January 3, 2011

Donald Berwick, MD, MPP, FRCP
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1503-FC
P.O. Box 8013
Baltimore, MD 21244-8013

Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011

Dear Dr. Berwick:

The American Gastroenterological Association (AGA), the American College of Gastroenterology (ACG) and the American Society for Gastrointestinal Endoscopy (ASGE) appreciate the opportunity to provide comments on CMS's final rule with comment period CMS-1503-FC, published on Nov. 29, 2010 in the *Federal Register*, regarding the several policy revisions to the 2011 Medicare physician fee schedule. Our three societies represent virtually all practicing gastroenterologists in the United States.

Our comments focus on the following three issues:

- Addendum C- Codes with Interim RVUs
- CY 2011 Identification and Review of Potentially Misvalued Services/Codes on the Multispecialty Points of Comparison List
- Global period assignment for CPT code 46930

<u>Addendum C- Codes with Interim RVUs</u>

CMS indicated that codes in Addendum C contain interim physician work, practice expense and malpractice (PLI) values and are subject to comment under this final rule. We are concerned that CMS rejected the RUC recommendations on codes in this addendum and has adjusted the values for budget neutrality for these codes without providing sufficient rationale.

There are several codes in this addendum that affect gastroenterology as detailed below.

CPT code	Descriptor	RUC Rec RVU	CMS Proposed Interim Value
91010	Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report; 2-dimensional data	1.50	1.28
91013	Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report; with stimulation or perfusion (eg, stimulant, acid or alkali perfusion)	0.21	0.18

The GI societies surveyed these two codes in 2010, and the RUC agreed that there was compelling evidence to change the work relative value associated with these services based on the following information. As reiterated in the AMA RUC comment letter to CMS on this final rule, when first valued during the Harvard studies the physician work for 91010 was valued at 1.65 RVUs, subsequently during the RUC's first Five-Year Review in August 1995, CMS lowered the work value to 1.25 based on the incorrect assumption that an upper gastrointestinal endoscopy would be co-reported with 91010. CMS claims data for 2008 demonstrates that 91010 is reported with 43200 Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure) (work RVU = 1.59) less than one percent of the time. It was further explained that advancements in technology have had an impact on the physician work. The manometry catheters and recording systems currently available provide more comprehensive data including multiple line tracings representing pressure change verse time at several discrete esophageal loci, which has added time and complexity to the physician's assessment of the data, and the performance of the service. Esophageal manometry is now a much more comprehensive and complex study than it was years ago.

To substantiate the value of 91010, the RUC compared the surveyed service to the Key Reference Service 91122 Anorectal manometry (work RVU = 1.77) and agreed that the services are similar in physician work but the reference service entails more overall physician work and time than the surveyed code. The RUC also compared 91010 to 91022 Duodenal motility (manometric) study (work RVU = 1.44 and total time= 61 minutes) and agreed that the physician work inherent in the services are analogous and should be valued similarly. Given these reference codes, and the specialty's strong survey results, the RUC recommended the survey 25th percentile work RVU of 1.50 for code 91010, placing this service in proper rank order with the reference codes.

To substantiate the value of 91013, the RUC compared the surveyed service to 75565 Cardiac magnetic resonance imaging for velocity flow mapping (List separately in addition to code for primary procedure) (work RVU = 0.25, 10 minutes intra-service, ZZZ global period) and 96365 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour (work RVU = 0.21, 9 minutes total time, XXX global period) and determined that these services provide analogous multi-specialty reference points. Finally, the RUC looked at reference code 96413 Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug (work RVU= 0.28, total time= 13 minutes) and agreed that new service 91013 should be valued similarly and further substantiated that the physician work RVU of 0.21 provides proper rank order among and across specialties.

Based on these arguments, the GI societies and the RUC both agree that budget neutrality should not be applied to these two codes and urges CMS to accept the RUC recommended value of 1.50 RVUs for 91010 and 0.21 for 91013. We also welcome the opportunity to participate in a Refinement Panel on these two codes if that occurs.

CY 2011 Identification and Review of Potentially Misvalued Services/Codes on the Multispecialty Points of Comparison List

In the proposed rule, CMS provided 33 codes that are currently used on the RUC multispecialty points of comparison list (MPC) that it believes are misvalued and recommended they be RUC surveyed for 2011. The GI societies submitted comments to CMS under the proposed rule on why we believe the codes on the MPC list are already appropriately valued and that CMS needed to show compelling evidence on why a review is warranted. In the final rule with comment period, CMS decided that it would ask the AMA RUC to request re-surveys of the 33 codes listed in the proposed rule.

CMS indicated in both the proposed rule and final rule with comment period that they believe the entire MPC list should be assessed to ensure that services are paid appropriately under the fee schedule. The GI societies request that CMS defer to the RUC process to review these codes in an appropriate manner. The MPC Workgroup currently intends to review all criteria for placing a code on the MPC list, review the current MPC list and determine which codes may be appropriate to place on the MPC list. We agree with the RUC request to CMS that it allow the RUC to postpone review of the MPC codes identified in the final rule until after the MPC Workgroup completes review and revision of the MPC criteria and list. We also agree that CMS may request the Relativity Assessment Workgroup to review MPC codes after the revision of the MPC list.

The GI societies will work within the RUC process to survey the four GI codes identified on the MPC list (43235 (upper GI endoscopy, diagnosis); 43239 (upper GI endoscopy, biopsy); 45380 (colonoscopy and biopsy); and 45385 (colonoscopy and polypectomy)) if requested after a more thorough review of the MPC list.

Global period assignment for CPT code 46930

The GI societies believe that CMS has incorrectly assigned a global period of 90-days to CPT code 46930 (Destruction of internal hemorrhoids(s) by thermal energy (eg., infrared coagulation, cautery, radio frequency). We have communicated this position to CMS over the past year and have received letters from beneficiaries sent to Congressional offices that the incorrect global period assignment and physician work valuation of this code has made it difficult for beneficiaries to access this procedure. When this code was RUC surveyed by the American Society of Colon and Rectal Surgeons (ASCRS) in 2009, it was surveyed as a 10-day global day period code but was changed to a 90-day global period by CMS in the 2010 final rule.

In response to a request from CMS to hear from ASCRS on this issue, the president of that society, David E. Beck, M.D., sent a letter to you on Oct. 27, 2010 with the request that this code be assigned a 10-day global period in 2011.

Gastroenterology is now the predominant biller of this code, followed by colon and rectal surgery. The GI societies agree with ASCRS's request that CMS re-evaluate the 90-day global period assigned to this code and instead reassign a 10-day global period. **We hope this correction can be made as soon as possible in 2011 through CMS's next quarterly update to the physician fee schedule or through a technical correction notice.**

Code 46930 does not appropriately fall under the category of a major surgical procedure that is typically assigned 90-day global periods. Destruction of internal hemorrhoids by thermal energy is more comparable to procedures with a 10-day global period such as code 46221, Hemorrhoidectomy, by simple ligature (eg, rubber band) or code 46910, Destruction of lesion (s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; electrodesiccation.

For code 46930, the standard of practice for performance of this procedure is for the physician to treat several quadrants at one sitting. If internal hemorrhoids continue to exist, another session may be clinically necessary to treat remaining hemorrhoids

Approximately 60% of Medicare beneficiaries undergo a repeat procedure within 90 days. Additional thermal treatments of internal hemorrhoids are performed, when medically indicated, at 3-4 weeks after the initial procedure.

As a result of CMS's valuation of code 46930 as a 90-day global procedure, the physician incurs 100% of the physician work, professional liability and practice expense of subsequent procedures. We believe that physicians should be fairly compensated for performing this procedure, which would be corrected by assigning the proper global period. **Again, the GI societies request that CMS can correct this issue by assigning code 46930 the appropriate global period of 10 days.**

Conclusion

The American College of Gastroenterology, the American Gastroenterological Association and the American Society for Gastrointestinal Endoscopy appreciate the opportunity to provide comments on the 2011 physician proposed rule. If we may provide any additional information, please contact Anne Marie Bicha, Director of Regulatory Affairs, AGA, at 240-482-3223, or abicha@gastro2.org; Brad Conway, Vice President of Public Policy, ACG, at 301-263-9000, or bconway@acg.gi.org; or Camille Bonta, consultant to ASGE at 202-320-3658 or cbonta@asge.org.

Sincerely:

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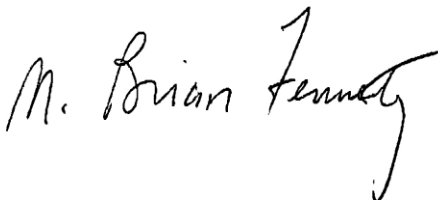

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