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**SOFIA FAUCHER:** Hello everyone and thank you for joining us today for Boston Scientific's webcast entitled, 2020 Medicare Reimbursement Changes and Policy Highlights for Gastroenterology. My name is Sofia Faucher, and I am part of the health, economics, and market access team at Boston Scientific. Today we are pleased to have Dr. Glenn Littenberg here with us. Dr. Littenberg will provide an in-depth overview of Medicare reimbursement changes and Medicare policy highlights for 2020.

A few notes before we begin. If you have colleagues who are unable to attend the live presentation today, please let them know that it will be available on demand. We are offering continuing education credits for today's program through the American Academy of Professional Coders, the AAPC. This program meets their guidelines for one CEU. Granting of prior approval in no way constitutes endorsement by AAPC of the program content or the program sponsor. In order to be eligible for the credit you must attend the entire program and then click the Get Credit button provided at the end of the webcast.

Throughout the presentation today we encourage you to ask questions. You can do this by utilizing the Ask Question button on your screen. Your questions will come directly to the panel. And we will answer all questions at the end of the webcast. All questions will be answered. Depending on the time available at the end of the presentation, we may follow up with you via email. Make sure to provide a valid email address along with your questions.

Before we go any further, I'd like to provide a few disclosures regarding today's webcast. This program is sponsored by the Endoscopy Division at Boston Scientific. Please note the disclosures, including conflict of interest and commercial and non-commercial support. Content contained in this presentation is informational only. Although Boston Scientific produces and distributes information to help health care providers better understand reimbursement and economics, we recommend that providers consult directly with appropriate health insurers, including Medicare administrative contractors, for information on proper coding and billing.

And now we are ready to start the presentation. Our presenter today is Dr. Glenn Littenberg. While maintaining a private gastroenterology practice and independent ambulatory endoscopy center in California, Dr. Littenberg has long represented GI and internal medicine to the AMACPT panel. In 2006 he completed an eight year term on the editorial panel. In addition, he has chaired the Coding Subcommittee of the American College of Physicians for several years. Dr. Littenberg is an expert in GI reimbursement. Currently he is the CPT Advisor for the American Society for Gastrointestinal Endoscopy and chair of their reimbursement committee, in addition to having served as chair of the Practice Management Committee for six years.

He wrote and edited many chapters of the ASGE's coding primer, a guide for gastroenterologists, and speaks widely on health care reform, coding, Medicare compliance, and trends in GI practice. He is the chief medical officer of the 65 plus physician GI group, Insight Digestive Health Care, which now spans from San Francisco to Orange County and is the largest GI group in California. At this point, I'm going to turn the floor over to Dr. Littenberg.

**DR. LITTENBERG:** Thank you very much, Sofia. All right, so I appreciate all of you joining. Good afternoon, unless you're in Hawaii. Then if so, good morning. I'm going to talk about the 2020 changes in Medicare reimbursement starting with hospital outpatient, talking briefly about inpatient and then about ambulatory surgery. And then a little bit about the physician fee schedule changes. But also some Medicare policy changes that are pending that I think will affect GI practices across the country in pretty substantial ways. Finally, there are some resources that you can utilize for more information. And then we'll try to allow enough time for whatever questions and discussion we can manage today.

So for the outpatient world, it's estimated that the total payments to hospital outpatient are going to increase by about 2.6% in 2020. That's about $6 billion, in case anybody's counting. That actually sounds like real money. And that gets distributed across about 4,000 participating hospitals for Medicare.

So GI is actually a pretty important service for the typical hospital. There's quite a lot of revenue that GI brings in, directly and indirectly. And so making economic sense out of how hospital outpatient GI works is certainly very important for most hospitals. I'll remind you that the payment mechanism for outpatient is basically one fee for the entire procedure. That includes whatever devices are used, the actual scopes, all the personnel, all the medications, the room time, et cetera. And Medicare has a system they call it ambulatory payment classifications, or APCs.

APCs are divided up to attempt to categorize things that are clinically somewhat similar and in resource costs, somewhat similar. And they basically do a weighted average approach, and then pay one fee for any of the services that are part of that APC. These are updated periodically, because of changes in costs, new technology that comes along, new procedures that we do. And so we're always keeping a close watch on how Medicare is divvying up the APC. It's not just the payment involved, but whether each procedure is categorized in what seems like a fair way. And part of our lobbying from GI Society, as well as device makers and companies like Boston Sci, is to try to make sure they get it right.

So for example, if you look at the changes for 2020, you'll see small increases for many procedures. Level 1 upper GI procedures are the most common, upper GI endoscopy, as an example. And these go up about 3%. More complex GI procedures in the upper range are categorized in one or two of the other APCs. And we'll see that goes up as far as $3,000 for 2020. So this would be, as an example, procedure involving a stent. Which goes up about 6%. And then there are also three APCs for lower GI procedures. And one other APC, which includes a few very complex GI procedures that are, to a great degree, I believe, non endoscopic. And go up a fair bit.

Some of these, you might notice in your slide, are asterisks, and refer to waters what's called comprehensive APCs. It used to be for example, that if you put in more than one stent, you get paid extra for that second or subsequent stent. And other things might be paid separately. But few years ago, Medicare started bundling more of the particular payments that might occur within a given procedure into what's called a comprehensive APC. And ordinarily, there's no billing for extra stuff that you do. You get one fee, which was updated to include the costs of things typically used.

So for an example of some of the actual procedures, you can look, for instance, at upper GI endoscopy. These are paid-- the most common, just diagnostic and biopsy, are paid at the lower levels. Some maybe $6 for 2020, representing a 3% increase. A somewhat more complex procedure, like placing a gastrostomy tube, is paid virtually double that. And if you go way up to stent placements, you'll see even higher levels.

And if you look at some of the lower GI codes, you'll see that diagnostic colonoscopy, which would include the screening colonoscopies, the GO125, the GO121 Medicare payments, paid at $764. Whereas, if you start doing other things like biopsy, or submucosal injection, or lesion removal, the APC changes and the payment then goes up proportionately. And you'll see ERCPs are in a different APC, which brings a much better reimbursement, considering all the tools that we typically use during the ERCP. And again, here for a stent, the actual payment goes up to $4,781. So again, this represents what might be one stent or multiple stents, depending on the procedure. The unit won't be paid differently. So it still keeps us motivated to keep our resource costs as low as we can manage them, in terms of what we purchase and in terms of what we utilize. And being efficient so we don't wind up messing things up and having to use an extra stent because something got screwed up in the way it was used.

Now, one other point to make is, the procedure called endoscopic mucosal resection. There's a lot of confusion about what this is, compared to just a inject and cut, or lift and snare, kind of a procedure. But this year hospital outpatient payment has increased substantially from the range of $980 to $2,344. So it's certainly important to get this right. Comparatively, if you just do a lift with injection under the lesion and a snare polypectomy, the payment winds up being about $1,506. So that extra increment is important, but EMR is not just simply a lift and cut or lift and snare type of a procedure. It's usually for much broader based lesions. And it usually actually requires use of a cap assisted or litigation assisted technique.

So it is different, and the report should say endoscopic mucosal resection, or EMR, in the operative report in order to take credit for billing that. So there EMR codes that are in the upper endoscopy segment of the esophagus and upper GI. They're in the sigmoid, in the stoma section, and in the colon section. There are separate EMR codes. So in most of these instances, there are increases in 2020. But the coding needs to be done right. And if physicians aren't quite clear on the difference, they should be educated.

One of the things that's been controversial and will remain so, is an attempt by CMS to try to move to a more uniform method of paying for outpatient visits. Now, many hospitals have outpatient clinics because they employ physicians. And for a number of years they've been highly motivated to utilize these clinics because a pretty substantial extra facility fee would be paid to the hospitals for these kinds of visits. When I do a visit in my office, I don't get a facility fee. I get one payment.

There's a little difference in the way that Medicare pays for evaluation and management services that are done at a facility so some degree of extra payment is appropriate because they don't pay a separate practice expense component. But for many years, the amount paid was quite a bit higher. CMS has been trying to reduce them to make them equal for between offices and hospitals. So as not to give hospitals an undue incentive to utilize these or to acquire more physicians because they can make more money off of their evaluation management visits. An attempt to do this retroactively led to a lawsuit that CMS lost. They've attempted to implement it again for 2020. And again, a lawsuit has been filed. And we'll see what happens.

Many of us, particularly in private practice, or in large groups that are not part of hospital systems certainly think this kind of site neutral payment mechanism ought to be implemented. But clearly hospitals will be fighting this, as they did in the past, and as they've already filed going forward. So something to keep track of, if this affects you.

Hospital outpatient quality measures. There are a number of outpatient measures that have been removed for 2022, 2021. Affecting GI is the OP-30. Which is the interval for patients who have had adenomatous polyps. When are they coming back, when are telling them to return? This is a measure that really was reported by physicians and reported in AFCs also. It didn't really make a lot of sense for hospitals to have to separately report it. So sensibly, this is being taken away. And there are no proposals that are being proposed as new quality measures for the outpatient environment. So a little bit of good news.

The one that exists right now for return to the facility within seven days, if you have a colonoscopy and a patient then winds up with an admission, or observation stay, or emergency department visit, then you're supposed to report the frequency of these. Beginning this year, the reporting period, though, is going to change to three years instead of one year. Recognizing that these events are pretty uncommon and how many actually have to do with something that happened during the colonoscopy or as a complication of the colonoscopy. Those are so infrequent that unless you look at them over a long period, you're really not going to get any kind of valid data.

So you're allowed to get at your own quality data. If you have the right credentials, you can look at QualityNet.org and get at that. So this will be a continuing requirement, but over a three year period.

Now something on the payment side that is potentially important, is that CMS finalized a proposal to allow devices which receive an FDA designation called breakthrough. FDA reviews new technology. And if they believe it's pretty substantial and will improve clinical care, they may award that a designation of a breakthrough. And CMS used to have separate criteria to decide whether to pay something extra in addition to the underlying procedure, what's called a pass through. But one of those criteria was that it had to show substantial clinical improvement. And what's happened is CMS is going to keep their process such that, anything that gets the FDA designation will automatically meet the substantial clinical improvement criterion.

Now there's still other criteria that CMS requires before you can get a pass through. Part of it has to do with how new the technology is. Part of it has to do with the amount that it costs relative to the cost of the rest of the procedure. But this will start applying as of January of this year. So potentially new technologies may be affected by this in a way that may facilitate extra payments to hospital outpatients for things that they implement that are different. But again, you have to meet hurdles that CMS still has.

I'm going to intersperse this talk with a few photos taken at Death Valley not too long ago. I was there for several days at a time when, at night the Milky Way was rising over the cliffs. And it's a fun time to be there. There are a lot of beautiful areas in Death Valley. This is the area known as Badwater, which is about 282 feet below sea level. And it's marked by this-- all the way out to the horizon, these little salt flats that are made up of these little intersecting cells. It's really a fascinating place to wander around. Those mountains, which look rather close, are actually about 10,000, 11,000 foot mountains. So they're not as close as they seem. You start walking in that direction, you're going to keep walking a long time.

So we'll talk briefly about hospital inpatient, here. Just as on the outpatient side, CMS has increased payment rates by an average of about 1.85%, assuming that you participate successfully in the various inpatient reporting mechanisms for quality, and in the EHR. That's the equivalent of the outpatient MIPS for physicians. This will amount to about $3.5 billion. And after all the other updates and changes are incorporated, that's about a 3% increase, actually. So this is, again, helping hospitals keep up with cost of living, costs to practice.

On the inpatient side, the payment mechanism is different. What's called the DRG, diagnosis related group. Basically one payment made for the entirety of the admission. But there is a wide variation that reflects the patient's comorbidities and complications. That's why your medical records department is very careful to try to document everything that's a significant comorbidity or a complication of care that occurs. Because it may markedly influence the amount of payment.

So for example, if you have a patient who winds up with a colon stent inserted during the hospital stay. The range of payments may go from anywhere from $6,200 to $30,000 in 2020. Representing about a 1.6% increase. So many of these patients will end up with an operation. Many will end up with long hospital stays or have other things done for the disease that caused the stricture that needed the stent. Same goes with biliary procedures and esophageal disease that requires stenting. So the inpatient stays are quite varied but again, sort of everything is bundled in unless there are extreme outliers.

So what's happening on the quality side with the hospital? There are a number of programs that have nice designations, like VBP, RRP, HAC. So these are things that relate to quality measures of different kinds. There are quite a few measures your hospital winds up measuring and reporting to CMS and other payers. There's a penalty, potentially, if you have a high readmission rate over the prior three year period for conditions like acute MI, pneumonia, heart failure, total knee replacement, coronary bypass graft. None of these are GI conditions, but your hospital's payment will depend on managing the hospital discharge process so as not to get unnecessary re-admissions.

CMS does seem to save half a billion dollars on this. So they're not ready to let it go, even though it's controversial. And there's also a potential penalty if certain hospital acquired conditions occur. Anything from urosepsis related to catheters to C difficile colitis. Hospitals that are in the lower performing group get a penalty. So if your hospital is doing poorly on the VBP, RRP, HAC, your hospital may wind up MIA. So hospitals pay a lot of attention to all of these quality measures and trying to improve quality of care so they perform well, can report good data.

On the inpatient side, there's something rather equivalent to that breakthrough designation that I mentioned about hospital outpatient. There is potentially a new technology ad on payment made for things that receive an FDA marketing authorization under what's called the Breakthrough Devices Program. So it's a little different than what I was talking about, but has similar notions to it. New technology that seems to be clinically important and of significant costs will potentially be paid more starting in 2021 as an add on to the hospital DRG.

They will automatically be applied as new, and don't really require substantial clinical improvement be proven to CMS, as long as they've gotten the FDA designation. It will still have to meet certain cost criteria, though, so that it actually has a significant resource costs if you adopt it and start using it. This will be applying in 2021. So, little by little, CMS is trying to recognize the fact that we have new technologies that we have to invest in have significant expense involved. And they're trying to find ways to pay for these and try to put this in more sync with FDA approvals.

Now here's another picture. A photograph taken in Death Valley. This was early in the morning when the sun was just barely starting to come up over the sand dunes at the north end of the park. Beautiful place to wander around. If there was a person at the top of one of these hills, they would be a minute speck, to give you some idea of the height of these sand dunes. These are quite substantial. It's quite a hike to get up to the tops of some of these. But early in the morning, when the sun when the wind has made these nice and smooth, they're quite beautiful and the shadow pattern is quite extraordinary. Another fun place to go.

So ASC changes for 2020. Well, what you see here is a curve that shows not only lower numbers by far, relative to hospital outpatient side, but also a very slow up slope in the payment rates over the years. There are small increases. But this followed what was four consecutive years of major decreases in payments that occurred about four years before this slide starts. And so, now there have been small increases occurring. On average, you can think about the ASC payment for a facility being at around 55% what it is for the hospital outpatient, even if we're talking about doing the same procedures with the same people and the same doctors receiving the same professional fees. There's a substantially lower payment made to the ASC.

For some procedures it does go up a little bit for 2020. But what we realized is that many of the things that we might be able to do safely and the ASC, that say CMS would allow us to do, really we can't economically afford to do. So that upper line, the level 2 upper GI Procedures, are generally things we just will not do in an ASC, because we're just not going to get paid enough to recognize the practice expenses.

So payments will increase by about $230 million in 2020. Again, remember, it was more like $2 to $3 billion for the other segments. Total payments to ASCs will approximate $5 billion. So it's still quite a huge industry overall. 5,300 Medicare participating ASCs, a very large percent of which do GI procedures. Many of which only do GI, like my own endoscopy unit in Pasadena.

So for example, if you look at some of the 2020 payments for specific procedures, were paid also by the same APCs, it's simply that the APC rates are a lot lower. And you see payment increases that are 1% to 3% for certain things. And in the colonoscopy section, really just a very small pittance of an increase. So again, many of the procedures we do commonly are paid enough to get by for Medicare. But if you look at your own margins in an ASC, in many cases they are pretty negligible for many of the procedures we do. So Medicare continues to be reasonable for us but not always easy and we have to be very prudent about our resources.

Similarly for the quality measures, we'll be reporting the seven day return after outpatient colonoscopy to an emergency room or admission or observation stay, going up to a 3 year reporting sequence. And we'll be not having to report the Avoidance of Inappropriate Use measure for adenomatous polyps, just like on the hospital outpatient. Strangely, CMS estimated this is going to save $2.2 million in resource costs just to remove one quality measure. I'm a little dubious about that. I'll apply to get a rebate, but I don't think it's going to pay me anything.

CMS also is trying to move towards greater payment neutrality between sites of service by approving more procedures that can be done in an outpatient environment, but none of these are endoscopic. I included here a table of some of them that were added. What you can see is that many of these are orthopedic procedures, including total knee replacement, which could be done in an ASC. Cardiac stenting, which could be done in an ASC. Again, whether things like this will be taken out of the hospital and done in an ASC in your neighborhood, really depend upon the cardiologists, on the facilities, on the economics of all of this. But I know in many communities on the commercial side, total knee replacement is starting to be a single day process done in ASCs. And cardiac stents in some communities are also being done. So quite a few things may be shifting over coming years to the ASC environment, if it works from the point of view of safety and from the point of view of economics.

Another photograph, this was one of my favorites. I call this shooting the moon. My colleague, Dan DeMarco, is a CPT alternate advisor with me. And we went out one night at a place called The Racetrack in Death Valley. Very, very flat, very cold, very blustery, windy. Waited until the Milky Way came up above the horizon and the moon was just setting. It's really a tiny sliver of moon, but when you expose a photograph you see Dan's light from his headlamp on across the Racetrack, the moon and the stars above. So it was very cool trying to photograph this and get it right. Lot of fun.

So what else is affecting physicians and their fee schedule? Well not a whole lot. Payment rates, as a whole, decreased a bit for physicians in 2020 in GI. The overall fee schedule goes up by a nickel to $36 per RVU. So it's essentially a flat fee schedule, which it has been for many years. Really been no significant cost of living increases on the physician side, despite what it costs to run our practices. Continuing to remove 2% for the sequester that was put into place as a budget problem years ago. Still not going to go away, even until 2024. Keeps getting extended and probably will be extended further in coming years.

So on the physician side, things are not easy to continue to run a practice. Pay staff increases, cost of living, health insurance premiums, et cetera, et cetera. It would have been a little worse because they were also proposing that the way they pay a little portion of our fee for malpractice would have been calculated in a way that would have decreased GI payments by 2%. But the specialist societies and Boston Sci submitted comments to CMS pointing out a lot of methodological flaws. And CMS agreed and did not move forward with that proposal. But nonetheless, because of some cuts here and other cuts there, everywhere a little cut, cut, cut, cut, cut, we'll go down by about 1% for the year instead of going up at all.

So examples of some of the physician fees that your physicians get for doing some of these procedures. If you look at complex ones, like upper endoscopy with transmural pseudocyst drainage, making a hole into the wall of the pseudocyst, putting in some kinds of stents and doing a drainage procedure. It'll pay less by 1.2%, about $400. ERCP, removal let's say with stent placement, $482. One of the more complex procedures done by gastroenterologists. Things that are more common like colonoscopy with biopsy, will go down about 1.4% in the ASC. For the physician-- professional-- fee, about $200, a little bit more if you remove polyps. So it doesn't really matter whether physician does these procedures in the hospital outpatient, inpatient, or ASC. They're all paid the same.

So one of the big things that's going to come and will affect us all next year-- and your physicians will surely need to become extremely knowledgeable about-- is how the evaluation management services are paid for or will be paid for next year. We've had a five level system for outpatient, new patients, and follow up patients. And a very complex set of requirements for what we have to document to be in sync with a level of code that we bill.

CMS had originally proposed that they reduce all of the payments to a single payment level for levels two through four. So everything would be bundled, and they pay the same level two, a level three, a level four patient. For a new patient or an established patient, two different fees. Pay somewhat more for a level five, most complex patient.

But this received a lot of opposition, including from GI societies. And the AMA set up a workshop which developed a new way of describing these services and revisited the coding levels and documentation requirements. And ultimately, CMS has come to accept what the AMACPT passed. This was just passed last year in February, so just a year ago. And there are a lot of resources online through the AMA that you'll be able to look at the nuances of this.

So bottom line is that there'll still be five levels of coding for established patients, one of which is a non physician service. The others involve the physician. There'll be only four levels for new patients. The lowest level goes away, the 99201. Which is fine, because we really never did that anyway. And we revised the code definitions rather substantially.

And what's going to be different, is that the code decision will be based on either time-- not the face to face time-- but really, the entire time on the day the encounter that you spend. So what you do before the patient gets there, what you do afterwards, all gets potentially counted as time. Or you have the choice of basing your decision for coding on the complexity of the medical decision making.

Now, this only applies to office and outpatient services. So under this scheme, how much history appears in the note, how much physical exam appears in the note-- it should be what's medically pertinent or legally prudent to do. But it's not going to count, or have to be counted towards the complexity of what you bill. There will be allowances for prolonged service and some other aspects about complexity of care details of which are being worked out. How much extra value those may give remains to be seen.

But there's still big questions when you have, really, nothing that's planned for other sites of services. So the complex documentation requirements will still pertain to the inpatient hospital and some of the other sites of service where we work. How EMR software is going to adapt to all these changes is, really, very questionable to me. How to redesign so that you can take into account Medicare requirements. But what if all the other payers are not recognizing this? We just don't know what other payers are going to do in 2021 about all this.

The other aspect that's potentially quite troubling is that we're expecting the payment rates from many of the visit services to go up. And that's across many specialties, that they will go up. But the entire proposal is budget neutral. And that means that a lot of things may go down, maybe substantially. And that could include GI endoscopic professional fees, GI pathology fees, and remember that many GI groups, including our own, has its own path lab, our own full time pathologists. And also anesthesia services, the payments made for endoscopic anesthesia when CRNA or MD anesthesiologist administers propofol rather than moderate sedation. What's paid for that can also go down and again, many GI groups have their own anesthesia service as part of their ancillary care.

So if the GI professional fees and all of these ancillary services actually go down-- they may go down 5, 6%, who knows-- this is potentially quite a nasty hit to GI. It's hard to see how to make that up. But we'll see, we won't really know for a couple of years after this is implemented to see how this all plays out and how the extra that-- maybe if you get some extra payment for prolonged service or for certain kinds of complexity-- will affect us.

There are codes that pay for transitional care when patients come out of hospital and are seen with complex problems within a couple of weeks at the office. There's a way to bill more than the traditional office visit. And there are codes and payments for certain kinds of chronic care management that we do. And GI is starting to take some advantage of these codes' existence. And we're trying to figure out how to cope with telehealth and a number of other things that make good sense for patient care, but may or may not make good sense from a reimbursement perspective. So 2021, stay tuned.

One of the things that did not occur, fortunately. Now CMS had proposed that GI providers have to inform Medicare patients about possible cost sharing. There was fallout when, there was basically an oversight in the Affordable Care Act 2010 which, ultimately, took away co-payment and deductible costs for patients having screening colonoscopy. Now the problem is that at least 30% of those turned into therapeutic colonoscopy, because polyps are found, things are removed, or things are biopsied. And the law did not account for the fact that those then are subject to cost sharing. We've been trying to correct this through legislation every year since 2011. Still hasn't gone through, because it has a cost. And Congress doesn't want to pass things with the cost unless there's some way of making back those dollars.

So we got very close last year. But then all of the health related things basically got put off at the end of 2019. They're probably going to come back in May or so of this year. So whether this legislation piece will be part of it or not, who knows. But it made no sense to have to inform or get a signature that a patient understood they may have a copay or deductible if we find and remove a polyp. Indeed, we often don't see a lot of these patients for screening colonoscopy in our offices ahead of time. So instead of putting this requirement on physicians, or on the primary care referral source, CMS said that they'll take a comprehensive look at their outreach materials and try to educate the beneficiaries more.

So my hope is that the legislation will pass and then this becomes a non issue. It's a non issue on commercial insurances. The Feds released some requirements that private payers have to pay the copay and deductible when a screening procedure becomes diagnostic or therapeutic. So they just don't feel they have the legal authority to do that for Medicare.

So what else is occurring? I'll talk briefly about something that affects hospitals and physicians. But it's a physician quality program. What's called the MIPS, or Merit Based Incentive Payment System. I think somebody has a full time job making up these acronyms. It's part of the QPP, Quality Payment Program, that CMS has. And this has been implemented now for a number of years.

The idea is, if we're performing well on quality cost, using our electronic records properly, improving the way we deliver care, there should be a positive update to the Medicare fee schedule. And you have to perform above a certain level and submit data every year in order to even potentially qualify for what originally was up to a 4% bump in your Medicare rates. That bump or potential penalty is now up to 9%. But it also requires meeting a threshold of 45 points on a 100 point scale. And potentially some further bonus if you have an extremely high score.

Well the problem is, there were so few people who qualified-- or at least many people who didn't need to participate-- and the threshold was set so low that really nobody paid a penalty, very few physicians. And so there were almost no dollars to distribute to those who did really well in their quality measures. For example, our group got a very high score, would have qualified for some of the exceptional performance bonus. And I think, as a group of at that time, 50 some odd physicians, we got a huge bonus of, I believe, $1,500 for the entire group. So as an incentive, this has been a total failure.

Now the threshold is going to go up a lot. Maybe there'll be more dollars to distribute to those who are doing and showing evidence that they're performing at a high level and quality. But I'm still a skeptic when it comes to the MIPS program. We don't know what's going to happen a couple of years out because the legislation that set it up is due to sunset. So it will be revisited.

Also we need to report the quality data on 70% of the measures that we report. In other words, if you have 100 patients you have to report the quality data on 70 of them to even qualify for getting credit for quality. You have to have 50% of your group doing some of these improvement activities. And so the threshold, how high you have to perform, goes up and up. And yet the actual dollars that you may get are not clearly rising.

So the MIPS is made up of quality measures that are still about half of the score. Cost, which, nothing we need to report. But CMS looks at the cost of care that we provide compared to our peers in our geographic areas. That's 25%. The way we use our EHRs cost 15%. Promoting interoperability, the EHR use 25%. And the improvement activities, 15%. So they still rate quality highest of all of these things. But again, it's not easy to get a real high score and it's not clear how much difference that will make.

One of the things that CMS did that we are quite unhappy about is they removed one of the quality measures for the adenoma detection rate. Many of you involved in colonoscopy probably realized that the ADR as a quality measure is really one of the key things that we look at to see if gastroenterologists are performing their colonoscopies with high quality. We should, in screening exams, be able to identify adenomas and remove them in substantially more than 20% of patients. There are differences between gender, and these rates have been going up little by little as we get better at doing colon preps, better looking with better instruments, better with our eyes with what we can see.

And we thought that this is an extremely important quality measure. Because the higher you go on this, the less likely your patient there is to wind up with colon cancer or between screening exams. But Medicare thought that somehow the variables they like to see in these measures aren't really there and the ADR may go away. We're still arguing with them, we'll see. But I think most of us will continue to report our adenoma detection rates. And we have it kind of built into our electronic reporting systems, the way we record our endoscopy procedures. Many of you may be familiar with GI Quick in your hospital or ASC environment.

So there are other aspects to MIPS changes pending. CNS wants to implement something that they're calling the MVP, or MIPS Value Pathways. So instead of chopping up all of these types of quality measures and other measures like cost improvement activities, they're going to try to require a smaller set of measures that's more specialty based, outcomes based, and more aligned to the tiny number of alternative payment models that are out there. What this will mean, we will get some preview of during the spring or summer when Medicare produces what's called the Notice of Proposed Rulemaking and tell us more what they're thinking. I don't know if any of this will be an improvement or more of a problem. But just as we get adapted to one system, they want to change the rules and the methods of payment. So we'll see what the MVPs come up with. But I don't think it'll be most valuable payment, for sure, no matter what.

And as always the devil is in the details. One last photograph here. This was taken in another part of Death Valley called The Devil's Golf Course. I think that's a very nice description for this incredibly rocky environment that sort of goes out to the distant horizon in this area. Just many fascinating geologic formations in Death Valley. So, fun place to go. If you haven't been there, worth a trip. But don't go during the summer, it's about 120 degrees.

All right, so there are a lot of resources that you can utilize, particularly for GI billing. I would still strongly advocate the coding primer put out by the ASGE. We'll be updating this for some of the 2020 changes later in the year. But the information in here is very valuable and is the most comprehensive source in one place of coding and billing information about GI procedures. And it is kept up to date by people who are expert coders, and I play a role as editor. And I've written a number of the chapters in here to try to keep them accurate and kind of explain them in English to physicians who are generally not very knowledgeable about these areas.

And Boston Sci also has some very good resources available. I'll leave this slide on, phone number, website that you can get procedural reimbursement information with a lot of good details for things that you do. So, Sofia if you want to take it from here, we'll see if we have questions. We should have a ample amount of time to answer your inquiries. So I'll be happy to see what you have for us.

**SOFIA:** Great, Dr. Littenberg, thank you so much for a great presentation. And a sincere thanks for all who had joined us. So we do have time for a few audience questions. The first is-- can you explain, Dr. Littenberg, when the lower EMR code would be used versus lift and snare polypectomy codes? Is the lesion size the determining factor?

**DR. LITTENBERG:** No, it's not lesion size, really. It has to do with the technique. And it's not obvious at all when you look at the CPT book about it, because it just says endoscopic mucosal resection. You really have to go into the weeds to try to find the policy differences. When we were trying to distinguish the lift and cut from EMR, it seemed at the time that it was very common to utilize either a cap at the end of your endoscope, which can be helpful in the way you use certain instruments. Or utilize a specialized type of a snare when you actually go to remove the polyp, or the pseudo polyp. A lot of times it's a flat lesion, and by the way that you lift it up, you're able to create that in effect something that looks polypoid, even though it started out as a flat lesion. And by lifting it up and making a, sort of a pseudo polyp out of it, in many cases we utilize different kinds specialized kinds of snares that are used for this purpose.

So part of the higher valuation reflected the fact that you're utilizing different resources either a cap and/or a specialized snare. So these are generally things that need to be mentioned within the report itself. And of course, there should be devices in your outpatient environment-- your folks are recording that you've used these things, different than your standard snares. But so it's not really that it's a matter of that you're objecting to lift the lesion and then cutting with a snare. That you can report by the traditional codes. And you can remove some pretty large lesions piecemeal or whole just using the traditional techniques.

But if you're really doing EMR, or you're using specialized equipment. And you're only needing those typically for some very large and fairly substantial lesions. Now that, too, is different than endoscopic submucosal dissection, ESD, which does not have payment codes, and is for even larger, typically flat lesions in the GI tract where cutting instruments are used to free up the attachment underneath of the polyp before the polyp is removed. And that's a whole other topic. And because there are no CPT codes right now for it, if you're doing ESD at your place-- which is going to be hospital, outpatient or inpatient-- you should, again, be looking to ASGE and others as far as guidance for how do you actually report and bill these and what you should be documenting.

So I know it's confusing. We've been fighting this confusion battle for a long time. The problem is, if we go back to CPT and try to clarify the language of it, we may also wind up undermining the extra resource payments involved for it. So we don't want to hazard the payment rate, which is higher on the physician side, as well as, as you saw, on the facility side.

**SOFIA:** Great we have an additional question related to EMR. Can you talk a little bit about demarcation? Is there a specific technique required?

**DR. LITTENBERG:** No, there's really no mention of demarcation within the requirements for billing the code. But demarcation is commonly done for EMR and ESD. And demarcation really just means that you're trying to identify the edges of the polyp accurately. Some people will just use a water flush, some will use chromoendoscopy. Some will turn on the NBI part of their device in their endoscope so they get a little different color spectrum on it. You may be using a cautery device to kind of mark the parts of the edge, so you know what's the extent that you'll need to remove. But other polyps, that you'll use EMR for are quite obvious already. You don't necessarily need to demarcate them.

Demarcation is really much more routine as part of ESD, just because you're talking about much larger lesions that may be even more ill-defined around the edges. So demarcation isn't necessary, but it's commonly done. That alone though, doesn't mean that what you're doing is EMR. OK, so just because you do some kind of marking doesn't mean that, ultimately, the technique you're using is going to be EMR.

**SOFIA:** Great. Next question, can you bill for prophylactic clip placement to prevent bleeding using CPT code 45382?

**DR. LITTENBERG:** The answer is, yes you can bill but you won't get paid. Basically, treatment of bleeding or preventive treatment of bleeding, whichever way you do it-- putting clips on doing some cautery-- is all part of the procedure of polyp removal. And that's true whether you're talking about standard polypectomy with snare removal or EMR. Anything you're doing to control bleeding ahead of time or after the fact during the same session is all considered bundled.

Now, if a patient gets discharged in the morning and then they come back at night with bleeding and you take them back in, you do a control of bleeding. There are ways to report that separately with a separate modifier to indicate it was a separate return to the procedure room on the same day. But during the same procedure, no, sorry. It's all part of the same thing

**SOFIA:** Great, thank you. And the slide regarding ASC payment increases, is this just the payment for facility or the professional and facility combined?

**DR. LITTENBERG:** There are a few instances where people have negotiated bundled payments to include facility, professional, sometimes path, sometimes anesthesia. But those are individual arrangements made with particular payers. It's not a Medicare thing at all. But otherwise, these are separate. So the ASC payment is the facility side and the professional fee is the professional fee, whether that physician works in their office, there are different fees there. But in the ASC, in the hospital outpatient or in the hospital inpatient, the fee schedule is the same for the physicians in all those instances.

**SOFIA:** OK. Can we expect any new GI codes in the near future?

**DR. LITTENBERG:** Well, it depends on how well we get our work done at CPT. We're hoping to move ahead with a code for POEM, the endoscopic myotomy done for treating a Achalasia patients. We're looking at some of the other services that we think we may be able to advance codes for pretty soon, including ESD, maybe. And very possibly, the necrosectomy as part of pancreatic pseudocyst treatment. The existing code is for psuedocyst drainage, sort of establishing an opening into the cyst and letting the cyst drain. But many times, psuedocysts are treated aggressively by going into the cyst and doing techniques to try to debride the cyst. That's called necrosectomy. It's often a repeated procedure done a number of times over a number of weeks.

So we think it's widespread enough and fairly standard in the way it's done that a code may be coming for that. We're talking about endoscopic bariatrics for balloon placements. There's a possibility for pursuing that. I think those are the key things that we're talking about in the GI societies. And the three GI societies, ACG, AGA, ASGE, we collaborate together on all our coding and reimbursement activities so that we're all on the same page. And we present the same info with the same ideas at CPT and at the AMA in terms of establishing value.

**SOFIA:** Great. Another question here related to call colonoscopy. Is it appropriate to bill for tattooing in the colon? Does it require a modifier to be reimbursed?

**DR. LITTENBERG:** Modifiers-- really your key place to look for whether you need modifiers or not, is what we call the NCCI, National Correct Coding Initiative. And you can get that through CMS and really see the entire code set. And once you understand how that's utilized, you can see whether a modifier is needed or not if you're reporting two or more procedures during the same scope entry. So example, when you're removing a polyp and you're doing either submucosal injection to raise the polyp, or you're putting a tattoo near the polyp site. It can be billing the submucosal injection code for either one of those services. And in the colonoscopy set, you do not need to have a separate modifier.

So if you're doing lift and cut, your reporting two codes 45385. 45381, no modifier. Strangely, in the upper GI section you do need a modifier when you're using either tattoos or you're doing submuscosal injection. Now, if there's a reason you wound up doing both things, you're still only reporting one instance of 45381 in the colon. Because there are polyps. We'll lift, we'll remove, and then we'll tattoo. But it's still all part of 45381, reported once. And that's true if you mark different lesions 45381, multiple or one, all the same.

But you can report both. You should report both. You get paid in increment. You don't get paid the entire second code. The difference in the professional fee is the difference between 45381 and the base code 45378. So it's probably about $25. The facility, though, gets 50% extra payment. So it's important to remember these whether you're on the facility side or on the physician side.

**SOFIA:** OK. And how do you recommend diagnosis coding order for high risk surveillance screening?

**DR. LITTENBERG:** Well, Medicare publishes a list of those codes that justify a screening using GO105 code. And, of course, if you find something, then the diagnosis, the CPT code, will change to what you did if you found a polyp, removed it. You'd be billing the colonoscopy with polyp code, whichever type you've done. But if it's a screening and you're reporting GO105, there's a whole set of codes, diagnosis codes, that CMS publishers.

But, by and large, what they reflect is personal history of colon cancer or colon polyps, family history, in some instances, and most of the inflammatory bowel disease codes where it's recognized that these patients will be coming back at more frequent intervals. So it distinguishes this from just the standard screening, low risk patient, which has its own ICD-10 codes. So these are, again, in the public domain through CMS if you need to get them. They're also covered pretty well in the coding primer from ASGE.

**SOFIA:** Great. I think we have time for just one last question. Have you heard of applying a 53 modifier when a colonoscopy is fully completed but the prep is not satisfactory and the patient is advised to repeat the procedure?

**DR. LITTENBERG:** Yes, that's not rare. I mean, sometimes the colon will look clean enough to go ahead and do it, and then we get to the right colon and we even enter the cecum and sure enough the prep is just really poor there. It's just not going to be adequate. So any time you are doing what you consider an incomplete colonoscopy, which you may have gotten to the cecum, or ileum, or crossed an anastomosis. But if the prep is not adequate, or if something happens during the course of the procedure, you have to abort. And you want to come back another day. It's important to report that 53 modifier.

You'll get a lower payment, but it will allow you to come back under the screening benefit. Meaning the patient will not have a copay or deductible when you come back, hopefully with a better prep. It allows you to come back within a much sooner frame. Usually it's recommended that be done the same year, rather than put off.

**SOFIA:** Great. So that wraps up our time for audience questions today. Thank you again Dr. Littenberg. So just a few final notes before we close out the webcast. For those who submitted a question that we did not have time to answer, be sure you provide your email address and we'll respond within the next 10 business days. At this time, please complete the survey by clicking on the link on your screen. If you are interested in CEU credit, please click on the Get Credit button on your screen. And then, in order to receive that credit, each participant must listen to the entire presentation and score correctly on seven out of the 10 questions offered at the end of that presentation.

So please be sure to let your colleagues know who may have missed the live presentation that it will be available later on. We also encourage everyone to visit the Bostonscientific.com/reimbursement section of our web site to access a suite of reimbursement tools. Again, I'd like to thank you for participating in the webcast today and we look forward to having you join us for future programs. Have a great afternoon, everyone.