NEW YORK SOCIETY FOR GASTROENTEROLOGY & ENDOSCOPY
48th Annual
NEW YORK COURSE
December 12-13, 2024 • New York, NY

NYSGE
New York Society for Gastroenterology and Endoscopy

Current Innovation in Endoscopy

Seth A. Gross, MD, FACG, FASGE, AGAF, NYSGEF
Clinical Chief of Gastroenterology and Hepatology
NYU Langone Health
Professor of Medicine
NYU Grossman School of Medicine
December 13, 2024

Disclosures

Cook

Olympus

Medtronic

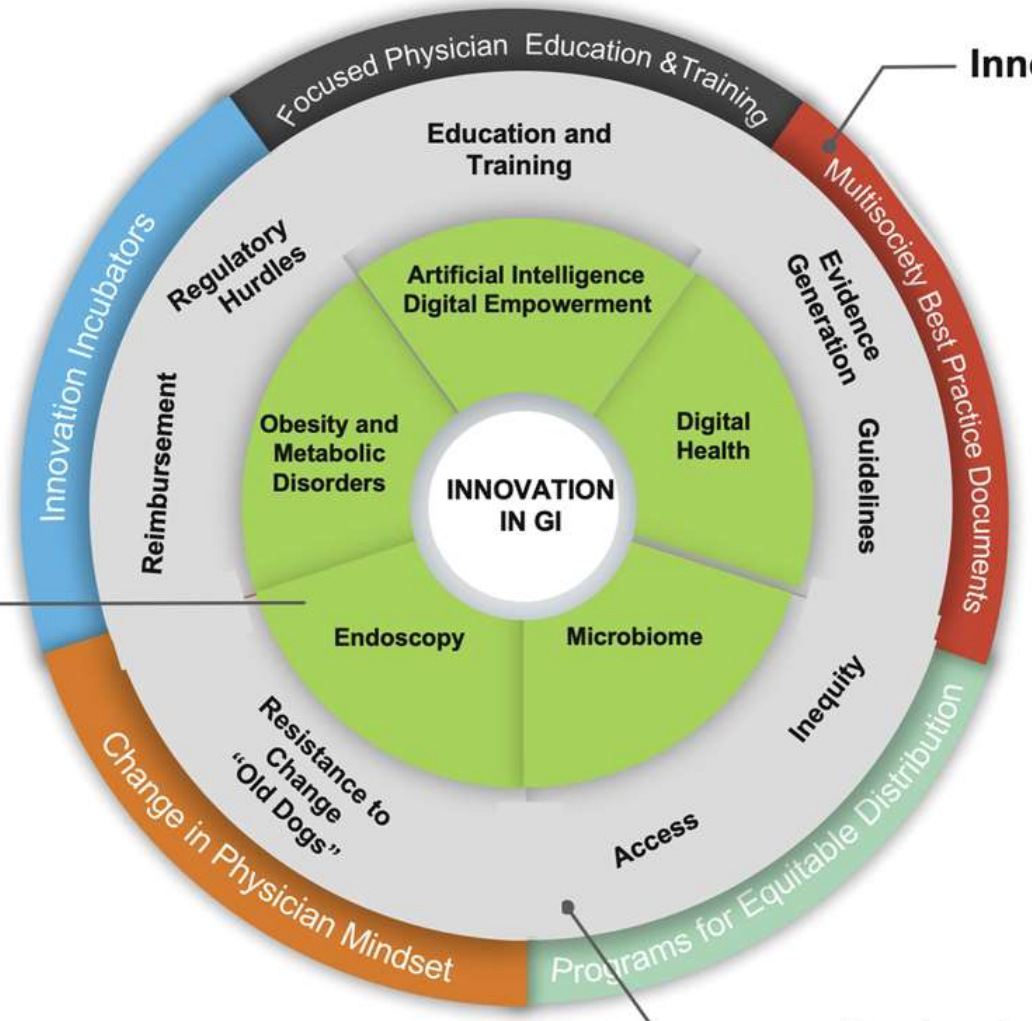
Microtech

Objectives

- Review what is needed to take innovation to a reimbursable service

NYSGE
48th Annual
New York Course

Innovations and Barriers in Gastroenterology



Benefits to innovation:

- Improvements in processes and technology, including EHR
- Better health outcomes
- Quality improvement
- Improved patient access

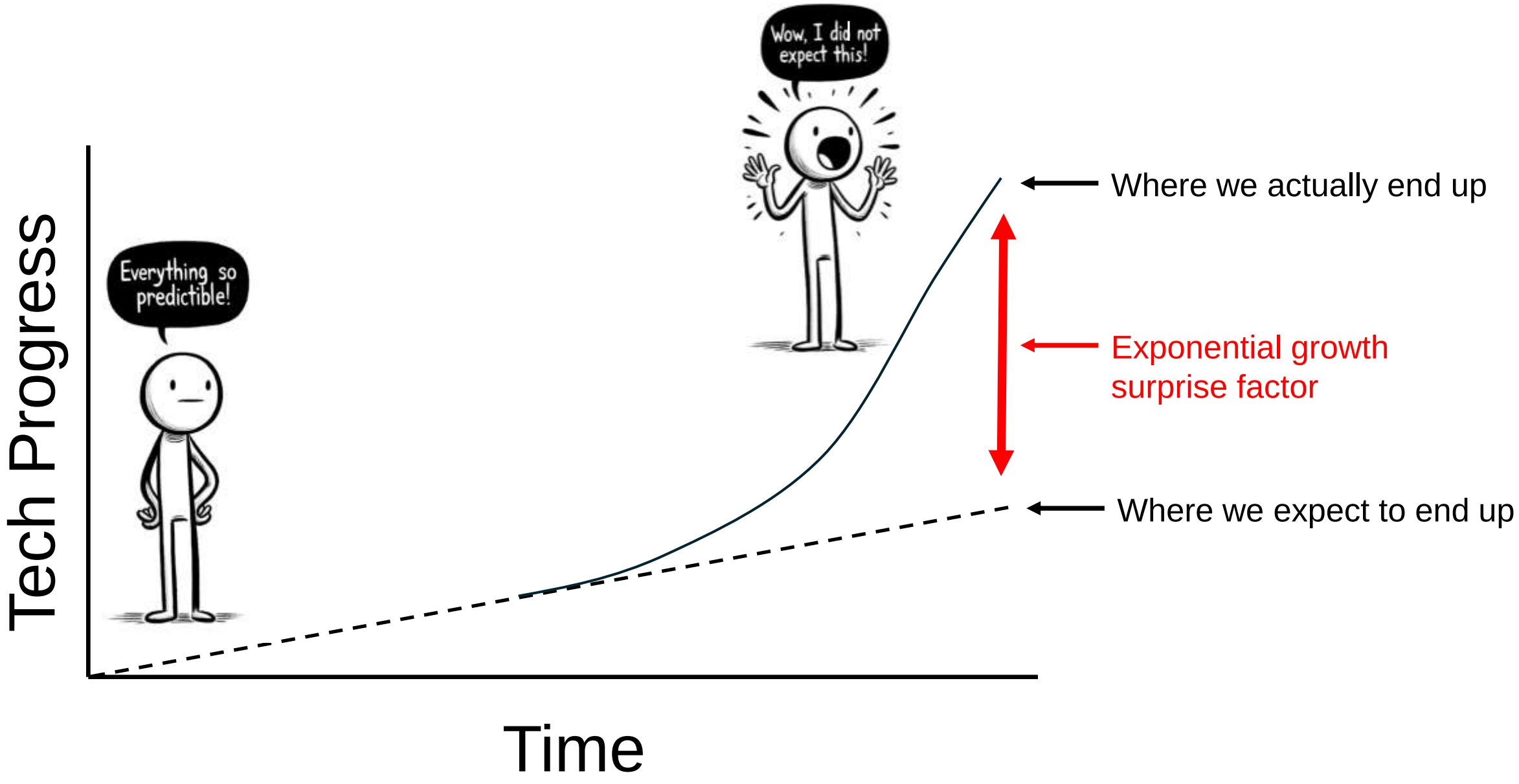
Komanduri S et al. AJG Aug 2023;118

“The progress in technology will become so rapid and profound that it will rupture the fabric of human history”

Ray Kurzell 2005
“The Singularity”

NYSGE
48th Annual
New York Course

Spiegel B. ACG Magazine 2024



NYSGE
48th Annual New York Course

Innovation to Reimbursement

- Questions are always the same
  - When will we get reimbursement?
  - Why don’t we have reimbursement ?
  - How come the GI societies don’t advocate for reimbursement?

- **Most physicians have no idea how we get paid!**

Tri-Society Collaboration on the CPT/RUC Process

- ACG, AGA and ASGE coordinate on all aspects of the CPT and RUC process
- Advisors, staff, and consultants from the three societies meet monthly to coordinate work and other related activities

Society	Advisor(s)	Staff/Consultant
ACG	Christopher Y. Kim, MD	Brad Conway, Marie Knoll, Sheila Madhani
AGA	Braden Kuo, MD, MSc Joe Losurdo, MD	Leslie Narramore
ASGE	Glenn Littenberg, MD Ed Sun, MD	Denise Garris, Lakitia Mayo

Society	Advisor(s)	Staff/Consultant
ACG	Bruce Cameron, MD	Brad Conway, Marie Knoll, Sheila Madhani
AGA	Patricia Garcia, MD	Leslie Narramore
ASGE	Seth Gross, MD Vivek Kaul, MD	Denise Garris, Lakitia Mayo

CPT and RUC processes directly impact physician payment

Medicare Physician Fee Schedule (PFS) Process

CPT Editorial Panel Process

1
Tri-Society submits a CPT code application (CCA) to the CPT Editorial Panel*

2
CPT Panel approves new/revised CPT code

RUC Process

3
Tri-Society conducts RUC survey process and submits work and practice expense (PE) recommendations to the RUC

4
Specialty societies present recommended work and PE values to the RUC for review/approval

5
RUC submits work and PE recommendations to the Centers for Medicare and Medicaid Services (CMS)

CMS PFS Process

6
Tri-Society may engage with CMS on potential proposals in the Medicare PFS proposed rule

7
July 1, CMS releases proposed rule with 60-day comment period. This rule provides public notice on whether CMS has accepted the RUC's recommendations , or chose valuations based on other criteria. **

8
Socities submits comments (in support or urging revisions) and may meet on proposed rule and may meet with CMS on these proposed values and reimbursement.

9
November 1, CMS releases Medicare PFS final rule with new/revised codes and values

10
January 1, policies become effective

CPT Panel

CPT Editorial Panel

Selected by the AMA Board of Trustees

Vote on code proposals

CPT Advisory Committee

Selected by the specialty societies

Review and provide comments on code proposals

Code Application Submitter

Specialty societies and other stakeholders can submit a CPT application

Submitters must defend their application

CPT Categories
(Current Procedure Terminology)

- CPT Codes fall into several categories
  - Category I
  - Category II
  - Category III
  - Proprietary Laboratory Analysis (PLA) codes
  - Unlisted

Category I

- **Category I**: Most common, contain descriptors that correspond to most of the procedures or services performed in inpatient and outpatient offices and hospitals
  - They are grouped anatomically and by service types (Anesthesia, Surgery, Radiology, Pathology, Medicine, Evaluation and Management)

Category I Criteria

- ✓ Unique and well-defined service
- ✓ Clearly distinguished from existing CPT codes
- ✓ FDA approved if required
- ✓ Performed by many qualified healthcare professionals across the country
- ✓ Clinically efficacious as documented in peer-reviewed literature

Literature Required

TABLE 1. Literature requirements for Category I code application

Category literature requirements	Utilization Technology	Typical New	Typical Existing or noncontributory	Limited specialized or humanitarian New	Limited specialized or humanitarian Existing or noncontributory
Maximum no. of peer-reviewed publications per distinct service(s)/technique(s)		5	5	5	3-5
For each additional distinct services/techniques within multicode family (maximum)		5	5	5	3-5
Minimum no. with majority U.S. patient populations		1	1	1	1
Minimum no. with no overlapping patient populations and no overlapping authors		2	2	1	1
Minimum level of evidence for at least one article		IIa	IIIa/IIIb	IIIb	IV
Make an "X" in the box for the type of utilization and technology that best fits the procedure/ literature being requested					

Levels of Evidence

Level of Evidence	Description
Ia	Evidence from systematic review of randomized control trials
Ib	Evidence from individual randomized control trials
IIa	Evidence from systemic cohort studies
IIb	Evidence from systemic review of case-control studies
IIIa	Evidence from systemic review of case-control studies
IV	Evidence from case series
V	Evidence obtained by expert opinion

Category III

- **Category III**: Temporary codes the cover new and emerging technologies, services, procedure, and service paradigms
  - Identify services that are not widely performed by healthcare professionals and may not have FDA approval/proven clinical efficacy. They are not grouped by service type
  - Archived after 5 years if it has not been accepted into Category I or Category III status has not been renewed
  - Not considered in the RUC because they have no RVUs assigned*

*This means the payment for Category III services are based on the payer policy. If it is covered, it is usually on a case-by case-basis

- ✓ IRB approved protocol for research being done
- ✓ Support from the specialty groups who would use the procedure/service
- ✓ Peer-reviewed literature available
- ✓ Descriptions of current US trials that provide data on the efficacy of service/procedure
- ✓ Other evidence of evolving clinical utilization

The Survey

Valid survey response: 30

- **STEP 1** – Review code descriptor and vignette (a short description of the typical patient)
- **STEP 2** – Review introduction & complete contact information
- **STEP 3** – Identify a reference procedure
- **STEP 4** – Estimate your time
- **STEP 5** – Compare the survey procedure to a reference procedure
- **STEP 6** – Moderate Sedation
- **STEP 7** – Estimate work RVU (relative value unit)

Pre-Service Period:

Defined: The pre-service period includes physician services provided from the day before the procedure or service until the time of the procedure or service

Pre-service Period Includes:
• Assessment of the patient's status for indications, contraindications, and fitness to undergo the procedure. May include procedural work-up, review of records, communicating with other professionals, patient and family, coordinating scheduling and preparation and obtaining consent.
• Dressing, scrubbing, and waiting before the operative procedure, preparing patient and needed equipment for the operative procedure and positioning the patient.

Intra-Service Period:

The intra-service period includes all “scope in to scope out” **physician** work that is a necessary part of the procedure.

NYSGE
48th Annual
New York Course

Post-Service Period

Defined: Post service period includes **physician** services provided **on the day of the procedure** after the procedure has been performed.

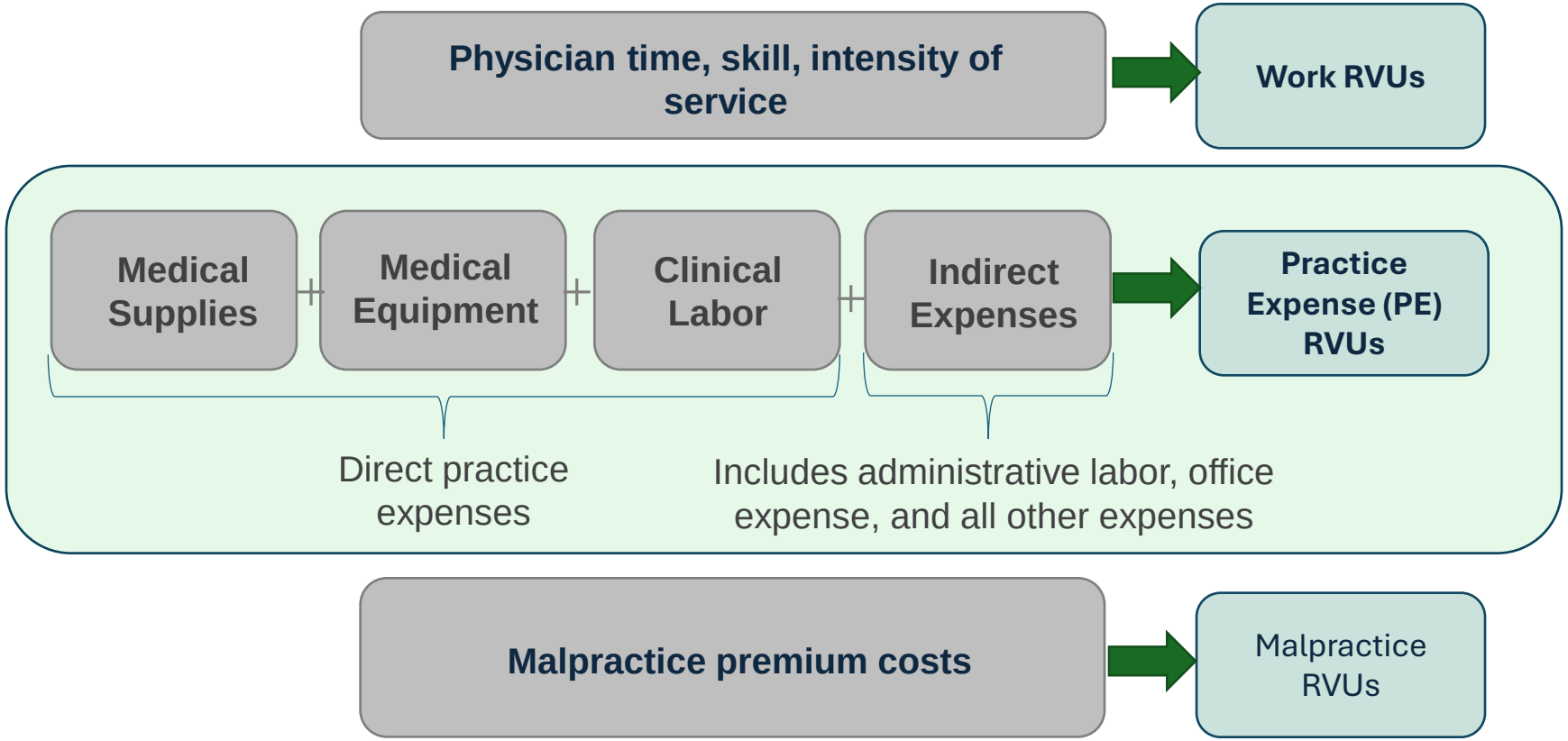
Post-service period may include:
Post-operative care on the day of the procedure
Non skin-to-skin work in the OR
Patient stabilization in the recovery room or special unit
Communication with the patient and other professionals
Patient visits on the day of the operative procedure

Complexity/Intensity

Key components:

- Mental effort and judgment
- Technical skill/physical effort
- Psychological stress

Inputs are Converted into a PE RVU



Transitional Pass Through Payments (TPTs)

- Ambulatory setting under Medicare Hospital Outpatient Prospective payment System (OPPS)
- Provide additional payment for new drugs, devices, and biologics
- Last max of 3 years
- Allows CMS to collect data to help assign permanent codes and rates.
- These time frames are meant to help CMS collect data and then assign appropriate permanent codes and rates.
- Example: single use duodenoscopes

New Technology Add-on Payments (NTAPs)

- For the Inpatient Prospective Payment System
- Last max 3 years
- Established in 2000, the NTAP was created as a supplemental payment to hospitals
- Criteria:
  - Novelty
  - Cost considerations
    - Cost must be higher then standard Medicare Severity Diagnosis Group (MS-DRG), where payment won't cover device
  - Demonstrates clinical improvement
  - Example: Hemospray

Final Thoughts

- Innovation in endoscopy will continue to grow at a rapid rate
- It’s important for early adapters to think ahead and partner with both GI societies and industry for a reimbursement pathway
- Don’t assume someone else will fill the survey out, stay aware and involved

NYSGE
48th Annual
New York Course