December 30, 2014

Marilyn B. Tavenner, MHA, BSN, RN
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015 (CMS-1612-FC)

Dear Administrator Tavenner:

The American College of Gastroenterology (ACG), American Gastroenterological Association (AGA) and the American Society for Gastrointestinal Endoscopy (ASGE), who collectively represent virtually all gastroenterologists in the United States, appreciate the opportunity to provide comments on the Centers for Medicare and Medicaid Services’ (CMS) final rule (CMS-1612-FC), published in the Federal Register on November 13, 2014, regarding policy revisions to the 2015 Medicare physician fee schedule (PFS).

There are a number of provisions in the final rule that impact practicing gastroenterologists and our patients. We offer comments in the following areas:

Payment Policy
- CMS’ Efforts to Improve Transparency
- Valuing New, Revised and Potentially Misvalued Codes
- Recommendations for Upper Endoscopy Codes
- Valuing Services That Include Moderate Sedation as an Inherent Part of Furnishing the Procedure
- Changes to Direct PE Inputs for Specific Services
- Use of Outpatient Prospective Payment System and Ambulatory Surgery Center Rates in Developing PE RVUs
- Reports of Payments or Other Transfers of Value to Covered Recipients

CMS’ EFFORTS TO IMPROVE TRANSPARENCY

Our societies applaud CMS for proposing a new process by which stakeholders can review potential reimbursement changes in the annual proposed rule instead of the final rule, which is typically released less
than two months prior to significant reimbursement changes taking effect. We agree with CMS that the current process provides very little time for medical practices to prepare for upcoming reimbursement changes. As we have stated previously, the reduction in value for many GI upper endoscopy procedures was significant and practices had very little time to prepare. CMS will use 2015 as a transition year and then implement a more transparent process by including most reimbursement changes in annual proposed rules beginning with CY 2017.

While our societies sought a delay in the colonoscopy family in order to achieve greater transparency, we agree with this 2017 timeline in light of the decision to delay the colonoscopy family review. Thus, the PFS proposed rule for CY 2016 will include values for the new, revised and potentially misvalued codes for which CMS receives recommendations from the American Medical Association Relative Value Scale Update Committee (RUC) in time for inclusion in the rule. This includes the colonoscopy family of codes, which will allow stakeholders the opportunity to review proposed changes in advance. We believe that CMS balanced the goals of easing the transition into a more transparent process while also affording stakeholders the opportunity to review proposed changes for CY 2016.

We thank the Agency for implementing these two changes to provide greater transparency in the Medicare rate-setting process.

VALUING NEW, REVISED AND POTENTIALLY MISVALUED CODES

Delayed Revaluation of Lower GI Endoscopy Codes

The GI societies appreciate and thank CMS for delaying revaluation of the colonoscopy codes until CY 2016, which will give stakeholders the opportunity to review proposed valuation changes as part of the CY 2016 proposed rule before they become final.

After CMS proposed the new transparency process in July 2014, the GI societies respectfully requested that CMS forego changes to the colonoscopy codes (including the flexible sigmoidoscopy and colonoscopy through stoma codes) in the 2015 Medicare payment year in order to allow these codes to be included in CMS’ process for greater transparency. Our societies also noted that a delay would afford CMS the opportunity to receive stakeholder feedback in developing a uniform process for valuing physician work when moderate sedation is considered inherent to the procedure. We believe that gastroenterology was uniquely affected by the moderate sedation issue because CMS specifically noted in the 2015 PFS proposed rule that, despite the fact that moderate sedation is inherent to these codes, the Agency intends to move forward with finalizing the review of upper and lower gastrointestinal procedures for the 2015 payment year. We commented that this is inconsistent with developing a “uniform approach” to valuing physician work for these services and that this also runs counter to the goal of an open and transparent regulatory review process. As such, we thank CMS for implementing this one-year delay and welcome the opportunity to further review and discuss with Agency officials throughout 2015. We share the same goal in seeking to avoid any policy change that threatens the public health success story of colonoscopy.

The falling rate of colorectal cancer is a public health success story in the United States; no other country can claim that both incidence and death rates from colorectal cancer are on the decline. CMS should be commended for its role as recent data show that screening rates are among the highest in the Medicare-aged population. Yet, more needs to be done. Our societies have joined the Centers for Disease Control and Prevention (CDC), Health and Human Services Office of the Assistant Secretary for Health, the American
Cancer Society and other patient advocacy groups to work toward the goal of screening 80 percent of eligible individuals by 2018. At a time when incidence and death rates from colorectal cancer continue to decrease, and a community commitment has been made to increase screening rates for all Americans, we need to ensure that the use of colonoscopy for the screening and detection of colorectal cancer remains accessible for all Medicare beneficiaries.

Future Review of the Colonoscopy Code Family

The GI societies welcome continued dialogue with the Agency in 2015 as it continues to review the colonoscopy code family. Our societies agree with CMS’ position that the best data available to determine physician work time and intensity for a particular service are derived from the surveys that specialty societies use as part of the RUC process. According to CMS:

For many codes, the surveys conducted by specialty societies as part of the RUC process are the best data that we have regarding the time and intensity of work. The RUC determines the criteria and the methodology for those surveys. It also reviews the survey results. This process allows for development of survey data that are more reliable and comparable across specialties and services than would be possible without having the RUC at the center of the survey vetting process. In addition, the debate and discussion of the services at the RUC meetings in which CMS staff participate provides a good understanding of what the service entails and how it compares to other services in the family, and to services furnished by other specialties.

As noted in the minutes from the January 2014 RUC meeting, our societies objected to the RUC’s physician work recommendations for the colonoscopy family of services. We maintain that the RUC failed to follow its own processes when considering the results of the statistically valid survey facilitated by the six surgical and gastroenterological societies whose members perform the majority of colonoscopy services for Medicare beneficiaries.

We remain committed to working closely with CMS to share objective data, analysis and other information that will provide additional context to the physician work RVU recommendations on colonoscopy and the other lower gastrointestinal endoscopy procedures that were submitted by the RUC. We also welcome the opportunity to offer other data and discuss important issues that are not part of the RUC’s review and mission, such as the power of preventive services and efforts to support the HHS policy goal of screening 80 percent of eligible individuals by 2018.

Use of Temporary Medicare G-Codes

To implement the new transparency initiative (discussed above), CMS finalized the use of temporary G-codes to facilitate continued payment for certain services for which CMS does not receive RUC recommendations in time to include values in annual proposed rules, or when there have been substantial changes/deletions/additions to new CPT codes.

Our societies agree with CMS that our members are better served by delaying the colonoscopy review for one year to afford the opportunity for a notice and comment process to obtain public comments in advance, and using transitional G-codes to implement this delay. Since the CPT code set is changing for CY 2015, including the deletion of some CY 2014 codes, creating G-codes is necessary to allow practitioners to report services to CMS in the same way in CY 2015 that providers did in CY 2014 and to maintain payment under the same valuations.
The GI societies agree that a stop-gap mechanism needs to be put into place by CMS when these situations occur. However, the Agency’s decision not to recognize the temporary G-codes under the Hospital Outpatient Prospective Payment System (HOPPS) has also caused significant confusion for our members as they rush to learn the new reporting rules for lower GI endoscopy procedures to Medicare. In the future, we urge CMS to consider the importance of consistency in coding between the MPFS and HOPPS fee schedules.

Our societies recognize that using G-codes as the transitional, but necessary, bridge may be an administrative and logistical burden for many medical practices as members will have to keep track of various codes for the same services depending on whether patients are Medicare beneficiaries or private insurance enrollees. This is all in the backdrop of preparing for upcoming ICD-10-CM changes scheduled to take effect in October 2015. As CMS considers other alternatives in the future to using the G-code as a temporary solution, our societies welcome the opportunity to share our members’ experiences with you.

Role of the Refinement Panel

We are pleased that CMS decided not to finalize its proposal to eliminate the refinement panel. In the final rule, CMS stated that it, “will use the refinement panel process for consideration of interim final rates for CY 2015 under the existing rules, and continue to explore whether the change in process eliminates the need for a refinement panel.” Our societies appreciate your recognition of the benefits of the refinement panel. Like many stakeholders, we are concerned that discrepancies in the methodology used to determine physician work values will still be inevitable in some circumstances, even when the recommendation is provided in the proposed rule. In view of this, the refinement panel remains a vital part of the RVU refinement process.

We urge CMS to retain the refinement panel as part of the RVU refinement process.

RECOMMENDATIONS FOR UPPER ENDOSCOPY CODES

CY 2014 Interim Final Work RVUs Considered by the Refinement Panel

In Table 14 of the 2015 PFS final rule, CMS presented information on the work RVUs considered by the refinement panel for 2014. The refinement panel considered the following five upper GI endoscopy codes:

- **43204** Esophagoscopy, flexible, transoral; with injection sclerosis of esophageal varices
- **43205** Esophagoscopy, flexible, transoral; with band ligation of esophageal varices
- **43213** Esophagoscopy, flexible, transoral; with dilation of esophagus, by balloon or dilator, retrograde (includes fluoroscopic guidance, when performed)
- **43233** Esophagogastroduodenoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)
- **43255** Esophagogastroduodenoscopy, flexible, transoral; with control of bleeding, any method

Even though the refinement panel recommended increases to **all** of the codes under consideration, upon review of the specialty societies’ arguments and the refinement panel’s recommendations, Table 14 reflects...
that CMS increased the physician work RVUs of only one code, 43233, over the CY 2014 interim final work RVU. The CY 2015 work RVU listed in Table 14 for 43233 is 4.26; however, in the text of the 2015 MFPS final rule CMS stated that the agency finalized 43233 at 4.17 RVUs, and the physician work RVU listed in Addendum B is 4.05. While CMS officials have clarified that there are many errors in the Addendum B file and have instructed that the information in the final rule is correct, there is conflicting information in the text of the final rule regarding whether the work RVU for 43233 is 4.26 as indicated in Table 14 or 4.17 as reflected in the text of section 10 (Esophagogastroduodenoscopy (EGD) (CPT Codes 43233, 43235, 43236, 43237, 43238, 43239, 43242, 43244, 43246, 43247, 43249, 43253, 43254, 43255, 43257, 43259, 43266, and 43270)) under Code-Specific Issues.

**TABLE 14: Codes Reviewed by the 2014 Multi-Specialty Refinement Panel**

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>43204</td>
<td>Injection of dilated esophageal veins using an endoscope</td>
<td>2.40</td>
<td>2.89</td>
<td>2.77</td>
<td>2.40</td>
</tr>
<tr>
<td>43205</td>
<td>Tying of esophageal veins using an endoscope</td>
<td>2.51</td>
<td>3.00</td>
<td>2.88</td>
<td>2.51</td>
</tr>
<tr>
<td>43213</td>
<td>Dilation of esophagus using an endoscope</td>
<td>4.73</td>
<td>5.00</td>
<td>5.00</td>
<td>4.73</td>
</tr>
</tbody>
</table>

We request that CMS clarify the correct CY 2015 physician work RVU for 43233 and immediately release a correction to Addendum B that accurately reflects the physician work and total facility and non-facility RVUs.

Furthermore, our societies are disappointed that CMS chose to disregard the refinement panel median rating for codes 43204, 43205, 43213, 43233 and 43255. The refinement panel is comprised of a multi-specialty panel of physicians with a diverse range of expertise. While we understand that CMS makes the final decisions regarding assignment of RVUs, the refinement panel’s votes reflect the panel members’ response to the compelling arguments and information presented by our societies during the refinement panel process.

**Code-Specific Issues**

The GI societies’ physician CPT and RUC advisors and staff appreciated the opportunity to meet with CMS on multiple occasions during 2014 to clarify the physician work, time, complexity and intensity of the upper GI endoscopy and codes (43200 – 43232, 43233 – 43259, 43260 – 43278). While we are encouraged that
CMS retracted the “10 minutes = 1.00 RVU” methodology established in the CY 2014 final rule, we do not agree with the rationale CMS used to replace it:

For CPT code 43200, which is the base code for flexible transoral esophagoscopy, we agree with commenters that another methodology is preferable to applying the work RVU ratio of 1 RVU per 10 minutes of intra-service time. In revaluing this service, we subtracted 0.07 to account for the 3 minute decrease in post-service time since the last valuation from the CY 2013 work RVU for the predecessor base code, which resulted in a work RVU of 1.52. We are finalizing this work RVU.

We believe that this is an oversimplified method used to determine the RVU. The physician work of esophagoscopy has not decreased, a fact that is demonstrated in the survey data. The total survey time for 43200 in 1995 was 55 minutes (12 minutes pre-service time evaluation, 0 minutes pre-service time positioning, 15 minutes pre-service time scrub, dress, wait, 15 minutes intra-service time, 13 minutes post-service time). The total survey time for 43200 in 2012 increased 5 minutes over the 1995 time to 60 minutes (25 minutes pre-service time evaluation, 5 minutes pre-service time positioning, 5 minutes pre-service time scrub, dress, wait, 15 minutes intra-service time, 10 minutes post-service time). It was the application of the RUC pre-time package that caused the appearance of a decrease in total procedure time. There has been no actual decrease in procedure time and no decrease in the work or intensity of this procedure.

In addition, CPT code 43200 was originally validated in 1995 during phase III of the Harvard study. The surveys of physician work used during the Harvard studies were different than the survey instrument used by the RUC in 2013, which makes direct comparison of the times problematic. Most notably, the Harvard time data are comprised not uncommonly of odd numbers. For example, the post procedure time for 43200 in 1995 was 13 minutes. However, the majority of the time data (over 80% in most cases) from the GI endoscopy surveys conducted between 2012 and 2014 end in 0 or 5, indicating a strong tendency of the participating physicians to round their times, which we noted to the RUC during the meetings. Therefore, it is most likely that the three minute decrease in post-procedure time does not represent an actual decrease in time.

We urge CMS to reconsider its decision to value 43200 at 1.52 RVUs and accept the RUC’s recommendation of 1.59 RVUs as supported by the survey data. Further, we urge CMS to apply this increase of 0.07 to the wRVU of code 43235 and the other esophagogastroduodenoscopy (EGD) procedures, in order to maintain the difference in work between the procedures.

**Valuing Services That Include Moderate Sedation as an Inherent Part of Furnishing the Procedure**

Our societies applaud CMS for recognizing the importance of delaying changes to values for codes in Appendix G, for which moderate sedation is an inherent part of the procedure, and we appreciate that CMS needs time to take into account the comments the agency received in response to the proposed rule. However, we are concerned that in the final rule CMS decided to move ahead by finalizing the upper endoscopy codes, for which moderate sedation remains a concern.

In the 2015 PFS proposed rule, CMS stated that its data clearly indicate that moderate sedation is no longer typical for some of the procedures in Appendix G. This was identified by our societies when we first met with CMS in the Fall of 2011 in response to the Proposed Rule, and this trend was reflected by the survey data collected during 2012 to 2014 and presented to the RUC for the GI endoscopy procedures. As CMS
moves forward to establish a uniform approach for valuing Appendix G services for which moderate sedation is no longer inherent, it will be vital for the agency to value moderate sedation accurately. The RUC has never valued or validated any of the components of moderate sedation inherent to procedures, including the induction, administration and monitoring which is currently accounted for in pre-service time, monitoring of the patient and adjustment of sedation dose in intra-service time and post-procedure monitoring.

Although the RUC made the assumption that the work of moderate sedation should be part of the pre-service package at 0.0224 RVW/min, it has never been valued through the RUC survey process. For perspective, 0.0224 RVW/min is the same intensity as taking a history, preparing for the procedure (i.e., check labs, plan, assess risks and review procedure), communicating with the patient and/or family, communicating with other professionals, check the room, supplies and equipment, check/prepare patient readiness (i.e., gown, drape, prep, and mark), prepare/confirm/review the procedure, and position the patient. Clearly, the administration of sedating agents and the risks associated with such are clinically different from the pre-service tasks described above.

Endoscopic services should not be inappropriately devalued because of flawed assumptions that are not based on data. Our societies do not understand how the clinical process of sedation induction that brings patients to a level of decreased responsiveness for adequate comfort, analogous to the induction process of anesthesiologist-provided propofol for upper and lower endoscopic procedures (00740, 00810), would carry such a trivial value. Adoption of an unevaluated intensity, which can impact the provision of these services, is unfair to the beneficiary and to the healthcare professional providing the sedation service, and may have unintended consequences, including changes in access to important procedures.

We are encouraged that CMS will take into account the comments received during the CY 2015 rule-making process and look forward to continuing this dialogue with the Agency on this important issue.

**CHANGES TO DIRECT PE INPUTS FOR SPECIFIC SERVICES**

**Updates to Price for Existing Direct Inputs**

In the CY 2011 PFS final rule, CMS finalized a process to act on public requests to update equipment and supply price and equipment useful life inputs through annual rulemaking beginning with the CY 2012 PFS proposed rule. During 2013, the ACG, AGA and ASGE requested to update the price of SD216 (catheter, balloon, esophageal or rectal (graded distention test)) from $217 to $237.50. The GI societies and the RUC recommended increasing the price of SA042 (pack, cleaning and disinfecting, endoscope) from $15.52 to $17.06 to reflect the addition of supply item SJ009 (basin, irrigation) to the pack. We thank the agency for accepting the RUC recommended updates to the price of the balloon for the graded distention test (SD216) and the endoscope cleaning pack (SA042), and for updating the price of the supply inputs.

**Moderate Sedation Practice Expense**

We are pleased that CMS finalized its proposal to add the stretcher to the moderate sedation package for the same length of time as the other equipment items in the moderate sedation package.

**Code-Specific Direct PE Inputs**
Micropigmentation needle (SC079) in CPT code 43201 -- In the final rule, CMS stated that an invoice for the micropigmentation (tattoo) needle was required for CPT code 43201 before CMS can include the item in the PE calculations. The Agency did not indicate in the proposed rule that an invoice was required for a supply that has an existing code (SC079) and an established price in the PE database ($12). However, we have included as attachments to Appendix A invoices from Boston Scientific, EndoChoice and Olympus as requested.

Biopsy cup (SL035) in CPT codes 43201, 43220, 43226, and 43231 -- We thank CMS for restoring the biopsy cup (SL035) for CPT codes 43201, 43220, 43226, and 43231 and the guidewire (SD090) for CPT codes 43220, 43249, and 43270.

Endoscopic dilation balloon (SD287) -- We thank CMS for using the endoscopic dilation balloon (SD287) in place of the proxy for CPT code 43220.

Liver elastography (CPT code 91200) -- Although this code was not specifically addressed in the text of the final rule, we would like to provide our input on the practice expense inputs of the code. We thank CMS for accepting the RUC recommendation for the practice expense inputs. We are concerned about the assumption that CMS used for the frequency of where the procedure is performed in the calculation of practice expense. To date, more than 50 percent of the liver elastography units sold in the United States have been purchased by physician groups for use in the non-facility setting. It appears that for CY 2015, CMS used an assumption which has a significant negative impact on the practice expense RVUs to a point at which the non-facility PE reimbursement does not cover the cost of performing the procedure. We urge CMS to revisit its volume assumptions for this procedure.

Esophagoscopy/Esophagoscopy Gastroscopy Duodenoscopy (EGD) (CPT Codes 43200, 43201, 43202, 43206, 43215, 43216, 43217, 43220, 43226, 43227, 43231, 43232, 43235, 43236, 43239, 43245, 43247, 43248, 43248, 43250, 43251, 43252, 43255, 43270) -- CMS finalized the direct PE inputs for the aforementioned CPT codes by refining the quantity of item “canister, suction” (SD009) from two to one. The GI societies have previously commented in response to the 2014 MPFS Final Rule with comment period that one suction canister is needed for suctioning the secretions from the mouth during the upper endoscopy, and another canister is needed for the suctioning function of the endoscope. For patient safety reasons, these suction units cannot be shared; nor is it appropriate to use the same canister for procedures performed on different patients. We are disappointed in CMS’ decision. There is a significant body of literature that supports the use of two suction canisters for upper GI endoscopy procedures as the standard of practice. We have included in Appendix B literature supporting the necessity of two suction canisters. From a patient safety and standard of care standpoint, we urge CMS to restore two (2) suction canisters to upper endoscopic procedures.

USE OF OUTPATIENT PROSPECTIVE PAYMENT SYSTEM AND AMBULATORY SURGERY CENTER RATES IN DEVELOPING PE RVUs

We are very concerned with CMS’ proposal to use Outpatient Prospective Payment System (OPPS) and Ambulatory Surgery Center (ASC) rates in developing practice expense PE RVUs. Our societies continue to show that many of the practice expense items that support the same endoscopy service have different costs when purchased by a hospital versus non-hospital owned ASC or a physician office. The inputs for one site cannot be assumed to fairly represent other sites. The top-down bundled methodology for setting OPPS rates differs significantly from the bottom-up process for obtaining practice expense inputs for establishing
physician payments in the non-facility setting. We urge CMS to carefully consider these issues before attempting to revise the process for developing PE RVUs.

**Identifying Provider-Based Services**

For professional claims, CMS will delete current POS code 22 (outpatient hospital department) and establish two new POS codes—one to identify outpatient services furnished in on-campus, remote or satellite locations of a hospital, and another to identify services furnished in an off-campus hospital PBD setting that is not a remote location of a hospital, a satellite location of a hospital or a hospital emergency department. The final rule states, “These new POS codes will be required to be reported as soon as they become available, however advance notice of the availability of these codes will be shared publicly as soon as practicable.” Although the POS codes would be less administratively burdensome than attaching a modifier to each service reported on the claim that was furnished in an off-campus provider-based department, substantial education of physicians and billing staff will be required to implement this change.

*Given that CMS has not determined a specific date on which the new POS codes will be released and education on the new process has not been initiated, our societies urge CMS to make the new POS codes optional for CY 2015 and delay requiring practices to report the new POS codes until CY 2016.*

**REPORTS OF PAYMENTS OR OTHER TRANSFERS OF VALUE TO COVERED RECIPIENTS**

In our comments on the proposed rule, our societies expressed serious concern for a CMS proposal that would eliminate existing provisions that exclude accredited continuing medical education (CME) activities from public reporting. We continue to believe that these accredited events provide substantial educational and collaborative benefits to the medical community. While we are committed to a more transparent health care system, we cannot support changes such as these that will hinder innovation, collaboration, technological advancement and patient care.

The final rule issued by CMS nonetheless chose to move forward with this policy proposal despite substantial opposition from the physician community. In the rule narrative, CMS sought to assuage physician concerns by indicating that the new rule would not require reporting of indirect CME transfers so long as the manufacturer did not require, instruct, direct or otherwise cause the payment to be made to a covered recipient, regardless of whether the manufacturer later learned that the payment went to a physician. In December, however, CMS posted information online that seems to contradict the rule by saying that indirect CME transfers are reportable in 2016 anytime the manufacturer learns the identity of a recipient by the end of the second quarter of the following reporting year.

We are extremely disappointed that CMS not only chose to move forward with this proposal over the objection of the physician community, but also included information in the rule’s narrative that was directly conflicted by later directions. Our societies continue to believe that accredited CME maintains a clear separation between developing educational content and pursuing and securing industry support, which benefits both physicians and patients. The obvious presence of effective safeguards precludes the need for the requirements adopted by CMS and we ask that any subregulatory guidance moving forward reflect the information contained in the final rule’s narrative explaining that CME indirect transfers are not reportable so long as the manufacturer does not require, instruct, direct or otherwise cause the payment to be made to a covered recipient.
CONCLUSION

In closing, our societies appreciate the efforts of CMS to move forward with steps to increase transparency in the reimbursement process while also acknowledging the importance of ensuring that codes currently undergoing review receive the same consideration. We look forward to continuing this dialogue in 2015 and participating in an open and fair process for determining appropriate reimbursement under the Medicare physician fee schedule.

The ACG, AGA and ASGE appreciate the opportunity to provide comments on the 2015 physician fee schedule final rule. If we may provide any additional information, please contact Brad Conway, Vice President of Public Policy, ACG, at 301-263-9000 or bconway@gi.org; Joshua Keepes, Director of Regulatory Affairs, AGA, at 240-482-3223 or jkeepes@gastro.org; or Camille Bonta, consultant to ASGE, at 202-320-3658 or cbonta@summithealthconsulting.com.

Sincerely,

Stephen B. Hanauer, MD, FACG
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American College of Gastroenterology

Anil K. Rustgi, MD, AGAF
Chair
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Colleen M. Schmitt, MD, MHS, FASGE
President
American Society for Gastrointestinal Endoscopy
Appendix A

Invoices for Micropigmentation Needle (SC079) in CPT Code 43201

Attachment One – “Boston Scientific Interject Needle Invoice.pdf”

Attachment Two – “Endochoice_micropigmentation needle invoice.pdf”

Attachment Three – “Olympus_invoice tattoo needle.pdf”
Appendix B

Selected Literature for Suction Canisters in EGD Codes


  “Two separate suction canisters should be available for endoscopy and oral or tracheal aspiration.”


  “Suction equipment: one wall unit suction canister each for the endoscope and patient.”


EQUIPMENT (MAKE SURE ALL EQUIPMENT IS WORKING PROPERLY
IV lock or IV infusion equipment
Normal saline flush for IV lock for adults; heparin flush for pediatrics
Local anesthetic for throat (spray or gargle)
Emesis basis/cup if gargle is used
Towel or linen saver pad
Medications for conscious sedation

Suction (2)
Personal protective equipment (gowns, gloves, mask, eyewear)
Alcohol sponges and 3 x 3 gauze sponges

Oral suction device
Water soluble device
Water soluble lubricant
Mouthpiece
Vital signs monitor and pulse oximeter (use monitor with EKG capability for patients with known cardiac arrhythmia, cardiac disease or chest pain)
Resuscitation equipment and narcotic antagonists
Specimen labels and cards

  “Suction canisters are discarded in the contaminated waste box and replaced after each patient use.”

  EQUIPMENT REQUIRED: Upper endoscope, light source, bite block, 2% viscous lidocaine, topical anesthetic spray, two suction sources, oral suction, water bottle, sterile water, oxygen with nasal cannula, ECG monitor available, pulse oximeter, blood pressure cuff or monitor, biopsy forceps, 10% formalin jars, gloves, face shield, disposable gown.


  Executive Summary: The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection at the VA Northern California Health Care System (the system), Sacramento, California, at the request of Senator Richard Burr, Ranking Member of the Senate Committee on Veterans’ Affairs. The purpose of the review was to determine the validity of multiple allegations regarding improper reusable medical equipment practices at Sacramento VA Medical Center, Martinez Outpatient Clinic, and McClellan and Redding community based outpatient clinics.

  We concluded that the system’s standard operating procedures and sterilization logs were generally inconsistent with the MI (manufacturer’s instructions). We substantiated the allegations related to bioburden testing, delayed reprocessing, endoscope reprocessing documentation, and staff competencies. We also found improvement opportunities regarding proper use and care of suction canisters and other accessories.

  “Suction canisters (used during endoscopic procedures to collect blood and body fluids removed from the patient) and tubing were only changed when the canisters were full or at the end of the day, contrary to best practice.

  “Suction Canisters and Tubings Not Changed Between Patients

  While GI staff we interviewed reported that it has been their practice to change the suction canisters and tubings between patients since 2008, they told us that they were aware of instances when the suction canisters and tubings were not changed between patients.”
In the interest of utmost caution, AORN espouses changing the clean air/water bottle and tubing for each patient, and some accreditation organizations survey for exchange of waste vacuum canisters and tubing for each procedure.” (Recommended practices for cleaning and processing endoscopes and endoscope accessories. In: Perioperative standards and recommended practices. Denver (CO): AORN Inc; 2010. p. 405–19)