September 1, 2016

Mr. Andy Slavitt, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Via online submission at www.regulations.gov

RE: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Low Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model (CMS-1654-P)

Dear Mr. Slavitt:

I am pleased to submit the following comments on behalf of the Ambulatory Surgery Center Association (ASCA) in response to the Centers for Medicare and Medicaid Services' (CMS) proposed rule regarding policy revisions to the 2017 Medicare physician fee schedule (PFS). From its inception, our industry has been focused on the high-quality, lower-cost care that can be provided at physician-owned and operated facilities. These comments focus on a few of the provisions that most directly impact ASCs, the surgeons who operate in the ASC environment and the Medicare patients who choose the ASC setting for surgical procedures.

Proposed Valuation of Services Where Moderate Sedation is an Inherent Part of the Procedure and Proposed Valuation of Moderate Sedation Services (CPT codes 991X1, 991X2, 991X3, 991X4, 991X5, and 991X6; and HCPCS code GMMM1)

CMS is proposing to remove the RVUs associated with moderate sedation from all procedure codes listed in Appendix G of the *CPT® Book*. Pursuant to this change, the value of moderate sedation would be backed out of the current value of the code and instead would be reported and paid separately when provided.

For CY 2017, the CPT Editorial Panel created separate codes for reporting moderate sedation services (CPT codes 991X1-991X6). When moderate sedation is reported for Medicare beneficiaries it is anticipated that the service would be most often reported using 991X2. As a result of survey data submitted to the American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee (RUC) by multiple national medical specialty societies which showed a significant bimodal distribution between endoscopic procedural services furnished by gastroenterologists and surgeons and procedures provided by other specialties, CMS proposes to create a new HCPCS code GMMM1 to be used for certain gastrointestinal (GI) endoscopy-specific moderate sedation services in lieu of code 991X2. CMS proposes a value of 0.10 work RVUs for GMMM1. This value is consistent with the physician work survey data presented to the RUC. CMS proposes to exclude esophageal dilation (codes 43450, 43453) and biliary endoscopy (43260-43265-43273-43278) procedures from reporting with GMMM1. Instead, providers will be directed to report code 991X2 when moderate sedation is performed

Ambulatory Surgery Center Association | 1012 Cameron Street Alexandria, VA 22314 | TEL 703.836.8808 FAX 703.549.0976 | asc@ascassociation.org ascassociation.org

by the same physician performing the procedure. CMS proposes the RUC-recommended work RVU of 0.25 for code 991X2.

ASCA appreciates the agency's consideration of the data that supports a separate code and valuation for moderate sedation services furnished with endoscopic procedures. Establishing a distinct HCPCS code to report GI endoscopy-specific moderate sedation services is appropriate given current medical practice. However, we are concerned by CMS's proposal to exclude esophageal dilation and biliary endoscopy procedures from this policy. CMS did not provide adequate basis or explanation for making this distinction. For example, CMS should be able to cite survey data indicating that the physician work of the endoscopist providing moderate sedation for these services is different from other GI endoscopy procedures or point to a clinical basis for this differentiation. Unless CMS can point to a credible, clinically-supported basis, we recommend that CMS allow GMMM1 to also be used with esophageal dilation and biliary endoscopy procedures.

Collecting Data on Resources Used in Furnishing Global Services

The Medicare Access and CHIP Reauthorization Act (MACRA) required that beginning no later than January 1, 2017, CMS must collect data on the number and level of visits furnished during the global service periods and beginning in 2019 use this data to assess and potentially revise the valuation of surgical services. In response to this statutory instruction, CMS is proposing a three-pronged data collection effort that includes:

- Comprehensive claims-based reporting of the number and level of pre- and post-operative visits furnished for 10- and 90-day global services;
- Survey of a sample of practitioners about activities and resources used to provide these visits; and
- A more in-depth study that will include direct observation of practice groups and accountable care organizations (ACOs).

ASCA's comments focus on the first part of this proposal: claims-based reporting on the number and level of pre- and post-operative visits furnished for 10- and 90-day global services. ASCA agrees with the underlying premise that physician work should be valued based on accurate and verifiable data, and that collecting such data is a necessary step toward achieving this objective. Nonetheless, we are very concerned with the breadth and scope of this proposal. CMS's proposed approach is overly burdensome for physicians who will need to report an enormous amount of new data on claims. In addition, we believe that this broad data collection effort will not result in useful and accurate data.

According to analysis of Medicare utilization data conducted by the AMA, there currently are 4,239 CPT codes with surgical global packages in the Medicare physician fee schedule. According to 2015 Medicare utilization, there are only 110 10-day global and 149 90-day global codes performed more than 10,000 times. **We support the AMA's recommendation that data collection should be limited to services with a volume of at least 10,000, and/or $10,000 in allowed charges and at least 100 separate physicians have performed the procedure.**

CMS proposes that any practitioner who furnishes a procedure with a 10- or 90-day global period report the pre- and post-operative services furnished on a claim using newly created G-codes. CMS proposes this option, citing numerous concerns including the inability to collect a sufficient volume of data, lack of knowledge regarding factors that drive variation in pre and post-operative care and how to identify a representative sample. Requiring all physicians to report on pre- and post-operative visits goes beyond the statutory mandate and is unnecessary and burdensome. Accordingly, **ASCA recommends that CMS collect pre- and post-operative visit data only from a representative sample of physicians practicing**

in a wide range of practice environments (small, medium-size, large and hospital-based) and geographic locations (rural, suburban, urban).

Finally, CMS is proposing a new series of eight G-codes (GXXX1-GXXX8) that are intended to collect the pre- and post-operative activities based on place of service and complexity of patient. Codes would be reported for each 10-minute increment of time. We believe that introducing a new family of codes will only add to the confusion and complexity of the data collection effort. In addition, we question the feasibility of collecting data in 10-minute increments. This overly focused level of reporting would require physicians and their staff to monitor time for almost every task they perform throughout the day, and might necessitate redeploying staff or hiring additional staff just to collect this detail time accounting. Using an existing code that captures the entire visit would be a more reasonable approach. CMS should use the second prong of the overall proposal, "survey of a sample of practitioners about activities and resources used to provide these visits," to collect more detailed information about the visits. **ASCA recommends that CMS use CPT code 99024 Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure once per visit to identify the number of post-operative visits associated with a surgical procedure.**

Work RVU Recommendations for Cystourethroscopy (CPT code 52000) and Hysteroscopy (CPT code 58558)

The RUC recently reviewed Cystourethroscopy (CPT code 52000) and Hysteroscopy (CPT code 58558), two high-volume surgical procedures, and recommended valuing these procedures at 1.75 work RVUs for CPT code 52000 and 4.37 work RVUs for CPT code 58558. Notwithstanding these empirically driven and clinically-based recommendations, CMS is proposing a 1.53 work RVU for CPT code 52000 and 4.17 work RVUs for CPT code 58558 on the basis of crosswalks to existing codes.

RUC recommendations are based on surveys of providers from across the country who perform the service, and are vetted by an expert panel composed of representatives from a wide spectrum of medical specialty societies who understand the highly technical and complex structure of the Medicare Physician Fee Schedule. Recommendations based on survey data are more robust than the recommendations based on crosswalks.

ASCA urges CMS to accept the RUC work RVU recommendations of 1.75 work RVUs for Cystourethroscopy (CPT code 52000), and 4.37 work RVUs for Hysteroscopy (CPT code 58558).

We appreciate the opportunity to provide feedback on the agency's work and are happy to discuss any of these issues further. Please contact Kara Newbury at or (703) 836-8808 if you have any questions or need additional information.

Sincerely,

William Prentice
Chief Executive Officer

Ambulatory Surgery Center Association | 1012 Cameron Street Alexandria, VA 22314 | TEL 703.836.8808 FAX 703.549.0976 | asc@ascassociation.org ascassociation.org