# Medicare's Revaluation of Gastrointestinal Endoscopic Procedures: Implications for Academic and Community-Based Practices

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*No sentient gastroenterologist has missed the fact that over the past 3 years, Medicare revalued our endoscopy codes. The impact of those reimbursement changes has been felt both by community gastroenterologists and those practicing in academic centers. Impacts are different, however, because funds flow, opportunities for ancillary income and compensation formulas all are different for private versus academic physicians. In this month's Road Ahead column, I have invited leaders from both camps (private practice and academic GI) to describe how reduced procedural reimbursement is affecting their practices. I was impressed and surprised at the level of detail and analysis provided by Drs Dorn and Vesy. There are few other sources of financial data that are embedded in real world experience. We all are concerned about our futures, and this article should spur us into serious discussions about practice strategies going forward. As I wrote in a recent article in* Gastroenterology *(2016;150:295–299), this is "No Time for WIMPs."*

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Gastroenterology practices generate the bulk of their revenue from endoscopic procedures. Over the past decade the professional fees Medicare pays for these procedures have generally declined. Meanwhile associated hospital outpatient facility fees have increased while ambulatory surgery center (ASC) fees remain below 2007 levels. This article surveys these changes and examines their significant impact on academic and private gastroenterology practices.

## Professional Fees for Endoscopic Procedures

Since 1992 physician professional fees have been linked to the Medicare Physician Fee Schedule, which assigns each service a certain number of relative value units (RVUs). First, the work RVU (wRVU) is based on the estimated physician time, mental effort, technical skill, and psychological stress required to provide a service. Second, a practice expense RVU (PE RVU) reflects the direct and indirect costs of providing the service. For procedures performed in office-based settings the PE RVU includes rent, nonclinician staff, equipment, and supplies, on average amounting to 44% of the total RVU. For procedures performed in hospital outpatient departments (HOPDs) and ASCs the PE RVU is much lower, because most costs are incurred by the facility (which receives a separate facility fee), rather than the physician practice. Third, a small proportion of the overall RVU is linked to malpractice insurance costs (MP RVU). The RVU components are geographically adjusted, combined, and then multiplied by a conversion factor (CF; which in 2016 is $35.80) to determine actual Medicare payment (Payment = [wRVU + PE RVU + MP RVU] × CF).[1]

To address potential distortions in this physician fee schedule, The Affordable Care Act directed the Secretary of Health and Human Services to establish a formal process to review potentially misvalued procedure codes. Between 2012 and 2014 multiple gastroenterological and surgical societies surveyed practicing physicians on the physician work, time, and intensity required

***Abbreviations used in this paper:*** **APC, ambulatory payment classification; ASC, ambulatory surgery center; CF, conversion factor; CMS, Centers for Medicare and Medicaid Services; GI, gastrointestinal; HOPD, hospital outpatient department; MP RVU, malpractice relative value units; OPPS, outpatient prospective payment system; PE RVU, practice expense relative value units; RVU, relative value units; TDDC, Texas Digestive Disease Consultants; wRVU, work relative value units.**

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# PRACTICE MANAGEMENT: THE ROAD AHEAD, *continued*

to perform more than 120 services in question, including esophagoscopy, esophagogastroduodenoscopy, endoscopic retrograde cholangiopancreatography, flexible sigmoidoscopy and ileoscopy, pouchoscopy, and colonoscopy. At the same time, these societies assembled an expert panel of practicing physicians to determine the practice expenses associated with these procedures. The societies analyzed the results and presented recommendations to the American Medical Association/Specialty Society Relative Value Scale Update Committee, which, in turn, presented their recommendations to Centers for Medicare and Medicaid Services (CMS).[2] In 2014 CMS accepted approximately three-quarters of the Relative Value Scale Update Committee's recommendations, ultimately decreasing wRVUs, increasing PE RVUs for procedures performed in office-based settings, and leaving MP RVUs unchanged for most upper endoscopy and endoscopic retrograde cholangiopancreatography procedures. These changes translated into significant 2015 payment reductions for esophagoscopy and esophagogastroduodenoscopy (4%–42%), endoscopic ultrasound (10%–35%), and endoscopic retrograde cholangiopancreatography (0%–37%) performed within facilities, with less effect for those performed in office-based settings. At that time, "in light of the substantial nature of [the colonoscopy] code revision and its relationship to the policies on moderate sedation," CMS delayed revaluation of the lower gastrointestinal (GI) endoscopy codes.[3] This reprieve is now over: the 2016 Medicare Physician Fee Schedule Final Rule includes up to 17% cuts (12% on average) to the wRVU associated with these lower GI procedures (Table 1). For office-based procedures (but not facility-based procedures) these wRVU cuts are buffered (and sometimes offset) by general increases in PE RVUs.

## Facility Fees for Endoscopic Procedures

Compared with the small percentage of endoscopic procedures that are performed in office-based settings, those performed in HOPDs and ASCs entail a lower professional fee plus a separate facility fee. Since 2000 CMS has paid for services provided in HOPDs using the outpatient prospective payment system (OPPS). Clinical services are first classified into ambulatory payment classifications (APC) on the basis of clinical and cost similarity. Next, services within an APC are assigned a single relative payment rate, which is linked to the resources required to perform the service. The APC payment rate is geographically adjusted and then multiplied by a CF to determine an actual dollar amount.[4]

Since 2008, CMS has used a nearly identical mechanism to pay for facility services provided in ASCs. Services are classified using the same APCs and same relative weights as the OPPS. The difference is that the ASC CF is less than the OPPS CF (the 2016 ASC CF is 58% of the OPPS CF), translating into lower dollar payments for ASC services.[5] Of note, in 2008 ASC rates were cut significantly when CMS adopted this methodology for

**Table 1.** National Professional Fees for Common Upper and Lower GI Procedures Performed in HOPDs and ASCs Since 2010

| HCPCS code | Description | 2010 payment[a] | Equivalent to 2015 real dollars (CPI)[b] | 2016 payment[a] | Dollar change | Percent change | Real dollars (CPI) change | Real dollars (CPI) percent change |
|---|---|---|---|---|---|---|---|---|
| 45378 | Diagnostic colonoscopy | $219 | $238 | $200 | ($19) | −9 | ($38) | −16 |
| 45380 | Colonoscopy and biopsy | $263 | $286 | $217 | ($46) | −17 | ($69) | −24 |
| 45385 | Lesion removal colonoscopy | $312 | $340 | $274 | ($38) | −12 | ($66) | −19 |
| G0105 | Screening colonoscopy, high risk | $219 | $238 | $200 | ($19) | −9 | ($38) | −16 |
| G0121 | Screening colonoscopy, low risk | $219 | $238 | $200 | ($19) | −9 | ($38) | −16 |
| 45330 | Diagnostic sigmoidoscopy | $62 | $67 | $58 | ($4) | −6 | ($9) | −13 |
| 45331 | Sigmoidoscopy and biopsy | $75 | $82 | $76 | $1 | 1 | ($6) | −7 |
| 43235 | EGD diagnostic | $147 | $160 | $135 | ($12) | −8 | ($25) | −16 |
| 43239 | EGD with biopsy | $173 | $188 | $152 | ($21) | −12 | ($36) | −19 |
| 43255 | EGD with control of bleeding | $287 | $312 | $217 | ($70) | −24 | ($95) | −30 |

CPI, Consumer Price Index; EGD, esophagogastroduodenoscopy; HCPCS, Healthcare Common Procedure Coding System.
[a]Available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/'lookup/index.html.
[b]Available at: http://www.bls.gov/data/inflation_calculator.htm. Based on the CPI for 2015 (2016 CPI data were not available at the time of publication). For instance, $238 in 2015 has the same purchasing power (real dollars) as $219 in 2010. Consequently, for Code 45378 the 9% reduction translates into a 16% reduction in real dollars.