Proposed 2016 Colonoscopy Reimbursement FAQs

On July 8, 2015, CMS released the 2016 Medicare Physician Fee Schedule Proposed Rule, which publishes proposed reimbursement rates for lower and upper GI endoscopy procedures effective Jan. 1, 2016.

The rule proposes significant cuts to reimbursement for colonoscopy. The proposed rule can be reviewed at https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-16875.pdf.

The cuts were significant and not based on data. The GI and Surgical societies presented recommendations on physician work and practice expense related to colonoscopy to the American Medical Association’s (AMA) Relative Value Update Committee (RUC), the body that makes relative value recommendations to CMS, in February 2014. The survey data collected by the societies was robust and representative, and showed that physician time and intensity to perform the procedures had not changed from the prior valuation (put the year). The RUC failed to follow its own processes during its review of the colonoscopy codes. ACG, AGA and ASGE are developing a detailed analysis of the proposed rule and its potential impact on colonoscopy and upper GI reimbursement. We will be meeting with CMS leadership in the coming weeks to discuss the proposed cuts.

The following information will help you understand the process. Watch your email and check this page for more information.

Q: What is the proposed impact of the cuts to the colonoscopy family?
A: The impact of the proposed physician work cuts to the colonoscopy family are up to 19 percent for some codes. Errors in the data files posted by CMS prevent us from estimating the total impact at this time. We will provide that information as soon as possible.

Q: Are these values final?
A: No. The values for colonoscopy and lower GI endoscopy procedures are proposed, meaning that CMS may choose to revise the values before they are finalized, presumably in the 2016 Medicare Physician Fee Schedule Final Rule, which will become effective on Jan. 1, 2016.

Q: Why did CMS revalue colonoscopy?
A: In the 2012 Medicare Physician Fee Schedule Final Rule published in November 2011, CMS identified colonoscopy, EGD and other GI endoscopy procedures as being potentially misvalued. Misvalued codes can include procedures with fast growth in the number performed over several years, substantial change in practice expense, new technologies or services, multiple codes frequently billed together, codes with low relative values, and so-called “Harvard-valued codes,” which have not been reviewed by the AMA/Specialty Society RUC since their values were established in the early 1990s.

Q: What have you done to protect reimbursement for colonoscopy?
A: ACG, AGA and ASGE enacted a multi-faceted public relations, regulatory and legislative strategy over the past three years.
CMS: ACG, AGA and ASGE successfully delayed revaluation of colonoscopy and other lower GI endoscopy procedures for a year.

The GI society presidents, RUC advisors and staff met with leadership at CMS, including Administrator Marilyn Tavenner, four times during 2014 to provide information to help CMS value colonoscopy and the upper and lower GI endoscopy codes fairly.

Capitol Hill: We conducted a successful Hill campaign that resulted in revisions to the way CMS will implement changes to reimbursement to allow more transparency in the process, so that we have the opportunity to review and comment on any changes before new rates are implemented.

AMA: We worked through the AMA’s CPT process to update the language of existing codes to reflect current medical practice and add codes for new procedures. We conducted surveys of physician work to demonstrate to the RUC and CMS that the work of colonoscopy has not changed.

Q: What is the RUC and how does it influence CMS’s decisions on code values?

A: The RUC was established by AMA and provides recommendations to CMS for its use in annual updates to the Medicare physician relative value fee schedule. The RUC is not a federally appointed committee and CMS is not compelled to accept its recommendations.

The RUC conducts its review from data collected by the specialty societies from their members via the RUC survey process and the specialties’ recommendations to the RUC. The RUC can decide to accept the specialty societies’ recommendation or determine its own recommended RVUs based on methodologies, including comparing the value to other codes of similar physician work and applying Medicare payment rules. The RUC submits its recommendations to CMS, which makes the final relative value determinations.

If the specialty society does not agree with the RUC’s recommendation, it can appeal via the RUC’s reconsideration process or take its concerns directly to CMS. The GI societies voiced our opposition to the RUC recommended values to the RUC and in subsequent meetings with CMS.

Q: What was the GI societies’ role at the RUC?

A: ACG, AGA and ASGE have physician representatives to the RUC, but gastroenterology does not have a voting seat on the RUC. The GI societies administered the RUC surveys of the GI endoscopy codes. The GI societies’ RUC Advisors analyzed the data and presented recommendations on physician work and practice expense to the RUC based upon the results of the surveys and other precedents used when valuing physician work and practice expense. The GI societies participate in this review process because otherwise the RUC would make recommendations for our codes to CMS without our input.

Q: What can I do?

A: Watch for alerts from the GI societies to express your concerns to CMS about potential problems/errors in the valuation of GI services. Be prepared to contact your member of Congress if CMS does not follow through with its promise to make its code revaluation process more transparent.