

September 24, 2018

Seema Verma, MD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1695-P
P.O. Box 8013
Baltimore, MD 21244-1850

RE: [CMS-1695-P] Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs

Dear Administrator Verma:

The American College of Gastroenterology (ACG), American Gastroenterological Association (AGA) and the American Society for Gastrointestinal Endoscopy (ASGE) welcome the opportunity to provide comments on the Centers for Medicare and Medicaid Services' (CMS) proposed rule (CMS-1695-P), published on July 31, 2018 in the *Federal Register*, regarding the proposed policy revisions to the CY 2019 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment Systems. Together our societies represent virtually

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Our societies applaud CMS for its proposal to replace the Consumer

Definition of ASC Covered Surgical Procedures

Since 2008, CMS has defined ASC covered surgical procedures as those described by Category I CPT codes in the surgical range from 10000 through 69999, as well as those Category III CPT codes and Level II HCPCS codes that directly crosswalk or are clinically similar to procedures in the CPT surgical range that CMS has determined do not pose a significant safety risk, would not expect to require an overnight stay when performed in an ASC, and are separately paid under the OPPS.

For CY 2019, CMS is proposing to revise its definition of surgery to include certain “surgery-like” procedures that are assigned codes outside the CPT surgical range but directly crosswalk or are clinically similar to procedures in the Category I CPT code surgical range that have been determined to not pose a significant safety risk and would not require an overnight stay when performed in an ASC. Our societies support this proposal. However, as we stated in our comments last year, **our societies recommend that CMS further revise the definition of an ASC covered surgical procedure to include invasive procedures that do not pose a significant safety risk, would not expect to require an overnight stay when performed in an ASC, and are separately paid under the OPPS.** Expanding the definition to include other invasive procedures would better accommodate not only existing procedures, but also future procedures made available through technical advances. **Moreover, broadening the definition to allow invasive procedures to be performed in an ASC (in addition to a HOPD), would permit these services to be performed in the more efficient, lower cost ASC setting, which may reduce Medicare spending and lower beneficiary out-of-pocket costs for these services.**

Annual Update to the ASC List

As CMS undertakes its annual update to the ASC list of covered surgical procedures and covered ancillary services and considering the interest in expanding the scope of covered services, we again request that CMS

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CPT Code!	Descriptor!	Rationale!
91022!	Duodenal motility (manometric) study!	Invasive procedure involving placement of probes or catheters into a body cavity!
91030!	Esophagus, acid perfusion (Bernstein) test for esophagitis!	Invasive procedure involving placement of catheter into a body cavity; performed in conjunction with other invasive procedures!

91034! Esophagus, gastroesophageal reflux test; with nasal catheter
 pH electrode(s) placement, recording, analysis

CPT Code!	Descriptor!	Rationale!
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in patients who are at average risk of developing colorectal cancer. Therefore, a significant number of Medicare beneficiaries are surprised to find out after their screening that they must pay a coinsurance. Medicare beneficiary cost-sharing should be waived for screening colonoscopies reclassified as