td>Summer 2013</td>
<td>October 2013</td>
<td>2014</td>
</tr>
<tr>
<td>Flexible Sigmoidscopy</td>
<td>45330-45345</td>
<td>13</td>
<td>Summer 2013</td>
<td>October 2013</td>
<td>2014</td>
</tr>
<tr>
<td>Colonoscopy through Stoma</td>
<td>44387-44397</td>
<td>8</td>
<td>Fall 2013</td>
<td>January 2014</td>
<td>2015</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>45378-45392</td>
<td>12</td>
<td>Fall 2013</td>
<td>January 2014</td>
<td>2015</td>
</tr>
<tr>
<td><strong>Total Codes</strong></td>
<td><strong>102</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
RUC Surveys of GI Endoscopy Services

- From ASGE, AGA; applies to physician fees only; only resurveying work RVUs
  - Time, intensity; pre-scope, intra-scope, post-scope same day
- Random sampling + focused sampling of low volume-high tech services
- Inadequate response rate means peers won’t have much input into ultimate fees (RUC makes cuts, CMS makes cuts)
- Surveys take time (e.g., 1-2 hours per batch per doctor)
  - Can pause, go back to finish
  - Educational slide set
- WE NEED VOLUNTEERS: Please e-mail sreynolds@asge.org or lnarrimore@gastro.org
Esophagoscopy CPT changes
- Code sets for rigid, flexible and trans-nasal esophagoscopy
- Some dilation codes (achalasia) will be endoscopy codes
- EMR (endoscopic mucosal resection) code
- Ablation (e.g. Barretts) will include dilation if done

EGD series
- EMR code

ERCP codes: Stay tuned
- (February 2013 CPT meeting)

Enteroscopy: Stay tuned
- (February 2013 CPT meeting)

2015: All the rest.....

Note: Please be aware that these actions are a reflection of the discussions at the most recent Panel meeting. Future Panel actions may impact these items. Codes are not assigned, nor exact wording finalized, until just prior to publication. Release of this more specific CPT code set information is timed with the release of the entire set of coding changes in the CPT publication.
Summary of Medicare Payment Changes for GI Procedures for 2013

- Outpatient Hospital
- Inpatient Hospital
- Ambulatory Surgery Center (ASC)
- Physician
2013 Medicare Hospital Outpatient Changes
Medicare Hospital Outpatient Payment

Ambulatory Payment Classifications (APCs)
Fixed Fee per Outpatient Procedure

- Medical devices
- Lab fees
- Procedure charge
- Ancillary care
- Nursing care
- Diagnostics
- Goods and services used during stay
- Operating room time

Procedure charge

$
Medicare Hospital Outpatient Payment Has Consistently Increased Over 9 Years

Medicare Outpatient Hospital Payment Trends 2004-2013: Select Endoscopy Procedures

- ERCP & Cholangioscopy
- Upper GI Procedure Level II: Dilation & Hemostasis
- Upper GI Biopsy Procedure Level I: Biopsy
- Lower GI Procedures: Dilation & Hemostasis
- Biliary Stenting
Key Themes: 2013 Final Outpatient Hospital Rule (HOPPS)¹⁰

- Payment rates for acute care hospitals to increase 1.8%
- Total 2013 payments estimated $48.1 billion
- Payments are now based on geometric mean costs rather than median costs
- No addition of quality measures, but CMS made several changes to the program including changing data collection timelines for 2 measures
  - Finalized the automatic retention of the Hospital Outpatient Quality Reporting Program (Hospital OQR) measures.
2013 GI Final Medicare Hospital Outpatient Payment

• Payments for GI procedures to stay stable or increase up to 5%

• GI procedures seeing increases include:
  • GI Stenting (3%)
  • Hemostasis (5%)
  • Upper GI EUS (5%)
  • Dilation (5%)
  • Biopsy (5%)

• Please remember to report C-codes & associated costs for applicable devices!
  – Helps improve accuracy claims data driving Medicare hospital outpatient payment
## 2013 Medicare National Average Final Hospital Outpatient Payment

<table>
<thead>
<tr>
<th>APC</th>
<th>Description</th>
<th>Select APC Procedures</th>
<th>2012 Final Payment</th>
<th>2013 Final Payment</th>
<th>% Change 2012-2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>141</td>
<td>Upper GI Endoscopy</td>
<td>Upper GI w/ biopsy, Diagnostic Upper GI</td>
<td>$592</td>
<td>$623</td>
<td>5%</td>
</tr>
<tr>
<td>146</td>
<td>Sigmoidoscopy, Level I</td>
<td>Sigmoidoscopy w/ biopsy</td>
<td>$436</td>
<td>$420</td>
<td>-4%</td>
</tr>
<tr>
<td>147</td>
<td>Sigmoidoscopy, Level II</td>
<td>Sigmoidoscopy w/ balloon dilation</td>
<td>$775</td>
<td>$716</td>
<td>-8%</td>
</tr>
<tr>
<td>151</td>
<td>ERCP</td>
<td>Diagnostic ERCP, ERCP with biopsy</td>
<td>$1,729</td>
<td>$1,727</td>
<td>0%</td>
</tr>
<tr>
<td>151</td>
<td>ERCP</td>
<td>Cholangioscopy</td>
<td>$1,729</td>
<td>$1,727</td>
<td>0%</td>
</tr>
<tr>
<td>143</td>
<td>Lower GI Endoscopy</td>
<td>Diagnostic colonoscopy</td>
<td>$656</td>
<td>$691</td>
<td>5%</td>
</tr>
<tr>
<td>158</td>
<td>Colorectal Cancer Screening: Colonoscopy</td>
<td>Screening colonoscopy</td>
<td>$582</td>
<td>$612</td>
<td>5%</td>
</tr>
<tr>
<td>384</td>
<td>GI Stenting Procedures</td>
<td>ERCP, EGD, Colonoscopy with stent placement</td>
<td>$2,046</td>
<td>$2,117</td>
<td>3%</td>
</tr>
<tr>
<td>419</td>
<td>Level II Upper GI Procedures</td>
<td>EUS, Upper GI w/ dilation</td>
<td>$886</td>
<td>$927</td>
<td>5%</td>
</tr>
<tr>
<td>422</td>
<td>Level III Upper GI Procedures</td>
<td>BARR-X (RFA Barrett’s)</td>
<td>$1,818</td>
<td>$1,867</td>
<td>3%</td>
</tr>
</tbody>
</table>
### New in 2013: Endomicroscopy Hospital Outpatient Payment

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Procedure</th>
<th>2013 Final Outpatient Payment</th>
<th>2013 MD In-Facility Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>43206</td>
<td>Esoph optical endomicroscopy</td>
<td>$927</td>
<td>CONTRACTOR</td>
</tr>
<tr>
<td>43252</td>
<td>EGD optical endomicroscopy</td>
<td>$927</td>
<td>CONTRACTOR</td>
</tr>
</tbody>
</table>
2013 Final Medicare Hospital Inpatient Payment

Medicare Severity-Diagnosis Related Groups (MS-DRGs)
Fixed Fee per Inpatient Stay

- Lab fees / Drugs*
- Procedure charge
- Ancillary care
- Medical devices
- Diagnostics
- Goods and services used during stay
- Operating room time
- Nursing care

Medical devices

Fixed Fee per Inpatient Stay

2013 Final Medicare Hospital Inpatient Payment

Medical devices

Fixed Fee per Inpatient Stay

Lab fees / Drugs*

Procedure charge

Ancillary care

2013 Final Medicare Hospital Inpatient Payment

Medicare Severity-Diagnosis Related Groups (MS-DRGs)
Fixed Fee per Inpatient Stay

- Lab fees / Drugs*
- Procedure charge
- Ancillary care
- Medical devices
- Diagnostics
- Goods and services used during stay
- Operating room time
- Nursing care

Medical devices

Fixed Fee per Inpatient Stay

Lab fees / Drugs*

Procedure charge

Ancillary care

2013 Final Medicare Hospital Inpatient Payment

Medicare Severity-Diagnosis Related Groups (MS-DRGs)
Fixed Fee per Inpatient Stay

- Lab fees / Drugs*
- Procedure charge
- Ancillary care
- Medical devices
- Diagnostics
- Goods and services used during stay
- Operating room time
- Nursing care

Medical devices

Fixed Fee per Inpatient Stay

Lab fees / Drugs*

Procedure charge

Ancillary care

32
Key Themes: 2013 Final Medicare Inpatient Hospital Rule

- Updates acute hospital rates by 2.3%, net
- Includes 2% Documentation and Coding Adjustment (DCA) to offset overpayments in 2013
Inpatient DRG assignment is impacted by presence of complications/comorbidities (CC) or major complications/comorbidities (MCC)

Example: Disorders of the biliary tract

<table>
<thead>
<tr>
<th>MS-DRG</th>
<th>Description</th>
<th>2013 FINAL Inpatient Payment¹⁴</th>
</tr>
</thead>
<tbody>
<tr>
<td>444</td>
<td>Disorders of the biliary tract w/ MCC</td>
<td>$9,261</td>
</tr>
<tr>
<td>445</td>
<td>Disorders of the biliary tract w/ CC</td>
<td>$6,190</td>
</tr>
<tr>
<td>446</td>
<td>Disorders of the biliary tract w/o CC/MCC</td>
<td>$4,379</td>
</tr>
</tbody>
</table>
## 2013 GI Final Medicare Hospital Inpatient Payment

<table>
<thead>
<tr>
<th>Procedure</th>
<th>2012 Inpatient Payment&lt;sup&gt;13&lt;/sup&gt;</th>
<th>2013 Inpatient Payment&lt;sup&gt;14&lt;/sup&gt;</th>
<th>% Increase 2012-2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biliary Procedures (Including Cholangioscopy &amp; Biliary stenting)</td>
<td>$5,242-$10,108</td>
<td>$5,507 - $10,287</td>
<td>2% - 5%</td>
</tr>
<tr>
<td>Colonic Stenting</td>
<td>$4,908-$29,966</td>
<td>$5,087 - $30,372</td>
<td>1% - 4%</td>
</tr>
<tr>
<td>Esophageal Stenting</td>
<td>$4,078-$6,670</td>
<td>$4,259 - $6,870</td>
<td>3% - 4%</td>
</tr>
</tbody>
</table>
**Summary: Hospital Inpatient and Outpatient Payment**

- Payments for inpatient hospital services increasing 2.3% in 2013

- Payments for outpatient acute care hospitals increase by 1.8%
  - Endoscopy payments stable or increase up to 5%
2013 Medicare ASC Changes
Polling Questions

• Is your hospital/organization participating in an Accountable Care Organization in 2013 or 2014?
  (1) YES
  (2) NO
  (3) Don’t know

• At your facility, who is the primary decision maker for the purchase of medical devices?
  (1) ME
  (2) CEO
  (3) Supply Chain Director
  (4) MD
  (5) Other
Key Themes: 2013 Final Medicare ASC Payment

- 1-3% increases for the ASC facility payment for the majority of GI procedures

- CMS is applying a 0.6% update to the ASC payment system for CY 2013
  - Projected inflation rate 1.4 percent minus 0.8 percent productivity adjustment required by law.

- CMS also finalized revisions to the ASC Quality Reporting (ASCQR) program, including requirements for claims-based measures regarding the dates for submission, payment of claims and data completeness, and a methodology for reducing payment to ASCs that do not meet the program’s reporting requirements.
  - CMS previously finalized the measure sets that apply to the CY 2014 through 2016 payment determinations.
## 2013 Medicare National Average Final ASC Payment

<table>
<thead>
<tr>
<th>APC</th>
<th>Description</th>
<th>Select APC Procedures</th>
<th>2012 Final Payment</th>
<th>2013 Final Payment</th>
<th>% Change 2012-2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>141</td>
<td>Upper GI Endoscopy</td>
<td>Upper GI w/ biopsy, Diagnostic Upper GI</td>
<td>$341</td>
<td>$350</td>
<td>3%</td>
</tr>
<tr>
<td>146</td>
<td>Sigmoidoscopy, Level I</td>
<td>Sigmoidoscopy w/ biopsy</td>
<td>$65</td>
<td>$72</td>
<td>11%</td>
</tr>
<tr>
<td>147</td>
<td>Sigmoidoscopy, Level II</td>
<td>Sigmoidoscopy w/ balloon dilation</td>
<td>$446</td>
<td>$402</td>
<td>-10%</td>
</tr>
<tr>
<td>143</td>
<td>Lower GI Endoscopy</td>
<td>45378 Diagnostic colonoscopy</td>
<td>$378</td>
<td>$388</td>
<td>3%</td>
</tr>
<tr>
<td>158</td>
<td>Colorectal Cancer Screening: Colonoscopy</td>
<td>G0121 Screening colonoscopy</td>
<td>$336</td>
<td>$343</td>
<td>2%</td>
</tr>
<tr>
<td>384</td>
<td>GI Stenting Procedures</td>
<td>ERCP, EGD, Colonoscopy with stent placement</td>
<td>$1,181</td>
<td>$1,188</td>
<td>1%</td>
</tr>
<tr>
<td>419</td>
<td>Level II Upper GI Procedures</td>
<td>EUS, Upper GI w/ dilation</td>
<td>$511</td>
<td>$520</td>
<td>2%</td>
</tr>
<tr>
<td>422</td>
<td>Level III Upper GI Procedures</td>
<td>BARR-X (RFA Barretts)</td>
<td>$1,048</td>
<td>$1,048</td>
<td>0%</td>
</tr>
</tbody>
</table>
### ASC Payment as a Percent of Hospital Outpatient Payment

#### ASC Percent of Hospital Outpatient Payment By Year

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>43239</td>
<td>Upper GI Endoscopy with biopsy</td>
<td>87%</td>
<td>78%</td>
<td>69%</td>
<td>63%</td>
<td>56%</td>
<td>58%</td>
<td>56%</td>
</tr>
<tr>
<td>43249</td>
<td>Upper GI Endoscopy with balloon dilation of esophagus</td>
<td>87%</td>
<td>78%</td>
<td>69%</td>
<td>63%</td>
<td>56%</td>
<td>58%</td>
<td>56%</td>
</tr>
<tr>
<td>45378</td>
<td>Diagnostic colonoscopy</td>
<td>83%</td>
<td>76%</td>
<td>67%</td>
<td>64%</td>
<td>56%</td>
<td>58%</td>
<td>56%</td>
</tr>
<tr>
<td>45380</td>
<td>Colonoscopy with biopsy</td>
<td>83%</td>
<td>76%</td>
<td>67%</td>
<td>62%</td>
<td>56%</td>
<td>58%</td>
<td>56%</td>
</tr>
<tr>
<td>45384</td>
<td>Colonoscopy with removal of tumor by biopsy forceps</td>
<td>83%</td>
<td>76%</td>
<td>67%</td>
<td>62%</td>
<td>56%</td>
<td>58%</td>
<td>56%</td>
</tr>
<tr>
<td>45385</td>
<td>Colonoscopy with removal of tumor(s) by snare technique</td>
<td>83%</td>
<td>76%</td>
<td>67%</td>
<td>62%</td>
<td>56%</td>
<td>58%</td>
<td>56%</td>
</tr>
<tr>
<td>G0121</td>
<td>Colorectal scrn; not high risk ind</td>
<td>100%</td>
<td>83%</td>
<td>72%</td>
<td>66%</td>
<td>56%</td>
<td>58%</td>
<td>56%</td>
</tr>
</tbody>
</table>

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New ASC Payment System: GI Rates Have Been Decreasing

GI ASC Medicare Payment Trend 2007-2013

Medicare National Average Payment

- $0
- $100
- $200
- $300
- $400
- $500
- $600

2007 2008 2009 2010 2011 2012 2013

- Upper GI Procedures
- Therapeutic Colonoscopy
- Screening Colonoscopy
## 2013 Final Medicare ASC Payment: Full Impact of New Payment Method

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Procedure</th>
<th>2007 ASC Payment(^{15})</th>
<th>2013 ASC Payment(^{21})</th>
<th>% Change 2007-2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>43239</td>
<td>Upper GI with biopsy</td>
<td>$446</td>
<td>$350</td>
<td>-22%</td>
</tr>
<tr>
<td>43249</td>
<td>Upper GI with balloon dilation</td>
<td>$446</td>
<td>$520</td>
<td>17%</td>
</tr>
<tr>
<td>45380</td>
<td>Colonoscopy with biopsy</td>
<td>$446</td>
<td>$388</td>
<td>-13%</td>
</tr>
<tr>
<td>45382</td>
<td>Colonoscopy with control of bleeding</td>
<td>$446</td>
<td>$388</td>
<td>-13%</td>
</tr>
<tr>
<td>45385</td>
<td>Colonoscopy with removal of tumor(s), polyp(s), or other lesion(s) by snare technique</td>
<td>$446</td>
<td>$388</td>
<td>-13%</td>
</tr>
<tr>
<td>G0105</td>
<td>Colorectal scrn; high risk ind</td>
<td>$446</td>
<td>$343</td>
<td>-23%</td>
</tr>
<tr>
<td>45378</td>
<td>Diagnostic colonoscopy</td>
<td>$446</td>
<td>$388</td>
<td>-13%</td>
</tr>
</tbody>
</table>

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ASC Quality Measures 2012-2013
2% penalty 2014 for non-reporting

CLAIM BASED REPORTING WITH G CODES

Outcome measures:

- Burns G8908-has received a burn
  G8909-has NOT
- Falls G8910-has experienced a fall
  G8911-has NOT
- Wrong site, site, patient, procedure, implant
  G8912-has experienced a wrong...
  G8913-has NOT...
- Hospital Admission/Transfer
  G8914-has experienced hospital admission/transfer
  G8915-has NOT....
- **G8907-if all four Outcome measures are NEGATIVE**
- Infection Prevention: Prophylactic IV antibiotic timing
  G8916-ordered, initiated on time
  G8917-Ordered, NOT initiated on time
- **G8918-NO antibiotic ordered**

SAFE SURGERY CHECK LIST

- 1) prior to administration of anesthesia
- 2) prior to incision (endoscopy: scope insertion) especially if endoscopist not in room until anesthesia provider has patient induced
- 3) prior to the patient leaving the operating room.

ASCs can use any check list, if meets criteria
2013 Medicare Physician Fee Schedule Changes
Polling Question

• If Medicare physician payment cuts are implemented, what changes in your practice do you plan to make that will effect access to care for Medicare patients?

(1) Continue service without changes
(2) Stop taking new Medicare patients
(3) Stop seeing existing Medicare patients
(4) See Medicare patients via mid-level professionals only or reduce time spent with Medicare patients
(5) N/A
Key Themes: 2013 Physician Final Rule

• Pay cut
  – 26.5% January 1, 2013
    • Congress expected to avert cut but not fix SGR ($350 B)

• Changes to the Physician Quality Reporting System
  – Additional measures, lower threshold
  – Incentive changes: 1% in 2013, penalty by 2015
  – Electronic prescribing: penalty if not doing
  – EHR, meaningful use: penalty 2018, lower incentive 2013

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Key Themes: 2013 Physician Final Rule 2

• CMS seeking input other than RUC
  – Including stop watch studies...focus on efficiency, not complexity
  – Review physician work & PE simultaneously
  – Continuous, not 5 year, review
  – Public nomination of misvalued codes
  – ACA grants CMS more leeway to revalue services unilaterally

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## 2013 RVU Changes

### Path Level IV Code

**WHY IT MATTERS:** MANY GI GROUPS HAVE INTEGRATED GI TRAINED PATHOLOGIST, LAB INTO PRACTICE

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Procedure</th>
<th>2012 RVUs&lt;sup&gt;24&lt;/sup&gt;</th>
<th>2013 RVUs&lt;sup&gt;25&lt;/sup&gt;</th>
<th>RVU % Change 2012-2013</th>
<th>2012 MD In-Facility Payment&lt;sup&gt;24&lt;/sup&gt;</th>
<th>No Fix FINAL 2013 In-Facility MD Payment&lt;sup&gt;25&lt;/sup&gt;</th>
<th>Impact of RVU Changes if fix is implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td>88305 (TC)</td>
<td>Tissue exam by pathologist</td>
<td>2.05</td>
<td>0.99</td>
<td>-52%</td>
<td>$70</td>
<td>$25</td>
<td>$34</td>
</tr>
<tr>
<td>88305 (PC)</td>
<td></td>
<td>1.06</td>
<td>1.08</td>
<td>2%</td>
<td>$36</td>
<td>$26</td>
<td>$37</td>
</tr>
<tr>
<td>88305 (Global)</td>
<td></td>
<td>3.11</td>
<td>2.07</td>
<td>-33%</td>
<td>$106</td>
<td>$52</td>
<td>$70</td>
</tr>
</tbody>
</table>

### Why It Matters

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## 2013 GI Physician Payments
(As Finalized, No Fix / With Fix)

**Reminder:** Physicians receive same payment in the hospital & ASC settings

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Procedure</th>
<th>2012 MD In-Facility Payment</th>
<th>No Fix FINAL 2013 In-Facility MD Payment</th>
<th>Impact of RVU Changes if fix is implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td>43239</td>
<td>Upper GI Endoscopy with biopsy</td>
<td>$175</td>
<td>$128</td>
<td>$175</td>
</tr>
<tr>
<td>43249</td>
<td>Upper GI Endoscopy with balloon dilation of esophagus</td>
<td>$177</td>
<td>$130</td>
<td>$176</td>
</tr>
<tr>
<td>43251</td>
<td>Upper GI Endoscopy with removal of tumor(s) by snare technique</td>
<td>$222</td>
<td>$163</td>
<td>$222</td>
</tr>
<tr>
<td>43255</td>
<td>Upper GI Endoscopy with control of bleeding</td>
<td>$287</td>
<td>$210</td>
<td>$286</td>
</tr>
<tr>
<td>43256</td>
<td>Upper GI Endoscopy with stent placement</td>
<td>$258</td>
<td>$189</td>
<td>$257</td>
</tr>
<tr>
<td>43262</td>
<td>ERCP with sphincterotomy</td>
<td>$434</td>
<td>$317</td>
<td>$432</td>
</tr>
<tr>
<td>43268</td>
<td>ERCP with stent placement</td>
<td>$440</td>
<td>$322</td>
<td>$438</td>
</tr>
<tr>
<td>43273</td>
<td>Cholangioscopy</td>
<td>$129</td>
<td>$94</td>
<td>$127</td>
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<tr>
<td>45380</td>
<td>Colonoscopy with biopsy</td>
<td>$264</td>
<td>$193</td>
<td>$263</td>
</tr>
<tr>
<td>45385</td>
<td>Colonoscopy with removal of tumor(s) by snare technique</td>
<td>$313</td>
<td>$229</td>
<td>$312</td>
</tr>
<tr>
<td>45378</td>
<td>Diagnostic colonoscopy</td>
<td>$221</td>
<td>$162</td>
<td>$221</td>
</tr>
<tr>
<td>45387</td>
<td>Colonoscopy with stent placement</td>
<td>$351</td>
<td>$257</td>
<td>$350</td>
</tr>
</tbody>
</table>

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Program Impact on Budget in 2013 (in $$ billions)

- Expiration of Bush tax cuts $210
- No Alternative Minimum Tax patch 130
  - 70 million people instead of 2 million
- 2% payroll tax break expires 110
- R&D and other business credits expire 85
- Spending cuts (sequestration)(½ defense, ½ ‘discretionary’ programs) 109
- Unemployment insurance extension expires 35
- New Affordable Care Act taxes 25
- Medicare doctor payment cuts 14

TOTAL 2013 $718
Fiscal Cliff Notes -2-

• 80% of the cliff are tax increases
• Compromises?? Underway
  – Revenue increases from tax rate changes versus deduction reductions
  – Savings from which programs??
  – Figure Medicare still large target....
• Failure? Unemployment > 9%, recession
• REFERENCE: see “Greece”
Health Care Reform and Gastroenterology

**Some U Win**

- Increased access to colorectal screening
- Deductibles waived for screenings that become diagnostic/therapeutic (i.e., if polyp or lesion found)
- Procedure volumes expected to increase with increased enrollment

**Some U Lose**

- Political focus on deficits paralyzing fix to SGR
- Increased administrative and reporting burdens
- Health Information Technology (HIT) Mandates
- Changing practice models
- Politics playing with IPAB (Independent Payment Advisory Board)
- Falling reimbursement rates
Other Health Reform Topics

• Payment reform changes underway
  – “Shared savings” Accountable care organizations (ACOs)
  – Bundled payments, episodes of care payments
  – Value-based modifier for physician payments
    • Quality: PQRS data
    • Cost: measures of efficiency vs. peer specialty, geography
    • High “value” gets bonus, low “value” gets cut
    • 2013 data will determine payments 2015 forward
  – Move away from fee-for-service method & mentality
What’s The Priority In Our Backyard? Doing (with) Less

• Efficiency in colon cancer screening
  – Improving rates of adherence to guidelines
    • Registries, reminders, incentives
    • Direct access fine-tuned (we see <20% of our screening patients beforehand, ½ not appropriate)

• Guidelines in practice, disease management
  • Soon an extra scope won’t mean extra revenue
  • Team management (NP, PA): hospitalists, office programs

• Efficiency in the endoscopy unit
  – Improved quality = lower costs
  – More through-put with same or less resources
  – Continuous process improvement; data-based

Is your organization up to it?
ARE WE HAVING FUN YET??

“It is not necessary to change. Survival is not mandatory.”

W. Edwards Deming
<table>
<thead>
<tr>
<th></th>
<th>Sources</th>
</tr>
</thead>
</table>
Back-up Slides
CPT Process

Coding Suggestion → Staff Review
- Panel Has Already Addressed the Issue
  → Letter to Requestor Informing Him of Correct Coding Interpretation
- New Issue or Significant New Information Received → Specialty Advisors
  - Advisor(s) Agree No New Code or Revision Needed
    → Staff Letter to Requestor Informing Him or Correct Coding Interpretation or Action Taken by the Panel
    - Add New Code, Delete Existing Code or Revise Current Terminology
  - Advisors Say Give Consideration or 2 Specialty Advisors Disagree on Code Assignment or Nomenclature
    → Editorial Panel
      - Reject Proposal Change
      → Table for Further Study
RUC Process

CPT Editorial Panel Adopts Coding Changes

Specialty Society Advisors Review New/Revised CPT Codes

Codes Do Not Require New Values
No Comment
Comment on Other Societies’ Proposals
Survey Physicians; Recommended Values

RVS Update Committee

Centers for Medicare and Medicaid Services
Medicare Payment Schedule

After 3 years, the “new” CPT code may be re-evaluated by the RUC
Medicare RVU Process

**Spring Quarter:** CMS receives RUC recommendations in May

**CMS Medical Officers and Contractor Medical Directors review RUC Recommendations**

**Fall Quarter:** CMS publishes their RVU decisions (considered an interim RVU) in the Medicare Physician Fee Schedule (MPFS) Final Rule (published in November) with a comment period of 90 days from the date rule is put on display at the Federal Register (not from the date the rule is published)

Note: CMS agrees with the RUC recommendations more than 90% of the time, historically; about 80% recently

**Winter Quarter:** Entities believing CMS’ RVU decision is incorrect should submit comments to CMS. Consider collaboration with societies regarding submission of comments to CMS.

Note: Comments must be received before end of comment period.

**Summer Quarter:** MPFS Proposed Rule published. CMS’ initial response to comments received about “interim” RVUs will be found in the rule. There is a 90 day comment period in which interested parties can comment on the proposed changes.

**Fall Quarter:** CMS publishes their RVU decisions in the MPFS Final Rule, which includes CMS’ Formal response to all comments received since last November Final Rule.

“Interim” RVUs are transitioned to final RVUs after one year. Once RVUs are considered final, requests for RVU changes must go through the societies.