



August 28, 2009

Charlene Frizzera  
Acting Administrator  
Centers for Medicare and Medicaid Services  
Attention: CMS-1413-P, P.O. Box 8013  
7500 Security Blvd.  
Baltimore, MD 21244-8013

Re: Medicare Program: Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010

Dear Acting Administrator Frizzera:

The American College of Gastroenterology (ACG), the American Gastroenterological Association (AGA), and the American Society for Gastrointestinal Endoscopy (ASGE) appreciate the opportunity to provide comments on CMS's proposed rule, CMS-1413-P, published on July 13, 2009 in the Federal Register, regarding the proposed policy revisions to the 2010 Medicare fee schedule. Our three societies represent virtually all practicing gastroenterologists in the United States.

There were a number of provisions in the proposed rule that impact practicing gastroenterologists and the Medicare beneficiaries they treat. Our comments will focus on the following issues:

- Removing physician administered drugs from the SGR calculation
- AMA Physician Practice Information Survey (PPIS)
- Proposal to budget neutrally eliminate the use of all consultation codes
- Physician Quality Reporting Initiative (PQRI)
- Expansion of the Medicare Confidential Feedback Program (Physician Resource Use Report)
- Physician Value Based Purchasing (PVBP)
- Establishing a panel of experts separate from the AMA RVS Update Committee (RUC)
- Misvalued Codes

- Accreditation standards for suppliers furnishing the technical component (TC) of advanced diagnostic imaging services
- Competitive Acquisition Program (CAP)
- Initial preventive physical exam (IPPE)
- Office Endoscopy

### **Removal of Physician-Administered Drugs**

The GI societies are pleased that this proposed rule changes the definition of physician services under the sustainable growth rate (SGR) to exclude physician-administered drugs. CMS is proposing to remove drug costs retroactive to the 1996/97 base year of the SGR formula, which will greatly lessen the forecasted SGR cuts in years after 2010. The GI societies have advocated for years that CMS has the statutory authority to remove physician-administered drugs from the SGR formula.

**The ACG, AGA and ASGE support this proposal and request that CMS finalize its intentions to remove physician-administered drugs from the SGR formula in the 2010 physician final rule.**

While we are pleased with the Agency's proposal to remove physician-administered drugs from the SGR formula, this will not resolve the underlying problem posed by the application of the SGR formula, which has resulted in a negative update every year since 2002. The GI societies are advocating for appropriate reforms to the SGR formula as part of long-term health-care reform to avoid the -21.5 percent cut for 2010, absent Congressional intervention.

Congressional action has been required to avert payment reductions since 2003. A system that requires annual fixes by Congress is a broken system that contributes to the lack of access to the high quality of care that Medicare beneficiaries expect and deserve. For example, since the Medicare colorectal cancer screening benefit was enacted in 1997, the physician fee schedule payment for screening and diagnostic colonoscopies has been cut by almost 45% from a little over \$300 in 1997 to an estimated \$164 in 2010. CMS recognizes in its 'Colorectal Cancer Screening Overview' that use of the benefit is low and "[t]here is clearly an opportunity to improve colorectal cancer screening rates in the Medicare population." Yet, CMS contributes to the low utilization of the benefit by continuing to cut reimbursement. Colorectal cancer screening with colonoscopy is the one preventive intervention that is a proven cost saver, and has the only Grade 'A' recommendation for cancer screenings by the U.S. Preventive Services Task Force.

We are concerned that sustained cuts will affect Medicare beneficiary access to gastroenterology services. Lowering reimbursements while increasing administrative costs could significantly decrease beneficiary access to vital GI diagnostic and therapeutic procedures. The current CMS payment policy contradicts the stated intentions of the Obama Administration and Congress to increase access to cost-effective and high quality health care.

**The ACG, AGA and ASGE urge CMS to align payments for services that further promote the expressed intentions of the Obama Administration and Congress. We also urge CMS to work with Congress and do everything in its power to prevent the devastating physician cut of 21.5 percent from occurring in 2010.**

### **Physician Practice Information Survey (PPIS)**

For 2010, CMS proposes to utilize the PE/HR developed using the AMA's Physician Practice Information Survey (PPIS) data for all Medicare recognized specialties that participated in the PPIS for payments effective January 1, 2010. Gastroenterology is one of the specialties that conducted a supplemental survey several years ago and whose data was accepted for use by the Agency.

**The ACG, AGA and ASGE are supportive of the Agency's proposal to implement the new practice expense data with the exception of the infusion services described below.**

Noting that our societies participated in the PPIS survey process, we are concerned that application of this data to the complex drug administration services, codes 96413 and 96415, results in a 40% reduction in reimbursement for these services which, at the proposed reimbursement for 2010, makes it financially unfeasible for physicians to perform these services in the office setting. As a result, physicians may have no choice except to refer Medicare beneficiaries requiring infusion services to the higher cost hospital outpatient setting, which may create access problems and would result in additional costs to Medicare Part B.

While half of the drop in infusion codes is attributable to the projected -21.5 percent reduction in the conversion factor, the other half is attributable to the new practice expense survey data. We are concerned that implementation of the PPIS data disregards the efforts made by the societies to work through the RUC process for infusion services. Earlier in this decade, gastroenterology, hematology, oncology, infectious diseases, rheumatology, and other specialties who provide infusion services worked with the RUC to make extraordinarily detailed physician work and practice expense recommendations to CMS regarding these services. Implementing the PPIS data would lead to unsustainable reimbursement rates for infusion services.

For those services where implementing the PPIS data would result in a greater than 10% change, we recommend that CMS phase-in the new practice expense data over a four-year period to minimize large initial drops in payments for specific procedures. We note that CMS used a phase-in approach for both the transition to resource-based practice expense and with the supplemental survey data to avoid large negative impacts on specific procedures or specialties, and urge CMS to consider such for this process.

**Since all specialties had the opportunity to encourage participation in the PPIS from its membership, we recommend that CMS implement the PPIS data beginning in 2010. However, we are concerned about the impact of the PPIS data on infusion services, and recommend that CMS not implement the PPIS data with regards to complex drug**

**administration services. In order to mitigate the impact of the PPIS data, we recommend a four-year phase-in of the new survey data for codes that would otherwise be impacted by a  $\pm 10\%$  change in reimbursement.**

### **Consultation Codes**

Beginning January 1, 2010, CMS proposes to eliminate the use of all consultation codes. Our societies are extremely concerned about this proposal. As noted in the proposed rule, consultation codes are mostly used by specialists. Consultation codes were given a higher relative value due to the complexity of the cases, as only those cases that require specialists' expertise require a consultation. We are concerned that while CMS seeks to make providers whole by an increase in work RVU's for non-consultation E/M services, eliminating consultation codes will lead to further payment cuts to our members.

**The ACG, ASGE and AGA strongly oppose this proposal. We believe it will result in diminishing the value of the important consultation services provided by internal medicine subspecialists such as gastroenterologists.**

Many specialties, such as gastroenterology, provide consultation services to beneficiaries. Consultation services allow the consulting physician to evaluate the patient and to provide feedback to the referring physician regarding the nature of the patient's condition, possible use or avoidance of further diagnostic testing and therapeutic management.

We believe the basic CMS assumption that there is no difference in work between a "consultation" and a "visit" is incorrect. Consultations are more complex than regular office visits because, by definition, the referring physician is unable to treat the patient without the advice of a specialist. Due to the higher level of cognitive work, the level of medical decision making is greater. Typically, the consultant must also collect and review previously gathered medical data, such as laboratory values and imaging results that had been obtained over time by the referring physician. Moreover, the consultant is required to provide the referring physician with a written report of the diagnosis and treatment plan, which requires additional time. The higher value of the physician work performed for a consultation versus a visit code was recently reaffirmed that during the third Five Year Review in 2006. At that time, the RUC reaffirmed the value of office or other outpatient consultation services are greater than visit codes reflected. CMS accepted these recommended values. We do not understand what has occurred in the interim for the Agency to no longer accept the values of consultation services, which were recently reviewed by the RUC and accepted by the Agency.

Our other concern with this proposal is that it sets a precedent for arbitrarily eliminating a set of CPT codes. While CMS has created G-codes when the Agency felt there was not an adequate existing CPT code to report a service, CMS has never refused to recognize an entire set of codes that are widely used by large numbers of physicians. We are very troubled by this action. The physician community and CMS have committed themselves, and an enormous amount of resources, to the CPT and RUC process. This process results in a code-set that is being used by Medicare, Medicaid and private payors. In addition to the resources expended towards

developing and maintaining the code-set, an enormous amount of resources and efforts are also expended towards educating providers and their staff on the appropriate use of these codes. Recognizing that CMS has been in discussion with the CPT Editorial Panel to resolve differences in documentation requirements and the proper definition of transfer of care, we strongly disagree that eliminating these codes is the correct approach in resolving these differences. We believe this approach threatens to undermine the CPT Editorial Panel process and a well established system to describe and report physician work.

It is also important to note that the provision of consultation services is an essential component of the Patient Centered Medical Home (PCMH) demonstration project. Elimination of consultation services will not allow CMS and policy researchers to track whether a PCMH facilitates improved care of beneficiaries and avoids unnecessary hospitalizations and procedures. From a practical perspective, if Medicare refuses to recognize codes that are widely accepted by private payors and commonly used by physicians, the administrative burden in coding and reporting could increase significantly.

In addition, we are concerned that the budget neutrality provisions of this proposal will inadvertently increase the reimbursement for 10 and 90 day global procedures. This is antithetical to the concern expressed that primary care and cognitive services are under-reimbursed compared to procedural services. With the increasing utilization of hospitalist services and the movement of procedures from inpatient to outpatient and ambulatory surgical settings, it is unclear whether the follow-up inpatient, discharge day, and outpatient E/M services bundled into the payment for global services are actually being performed.

While there are five consultation codes, there are only three initial hospital visit codes. We believe it will be confusing to physicians to have consultation codes available for private payer use but have a separate payment policy for Medicare purposes, and it will be impossible for physicians to uniformly apply E/M documentation guidelines.

Our societies are concerned that the process CMS used to make this recommendation was not transparent. Given that CMS acts on recommendations from the RUC in other aspects in this proposed rule, CMS should also recognize the importance of using the RUC to evaluate this proposal.

**Until there is appropriate evaluation of this proposal to eliminate consultation codes, the ACG, AGA and ASGE recommend that CMS withdraw this proposal for 2010 and continue to work with the AMA and specialty societies to further clarify its consultation policy guidelines.**

### **Physician Quality Reporting Initiative (PQRI)**

Initiated in 2007, the Physician Quality Reporting Initiative (PQRI) is a performance measure reporting program. Participants who successfully report based on criteria established by CMS are eligible for a bonus. The GI societies have been supportive of CMS's efforts to implement PQRI and we have all worked to complement the efforts of CMS with our own initiatives

encouraging PQRI participation. We are pleased that this proposed rule includes a number of provisions to improve the PQRI program.

We request that CMS include quality measures and measure groups for conditions more commonly treated by gastroenterologists. Even at this increased bonus rate, GI must weigh the administrative costs of limited participation to the incentive payment. Additional quality measures would increase GI participation and would also help to alleviate any fear that the lack of PQRI participation can be interpreted as a lack of desire to increase health care quality and patient care.

The GI societies are supportive of CMS's efforts to allow a variety of mechanisms for participation in the PQRI program, including claims-based reporting, registries, measures groups and electronic health record (EHR) based reporting. Although PQRI is not funded beyond 2010, we are hopeful that meaningful health reform will enable this valuable program to continue.

In a July 17 briefing of the proposed rule held at the AMA's Washington headquarters, CMS staff indicated they would try to post the 2010 measure specifications on its website by Nov. 15. We appreciate CMS's efforts to allow as much time as possible for practices to review and prepare for the specifications prior to Jan. 1.

#### *Individual claims*

In the proposed rule, CMS states it is considering significantly limiting the claims-based mechanism of reporting clinical quality measures for the PQRI after 2010. This would be contingent upon there being an adequate number and variety of available registries and/or EHR reporting options. We are concerned that this time frame may be too short to consider the elimination of claims-based measures. As we have been participants in the measure development process, our own experience reveals that timeframes approaching 18 months are needed for measure development and approval through a society's process, the AMA's Physician Consortium for Performance Improvement (PCPI), and endorsement by the National Quality Forum (NQF).

Because specialty societies are at different places in their quality measure development processes, we are troubled by comments in the rule to significantly limit the claims-based mechanism of reporting clinical measures for PQRI after 2010.

**The ACG, AGA and ASGE recommend that CMS retain claims-based measures as needed while specialties continue to work on developing registries and other alternative reporting mechanisms.**

### *Registry*

Due to measure complexity, a select number of measures are being proposed as "registry-only" measures. This means that such a measure would only be reported via a registry and not through the claims-based process. CMS is proposing to designate measure # 83, Hepatitis C: Testing for Chronic Hepatitis C-Confirmation of Hepatitis C Viremia, as a registry-only measure. We are confused by the rationale for this decision. Measure #83 is reported by gastroenterologists. We have reviewed the measure and do not find it to be inherently more complex than any of the other hepatitis measures.

Currently registry reporting is only available to a small number of physicians. By designating it as a registry-only measure, most gastroenterologists will not be able to report this measure. **We strongly urge CMS to withdraw the proposal to designate measure #83 as registry only.**

### *EHR*

The GI societies are pleased that CMS is moving forward with increasing the participation options for PQRI. We believe that greater flexibility in the program that recognizes and allows for participation of physicians from a wide variety of practice settings is the best way to expand and develop the program. However, PQRI measures captured by EMR/EHR are currently limited. Industry is understandably awaiting the 'meaningful use' definition under the HITECH Act to make such software and system revisions. There is already evidence that the HIT industry will not be able to meet provider demands for systems that comply with whatever the final 'meaningful use' requirements are by January 2010. Lastly, the 10 measures proposed for EHR-based reporting focus on preventive and chronic care and are not likely to be reported on by gastroenterologists.

Although we agree with CMS that the claims-based reporting option may be less efficient and accurate than registry or EHR reporting, unfortunately, for many physicians claims-based reporting is the only option. Until the other options become more widely available, CMS must protect the claims-based reporting option. In other parts of the rule, CMS has proposed linking PQRI with other Medicare programs such as the Medicare Confidential Feedback Program and the Physician Value Based Purchasing Program. If CMS is going to expand the use of PQRI data in the Medicare program, then the Agency needs to ensure that the program is accessible to as large a portion of providers as possible. PQRI is still in its infancy. Medicare should focus on encouraging participation, not creating barriers. We are pleased that CMS is focusing on improving this program, but we urge the Agency not to move too quickly to remove claims-based reporting.

### *Reporting period*

CMS has invited comments on its decision not to propose a six-month reporting period for claims-based reporting of individual measures. We encourage CMS to provide such a six-month claims-based reporting option. It is very feasible given the HIT issue described above, that during an EMR/EHR conversion, a practice may need to revert back to claims-based reporting. Additionally, given the poor rate of PQRI participation we believe that this option may encourage smaller GI practices to participate.

We see a six-month reporting period as another example of the Agency trying to increase the flexibility of the program. For many physicians, including gastroenterologists, reporting measure groups is not an option, nor is reporting through a registry. We believe that allowing for an alternative reporting period for these providers will encourage participation in the program. The initial implementation of the PQRI program can be daunting. The final measure specifications are not posted until November or December creating a very compressed timetable for a January 1 program implementation.

**The ACG, AGA and ASGE believe the alternative reporting period would be very helpful to many providers and we urge CMS to expand this option to providers reporting individual measures via the claims-based process.**

#### *Measure Groups Reporting*

CMS's proposal to increase the bonus to two percent and allow EHR data submission should be noted as positive changes. However, the measure groups published thus far do not relate to conditions commonly treated by gastroenterologists. Even at this bonus rate, our members must weigh the cost and burden of reporting versus the potential bonus.

#### *Group Practices*

The proposal defines a practice group as having at least 200 or more individual eligible professionals who have reassigned their billing rights to the TIN. Given that 39% of GI physicians practice in groups of fewer than six physicians, it is highly unlikely that gastroenterologists outside of academia will be able to participate under this category. **We strongly encourage CMS to re-evaluate and consider a more reasonable provider number for the definition of group practice.**

#### *Public Reporting*

As required by MIPPA, following the distribution of 2010 incentive payments, CMS will post on its website the names of electronic prescribers and group practices that satisfactorily report quality measures. **Given the problems encountered by our members with the Medicare physician site ([www.medicare.gov/Physician](http://www.medicare.gov/Physician)) regarding PQRI participation, we strongly encourage CMS to address and correct issues with that public reporting site before releasing any additional data including e-prescribing data.** Specific concerns with the current site include lack of accurate provider listings, poor and difficult to find disclaimer information regarding participation and poor user instructions. **It is essential that CMS post accurate data on PQRI participation, and enable physicians to correct data that is inaccurate.**

#### *Electronic Prescribing*

Our societies are pleased that there will be a two percent bonus available for successful electronic prescribers in 2010. CMS will also begin making incentive payments to group practices based on the determination that the group practice, as a whole, is a successful electronic prescriber.

CMS has acknowledged that electronic prescribing is not currently widespread and therefore provides additional methods for participation. **The ACG, AGA and ASGE are pleased that CMS is proposing to allow multiple reporting mechanisms for the reporting of the electronic prescribing measure to increase opportunities for participation.**

**We also request that CMS finalize its proposal to enable eligible professionals to choose whether to submit data on the electronic prescribing measure through claims, a qualified registry, or a qualified EHR product.**

### **Physician Resource Use Report**

The ACG, AGA and ASGE have identified several issues regarding the physician resource use reports that need to be resolved prior to wider implementation of these reports.

A large potential flaw of the resource use reports is the attribution methodology. We are concerned that greater transparency of the methodologies being utilized to assign attribution to a specific physician is needed. Many have noted that an attribution method which divides costs according to E&M reporting is potentially flawed. An attribution methodology based solely on costs attributable to a particular physician may not be in proportion to the E&M codes reported. For example, a single high utilizer that generates significant procedural expenses with low frequency E&M would distort the utilization of other physicians spending more time with the patient, such as a patient with inflammatory bowel disease, for whom the costs of surgery would be "shared" with a gastroenterologist who provides a large number of outpatient visits before and after the operation.

We are also concerned about the lack of a reliable severity adjustment in the resource use methodology, and note that more severely ill patients would be expected to utilize greater resources. Unless this is reliably tracked, subspecialty practitioners in referral centers who care for such patients will appear to be over-utilizers. This is exacerbated by the inaccuracy of claims data that are used for tracking co-morbidities and the limitations of existing ICD-9 codes.

We are concerned about providing resource use reports for physicians who treat patients with unusual or difficult conditions that lead to small sample sizes affecting the validity of the data being reported. This may be a disincentive to physicians to accept patients with difficult, unusual or high-cost conditions since this might worsen their "quality" statistics. We would anticipate significant access problems for beneficiaries with difficult, severe, or unusual diseases under such circumstances. CMS needs to qualify reports where there are small sample sizes.

**The ACG, AGA and ASGE are supportive of CMS's future plans to provide a confidential combined report that includes both resource use and reporting of PQRI and/or electronic prescribing measures. However, at this time, we recommend a slow phase-in approach that allows for sufficient time to implement a well-designed and appropriately focused program. We also recommend that physicians have the opportunity to correct their data and correct attributions if the methodology is incorrect or if the results contain invalid results.**

### **Physician Value-Based Purchasing (PVBP)**

Currently, Medicare health professional payments are based on the quantity of services or procedures provided, without recognition of quality or efficiency. MIPPA requires the Secretary to develop a PVBP program for Medicare payment for professional services paid under the physician fee schedule. By May 1, 2010, the Secretary shall submit a report to Congress containing the plan, together with recommendations for such legislation and administrative action as the Secretary determines appropriate. CMS is soliciting comments particularly in the areas of the appropriate level of accountability (i.e. group, individual, and region) and appropriate data submission mechanisms. The workgroup will use public comments to inform its development of the plan and report to Congress.

The GI societies strongly support the Agency's efforts to more effectively allocate Medicare resources. We appreciate the significant pressure on the Agency to meet the demands of the program with shrinking resources. **While we have been closely following the many discussions and various demonstration projects, it would be helpful if CMS would widely disseminate the findings of the demonstration projects to allow comment on specific programs. Payors, providers, and patients are all desirous of a more efficient system that provides high quality health care.**

**As CMS develops its plan, we encourage CMS to remember that value-based purchasing is not just about cutting costs, but also about providing Medicare beneficiaries access to high quality, cost-effective health care.** Given the diversity of medical practice, a single one-size-fits-all approach must be avoided, and physicians should have flexibility to adopt different approaches depending on their practices' composition and capabilities. No system should be implemented that requires physician participation on a mandatory basis without specific Congressional authorization following a thorough evaluation. The physician community can play an important role in contributing to the development of the Medicare PVBP program and we look forward to opportunities to collaborate with CMS.

### **Proposal to establish a group of experts separate from the AMA RVS Update Committee (RUC) to review RVUs**

In the proposed rule, CMS has requested input on the advisability of creating a group of experts separate from the AMA RUC to help the Agency improve the review of relative value units. Although gastroenterology does not have a permanent seat on the RUC, the specialty is an active participant in the process and has occupied the rotating internal medicine seat in the recent past. Mechanisms such as the five-year review of work values and practice expense values are currently in place to identify and review misvalued services. Since CMS has historically accepted over 90 percent of the RUC recommendations, it is unclear how a costly new bureaucracy would enhance the current process. We believe that the RUC process should continue to be used by CMS in establishing relative values. The RUC can best achieve these goals when all specialties have meaningful, effective input into the decision process.

**The ACG, AGA and ASGE believe a better approach would be to add additional seats to the RUC to ensure that internal medicine subspecialties are adequately represented.**

### **Misvalued Codes**

The RUC provides recommendations to CMS for the valuation of new and revised codes, as well as code identified as ‘misvalued’ or with high volume growth. CMS notes in this proposed rule that it has improved the process “for identifying misvalued codes by engaging in an ongoing review that includes screens for rapidly growing services with substantial shifts in sites of services.” While CMS does not propose any item relating to high volume growth codes, we believe it is important that CMS consider the reason for high volume growth before labeling codes ‘misvalued’ which would lead to payment cuts. For example, colonoscopy codes may experience an increase in volume growth because of Congress’s desire to increase colorectal cancer screening utilization. Other examples of legitimate volume growth include an increase in the Medicare population as our “baby boomer” generation becomes Medicare eligible, increases in the incidence of obesity and GERD, and the emergence of technologies that make certain procedures safer. We believe that it will be important for the RUC and CMS to distinguish between those codes that have experienced inappropriate growth in volume from those that have grown for legitimate reasons.

Our societies are participating in the RUC Five-Year Review Identification Workgroup that is responding to MedPAC and Congressional concerns over valuation of codes. CMS has previously asked the RUC to focus on codes with sites of service anomalies, high intra-service work per unit time (IWPUT) and services with high volume growth. We note that four GI services, represented by Codes 43236, 43242, 43259, and 45381, were included in Table 25 of the “Fastest Growing Procedure Codes.” We are concerned that our response to the RUC regarding these codes, acknowledging that this could be dealt with through a CPT Assistant article and/or re-survey in the future, was not acknowledged by CMS in this proposed rule.

**Our societies urge CMS to consider the reasons why certain services may have increased utilization and not make the assumption that these services are misvalued or that the utilization is inappropriate.**

### **Accreditation Standards for Diagnostic Imaging Services**

The ACG, AGA and ASGE strongly support approaches that aim to increase the quality and performance of imaging services. We are concerned that the implementation of accreditation standards does not address the appropriateness of clinical services, and could hinder that ability of Medicare beneficiaries to obtain access to diagnostic imaging services.

**We urge CMS to work with all relevant specialty societies in implementing standard accreditation and advanced imaging training services so that Medicare beneficiaries are not faced with various standards of care depending on the supplier of imaging services.**

### **Competitive Acquisition Program**

CMS is proposing a number of changes to the Competitive Acquisition Program (CAP) to make the program more flexible and workable for physicians and suppliers to encourage participation. The GI societies support the CAP program as an alternative mechanism for physicians to obtain and administer specified Part B drugs related to gastroenterology services for Medicare beneficiaries. **Although not repeated in this letter, we support the changes outlined in the proposed rule and recommend that CMS finalize these proposals for 2010.**

### **Initial Preventive Physical Exam (IPPE)**

The initial preventive physical examination (IPPE) also known as the "Welcome to Medicare Visit" is a benefit available to all Medicare beneficiaries within the first year of joining the program. We are pleased that CMS is proposing to increase the payment rates for the IPPE and believe the proposed increase in work RVU for code G0402 more accurately reflects the resources used in providing these services to beneficiaries.

The IPPE benefit was mandated by MIPPA to pay for an initial assessment of key elements of a beneficiary's health status within six months of the beneficiary's enrollment in Medicare Part B. The IPPE exam provides the opportunity for a physician to provide important information to a beneficiary that includes education and counseling about preventive services that are available, such as colorectal cancer screenings. Preventive measures such as a colonoscopy not only improve health and wellness but lowers Medicare costs as well. We are also pleased that Congress has extended the time period for the IPPE benefit to within one year of the beneficiary's enrollment in Part B.

**Our societies are supportive of CMS's proposal to increase payment for the IPPE and recommend it finalize this proposal for 2010.**

### **Office Endoscopy**

The GI societies are concerned that practice expense reimbursement is inadequate for office settings where physicians perform endoscopy services. In the State of New York, where a majority of office endoscopy occurs, state law has mandated that all offices providing sedation for surgical services must be accredited by a deemed agency (Joint Commission, AAAASF, or AAAHC). In order to achieve accreditation, an office setting that provides sedation must also provide a crash cart, a ventilator, an ambu bag, intubation equipment, capnography, and other equipment and supplies. We are specifically concerned that reimbursement for office endoscopy is low, in part, because CMS does not include the costs for these supplies in their calculations.

We recognize that credentialing of the office setting is a state, not a Medicare requirement. The GI societies support patient safety and quality of care standards for those offices who perform sedation for surgery, and note that, to date, over 20 states have established requirements to ensure patient safety. We also note that the Government Accountability Office has previously evaluated the appropriateness of office endoscopy and sedation, and did not express any

concerns that patient safety was compromised if a patient underwent endoscopic services in the office setting. We believe that, regardless of state requirements, those offices that have achieved accreditation by a deemed entity deserve to be adequately reimbursed for their practice expenses. We are also happy to assist CMS in any way possible as well as to work with other primary care and surgical specialties that may also perform these services in the office setting.

**The ACG, AGA and ASGE request that CMS bring this policy issue to the RUC to determine appropriate practice expenses for patient safety and quality of care for endoscopic and surgical-based procedures that are performed in the non-facility (office) setting.**

### **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 2010 physician proposed rule. If we may provide any additional information, please contact Brad Conway, Vice President of Public Affairs, ACG, at (301) 263-9000 or [bconway@acg.gi.org](mailto:bconway@acg.gi.org); Anne Marie Bicha, Director of Regulatory Affairs, AGA, at (240) 482-3223 or [abicha@gastro2.org](mailto:abicha@gastro2.org); or Sheila J. Madhani, consultant to ASGE (202) 419-2510, or [sheila.madhani@hklaw.com](mailto:sheila.madhani@hklaw.com).

Sincerely:

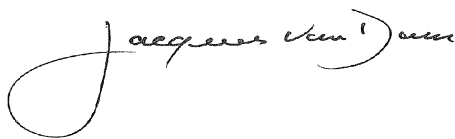
Sincerely:



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