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Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
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RE: Field Testing – Lower Gastrointestinal Hemorrhage Episode-based Cost Measure and Revised Total Per Capital Cost Measure

Dear Administrator Verma:

The American College of Gastroenterology (ACG), American Gastroenterological Association (AGA), and the American Society for Gastrointestinal Endoscopy (ASGE) appreciate the opportunity to provide feedback to the Centers for Medicare & Medicaid Services (CMS) on the Medicare Access and CHIP Reauthorization Act (MACRA) Episode-Based Cost Measures Field Testing. Together, our societies represent virtually all gastroenterologists in the United States.

Our societies applaud CMS' continued commitment to ensuring the engagement of physicians in the development of episode-based cost measures. Input from diverse clinicians and subspecialties is vital to the development of episode-based cost measures. We also appreciate the process improvements made to Wave 2 based on lessons learned from Wave 1. The development process continues to be inclusive, engaging and transparent. Unfortunately, the field testing process continues to be rife with challenges, which are exacerbated by an incredibly short timeline. While we appreciate that CMS extended the deadline for

comments by a few business days, the time allotted for review and comment continues to be insufficient given the volume and complexity of the material.

Together, ACG, AGA and ASGE urge CMS to provide additional time for review and comment on the episode-based cost measures, including the Lower Gastrointestinal (GI) Hemorrhage, Total Per Capita Cost (TPCC) and Medicare Spending Per Beneficiary (MSPB) measures. As our members have accessed and reviewed their test reports, a number of concerns have been identified. The test reports demonstrate how measure specifications interact to identify specific episodes included in each cost measure. This cannot be accomplished through review of the draft materials and mock test report, as these materials do not provide detailed information for the specific episodes identified by the draft measure specifications. Unfortunately, technical difficulties made it difficult for many of our members to access test reports early in the review process, so the feedback we have received from members has been limited. Additional review time will allow our societies to receive input from a broader sample of members. **If additional review time is not feasible for Wave 2, we encourage CMS to revise the timelines for future waves to allow for a longer field testing period.**

Below we provide our initial feedback on the Lower GI Hemorrhage, TPCC and MSPB measures.

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Lower GI Hemorrhage Measure

Post-Trigger Period

The Lower GI Hemorrhage measure methodology materials indicate that the episode window for the measure is as follows:

1. Episode trigger date = IP stay admission date
2. Episode start date = episode trigger date (= IP stay admission date)
3. Episode end date = 45 days after the episode trigger date (= 45 days after IP stay admission date)

As outlined above, the episode window for the measure is 45 days beginning with admission date of an applicable hospital inpatient stay. This approach standardizes the period over which costs are captured. However, because length of stay (LOS) will vary from episode to episode, the composition of each episode will also vary. Ideally, the measure would capture costs during the inpatient stay and 30 days after hospital discharge regardless of the inpatient length of stay.

However, we recognize that such an approach would result in different episode lengths and create potential inequities. Still, **ACG, AGA and ASGE urge CMS to refine the post-trigger window to achieve as best as possible an episode window that captures the inpatient stay and only the 30 days post discharge.**

Lower GI Hemorrhage episodes may be triggered by an inpatient stay corresponding to one of six Medicare Severity Diagnosis Related Groups (MS-DRGs or DRGs). Using publicly available Medicare data[1], the volume weighted arithmetic mean length of stay (ALOS) for the three surgical Medicare Severity Diagnosis Related Groups (MS-DRGs or DRGs) 356, 357 and 358 is 7.77 days and the volume weighted ALOS for the three medical DRGs 377, 378 and 379 is 4.12 days. As such, for surgically managed episodes, on average, 37 days of the post-trigger period will occur after hospital discharge. In contrast, for medically managed episodes, on average 41 days of the post trigger period will occur after hospital discharge. Data provided during the measure development process indicate that approximately 96 percent of final measure episodes are medically managed (i.e., DRGs 377, 378 and 379), which indicates that length of stay for measure episodes is typically between 4 and 5 days. To achieve a post-trigger window that captures the inpatient stay and only the 30 days post discharge, the post trigger window should be either 34 or 35 days long. **As such, our societies recommend a post-trigger period of 35 days.**

Triggers

The current draft measure methodology materials specify the logic used to identify and exclude episodes for the Lower GI Hemorrhage measure. The first step in each logic set is the assigned DRG. For inpatient stays, DRGs are assigned based on either operating room procedures (surgical DRGs) or principal diagnosis (medical DRGs), which is the diagnosis that represents the chief reason for the patient's inpatient stay and which is assigned after considering many factors including scope of care, diagnostic workup, and the therapy provided during the inpatient stay. Although, the assigned operating room procedures and principal diagnosis are the best indicators of the reason for the inpatient stay, the current logic set does not rely on either to distinguish lower GI hemorrhage episodes from other GI hemorrhage episodes. Instead, the logic looks at all diagnosis codes on the inpatient claim. As a result, the current logic may capture episodes that have a principal diagnosis that corresponds to upper GI bleeding. Moreover, this is not addressed through current exclusions because episode exclusions are based on the diagnoses that appear on Part B claims rather than on the inpatient claim.

[1] FY 2019 CMS-1694-FR AOR/BOR File. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2019-CMS-1694-FR-AOR-BOR.zip

ACG, AGA and ASGE encourage CMS to revise the current logic by incorporating assigned operating room procedures (Logic Set A and Logic Set B) or principal diagnosis (Logic Set C and Logic Set D) to increase specificity.

Below, in Table 1, Table 2, Table 3 and Table 4 we provide recommended revisions to the draft trigger logic sets.

Table 1. Recommended revisions to Logic Set A

Code Type	Code	Code Description	Current Logic Notes	Proposed Logic Notes
Rule A1 - MS-DRG	356	Other Digestive System O.R. Procedures W MCC	Rule A1 is satisfied if code(s) in this row occur on the trigger claim	No change
Rule A1 - MS-DRG	357	Other Digestive System O.R. Procedures W CC	Rule A1 is satisfied if code(s) in this row occur on the trigger claim	No change
Rule A1 - MS-DRG	358	Other Digestive System O.R. Procedures W/O CC/MCC	Rule A1 is satisfied if code(s) in this row occur on the trigger claim	No change
Rule A2 - ICD 10 DGN	K550	Acute vascular disorders of intestine	Rule A2 is satisfied if code(s) in this row occur on the trigger claim	Rule A2 is satisfied if code(s) in this row occur on the trigger claim as the **principal diagnosis**
Rule A2 - ICD 10 DGN	K551	Chronic vascular disorders of intestine	Rule A2 is satisfied if code(s) in this row occur on the trigger claim	Rule A2 is satisfied if code(s) in this row occur on the trigger claim as the **principal diagnosis**
Rule A2 - ICD 10 DGN	K5521	Angiodysplasia of colon with hemorrhage	Rule A2 is satisfied if code(s) in this row occur on the trigger claim	Rule A2 is satisfied if code(s) in this row occur on the trigger claim as the **principal diagnosis**
Rule A2 - ICD 10 DGN	K5731	Diverticulosis of large intestine without perforation or abscess with bleeding	Rule A2 is satisfied if code(s) in this row occur on the trigger claim	Rule A2 is satisfied if code(s) in this row occur on the trigger claim as the **principal diagnosis**
Rule A2 - ICD 10 DGN	K5733	Diverticulitis of large intestine without perforation or abscess with bleeding	Rule A2 is satisfied if code(s) in this row occur on the trigger claim	Rule A2 is satisfied if code(s) in this row occur on the trigger claim as the **principal diagnosis**
Rule A2 - ICD 10 DGN	K5751	Diverticulosis of both small and large intestine without perforation or abscess with bleeding	Rule A2 is satisfied if code(s) in this row occur on the trigger claim	Rule A2 is satisfied if code(s) in this row occur on the trigger claim as the **principal diagnosis**

Code Type	Code	Code Description	Current Logic Notes	Proposed Logic Notes
Rule A2 - ICD 10 DGN	K5753	Diverticulitis of both small and large intestine without perforation or abscess with bleeding	Rule A2 is satisfied if code(s) in this row occur on the trigger claim	Rule A2 is satisfied if code(s) in this row occur on the trigger claim as the **principal diagnosis**
Rule A2 - ICD 10 DGN	K5791	Diverticulosis of intestine, part unspecified, without perforation or abscess with bleeding	Rule A2 is satisfied if code(s) in this row occur on the trigger claim	Rule A2 is satisfied if code(s) in this row occur on the trigger claim as the **principal diagnosis**
Rule A2 - ICD 10 DGN	K5793	Diverticulitis of intestine, part unspecified, without perforation or abscess with bleeding	Rule A2 is satisfied if code(s) in this row occur on the trigger claim	Rule A2 is satisfied if code(s) in this row occur on the trigger claim as the **principal diagnosis**
Rule A2 - ICD 10 DGN	K625	Hemorrhage of anus and rectum	Rule A2 is satisfied if code(s) in this row occur on the trigger claim	Rule A2 is satisfied if code(s) in this row occur on the trigger claim as the **principal diagnosis**
Rule A3 - CPT/ HCPCS	37244	Occlusion of arterial or venous hemorrhage with radiological supervision and interpretation, roadmapping, and imaging guidance	Rule A3 is satisfied if code(s) in this row occur during the trigger event	No change

Table 2. Recommended revisions to Logic Set B

Code Type	Code	Code Description	Current Logic Notes	Proposed Logic Notes
Rule B1 - MS-DRG	356	Other Digestive System O.R. Procedures W MCC	Rule B1 is satisfied if code(s) in this row occur on the trigger claim	No change
Rule B1 - MS-DRG	357	Other Digestive System O.R. Procedures W CC	Rule B1 is satisfied if code(s) in this row occur on the trigger claim	No change
Rule B1 - MS-DRG	358	Other Digestive System O.R. Procedures W/O CC/MCC	Rule B1 is satisfied if code(s) in this row occur on the trigger claim	No change
Rule B2 - ICD 10 DGN	K921	Melena	Rule B2 is satisfied if code(s) in this row occur on the trigger claim	Rule B2 is satisfied if code(s) in this row occur on the trigger claim as the **principal diagnosis**
Rule B2 - ICD 10 DGN	K922	Gastrointestinal hemorrhage, unspecified	Rule B2 is satisfied if code(s) in this row occur on the trigger claim	Rule B2 is satisfied if code(s) in this row occur on the trigger claim as the **principal diagnosis**

Code Type	Code	Code Description	Current Logic Notes	Proposed Logic Notes
Rule B3 - CPT/ HCPCS	37244	Occlusion of arterial or venous hemorrhage with radiological supervision and interpretation, roadmapping, and imaging guidance	Rule B3 is satisfied if code(s) in this row occur during the trigger event	No change

Table 3. Recommended revisions to Logic Set C

Code Type	Code	Code Description	Current Logic Notes	Proposed Logic Notes
Logic C1 - MS-DRG	377	G.I. Hemorrhage W MCC	Rule C1 is satisfied if code(s) in this row occur on the trigger claim	No change
Logic C1 - MS-DRG	378	G.I. Hemorrhage W CC	Rule C1 is satisfied if code(s) in this row occur on the trigger claim	No change
Logic C1 - MS-DRG	379	G.I. Hemorrhage W/O CC/MCC	Rule C1 is satisfied if code(s) in this row occur on the trigger claim	No change
Rule C2 - ICD 10 DGN	K550	Acute vascular disorders of intestine	Rule C2 is satisfied if code(s) in this row occur on the trigger claim	**Remove** (Diagnoses in the K550 family are not principal diagnoses for DRGs 377, 378 and 379. Episodes involving acute vascular disorders of the intestine will be captured if they occur on an IP claim with a principal diagnosis of melena or GI hemorrhage, unspecified)

Code Type	Code	Code Description	Current Logic Notes	Proposed Logic Notes
Rule C2 - ICD 10 DGN	K551	Chronic vascular disorders of intestine	Rule C2 is satisfied if code(s) in this row occur on the trigger claim	**Remove** (Diagnoses in the K550 family are not principal diagnoses for DRGs 377, 378 and 379. Episodes involving chronic vascular disorders of the intestine will be captured if they occur on an IP claim with a principal diagnosis of melena or GI hemorrhage, unspecified)
Rule C2 - ICD 10 DGN	K5521	Angiodysplasia of colon with hemorrhage	Rule C2 is satisfied if code(s) in this row occur on the trigger claim	Rule C2 is satisfied if code(s) in this row occur on the trigger claim as the **principal diagnosis**
Rule C2 - ICD 10 DGN	K5731	Diverticulosis of large intestine without perforation or abscess with bleeding	Rule C2 is satisfied if code(s) in this row occur on the trigger claim	Rule C2 is satisfied if code(s) in this row occur on the trigger claim as the **principal diagnosis**
Rule C2 - ICD 10 DGN	K5733	Diverticulitis of large intestine without perforation or abscess with bleeding	Rule C2 is satisfied if code(s) in this row occur on the trigger claim	Rule C2 is satisfied if code(s) in this row occur on the trigger claim as the **principal diagnosis**
Rule C2 - ICD 10 DGN	K5751	Diverticulosis of both small and large intestine without perforation or abscess with bleeding	Rule C2 is satisfied if code(s) in this row occur on the trigger claim	Rule C2 is satisfied if code(s) in this row occur on the trigger claim as the **principal diagnosis**
Rule C2 - ICD 10 DGN	K5753	Diverticulitis of both small and large intestine without perforation or abscess with bleeding	Rule C2 is satisfied if code(s) in this row occur on the trigger claim	Rule C2 is satisfied if code(s) in this row occur on the trigger claim as the **principal diagnosis**
Rule C2 - ICD 10 DGN	K5791	Diverticulosis of intestine, part unspecified, without perforation or abscess with bleeding	Rule C2 is satisfied if code(s) in this row occur on the trigger claim	Rule C2 is satisfied if code(s) in this row occur on the trigger claim as the **principal diagnosis**

Code Type	Code	Code Description	Current Logic Notes	Proposed Logic Notes
Rule C2 - ICD 10 DGN	K5793	Diverticulitis of intestine, part unspecified, without perforation or abscess with bleeding	Rule C2 is satisfied if code(s) in this row occur on the trigger claim	Rule C2 is satisfied if code(s) in this row occur on the trigger claim as the **principal diagnosis**
Rule C2 - ICD 10 DGN	K625	Hemorrhage of anus and rectum	Rule C2 is satisfied if code(s) in this row occur on the trigger claim	Rule C2 is satisfied if code(s) in this row occur on the trigger claim as the **principal diagnosis**

Table 4. Recommended revisions to Logic Set D

Code Type	Code	Code Description	Current Logic Notes	Proposed Logic Notes
Logic D1 - MS-DRG	377	G.I. Hemorrhage W MCC	Rule D1 is satisfied if code(s) in this row occur on the trigger claim	No change
Logic D1 - MS-DRG	378	G.I. Hemorrhage W CC	Rule D1 is satisfied if code(s) in this row occur on the trigger claim	No change
Logic D1 - MS-DRG	379	G.I. Hemorrhage W/O CC/MCC	Rule D1 is satisfied if code(s) in this row occur on the trigger claim	No change
Rule D2 - ICD 10 DGN	K921	Melena	Rule D2 is satisfied if code(s) in this row occur on the trigger claim	Rule D2 is satisfied if code(s) in this row occur on the trigger claim as the **principal diagnosis**
Rule D2 - ICD 10 DGN	K922	Gastrointestinal hemorrhage, unspecified	Rule D2 is satisfied if code(s) in this row occur on the trigger claim	Rule D2 is satisfied if code(s) in this row occur on the trigger claim as the **principal diagnosis**

If the logic sets are revised to focus on principal diagnosis, any inpatient stays with a principal diagnosis that corresponds to upper GI bleeding should automatically be excluded.

Table 5 below lists the principal diagnoses that would be excluded by the proposed revisions.

Table 5. Upper GI Bleed Principal Diagnoses Assigned to MS-DRGs 377, 378 and 379

ICD-10 DGN	Code Descriptor
K250	Acute gastric ulcer with hemorrhage
K252	Acute gastric ulcer with both hemorrhage and perforation
K254	Chronic or unspecified gastric ulcer with hemorrhage
K256	Chronic or unspecified gastric ulcer with both hemorrhage and perforation
K260	Acute duodenal ulcer with hemorrhage
K262	Acute duodenal ulcer with both hemorrhage and perforation
K264	Chronic or unspecified duodenal ulcer with hemorrhage
K266	Chronic or unspecified duodenal ulcer with both hemorrhage and perforation
K270	Acute peptic ulcer, site unspecified, with hemorrhage
K272	Acute peptic ulcer, site unspecified, with both hemorrhage and perforation
K274	Chronic or unspecified peptic ulcer, site unspecified, with hemorrhage
K276	Chronic or unspecified peptic ulcer, site unspecified, with both hemorrhage and perforation
K280	Acute gastrojejunal ulcer with hemorrhage
K282	Acute gastrojejunal ulcer with both hemorrhage and perforation
K284	Chronic or unspecified gastrojejunal ulcer with hemorrhage
K286	Chronic or unspecified gastrojejunal ulcer with both hemorrhage and perforation
K2901	Acute gastritis with bleeding
K2921	Alcoholic gastritis with bleeding
K2931	Chronic superficial gastritis with bleeding
K2941	Chronic atrophic gastritis with bleeding
K2951	Unspecified chronic gastritis with bleeding
K2961	Other gastritis with bleeding
K2971	Gastritis, unspecified, with bleeding
K2981	Duodenitis with bleeding
K2991	Gastroduodenitis, unspecified, with bleeding
K31811	Angiodysplasia of stomach and duodenum with bleeding
K3182	Dieulafoy lesion (hemorrhagic) of stomach and duodenum
K920	Hematemesis

These revised logic sets would still capture episodes that had upper GI bleeding diagnoses reported as secondary diagnoses on the inpatient claims. Such episodes would be excluded using trigger exclusions.

Trigger Exclusions

The current and proposed revised trigger logic allows for episodes with a diagnosis of melena (K921) and unspecified GI hemorrhage (K922). Upper GI bleeding often presents as melena.

Additionally, inclusion of the diagnosis code, K922, for unspecified GI hemorrhage creates the potential for episodes of upper GI bleeding to be captured inadvertently. **The draft trigger exclusions should reflect all sources of upper GI bleeding that may potentially be captured as melena or unspecified GI bleeding.**

Specific causes of upper gastrointestinal bleeding include (1) peptic ulcer disease, (2) esophagitis, (3) gastritis/gastropathy and duodenitis/duodenopathy, (4) complications of portal hypertension (e.g., varices and portal hypertensive gastropathy), (5) vascular lesions (e.g., angiodysplasia, Dieulafoy's lesion, gastric antral vascular ectasia), (6) trauma or iatrogenic causes (e.g., Mallory Weiss syndrome, Cameron lesions and aortoenteric fistulas), (7) upper GI tumors, (8) hemobilia and (9) hemosuccus pancreaticus. Although many of these causes of upper GI bleeding are already captured by the draft trigger exclusions, some are not.

Additionally, the current and proposed revised trigger logic allows for episodes with concurrent upper and lower GI bleeding. **The draft trigger exclusions should also work to exclude these episodes.**

Below in Table 6, our societies propose revisions to Trigger Exclusion Logic Set A to ensure exclusion of episodes that include upper GI bleeding.

Table 6. Recommended revisions to Trigger Exclusion Logic Set A

Trigger Exclusion Name	Code Type	Code	Code Description	Current Logic Notes	Revised Logic Notes
Rule A1	MS-DRG	377	G.I. Hemorrhage W MCC	Rule A1 is satisfied if code(s) in this row occur on the IP trigger claim	No change
Rule A1	MS-DRG	378	G.I. Hemorrhage W CC	Rule A1 is satisfied if code(s) in this row occur on the IP trigger claim	No change
Rule A1	MS-DRG	379	G.I. Hemorrhage W/O CC/MCC	Rule A1 is satisfied if code(s) in this row occur on the IP trigger claim	No change

Trigger Exclusion Name	Code Type	Code	Code Description	Current Logic Notes	Revised Logic Notes
Rule A2	ICD-10 DGN	K921	Melena	Rule A2 is satisfied if code(s) in this row occur on the IP trigger claim	**Remove** (If the trigger logic is revised, this logic step is unnecessary.)
Rule A2	ICD-10 DGN	K922	Gastrointestinal hemorrhage, unspecified	Rule A2 is satisfied if code(s) in this row occur on the IP trigger claim	**Remove** (If the trigger logic is revised, this logic step is unnecessary.)
Rule A3	ICD-10 DGN	K25	Gastric ulcer	Rule A3 is satisfied if code(s) in this row occur on PB claims during the trigger event	Rule A3 is satisfied if code(s) in this row occur ~~on PB claims~~ during the trigger event
Rule A3	ICD-10 DGN	K26	Duodenal ulcer	Rule A3 is satisfied if code(s) in this row occur on PB claims during the trigger event	Rule A3 is satisfied if code(s) in this row occur ~~on PB claims~~ during the trigger event
Rule A3	ICD-10 DGN	K27	Peptic ulcer, site unspecified	Rule A3 is satisfied if code(s) in this row occur on PB claims during the trigger event	Rule A3 is satisfied if code(s) in this row occur ~~on PB claims~~ during the trigger event
Rule A3	ICD-10 DGN	K28	Gastrojejunal ulcer	Rule A3 is satisfied if code(s) in this row occur on PB claims during the trigger event	Rule A3 is satisfied if code(s) in this row occur ~~on PB claims~~ during the trigger event
Rule A3	ICD-10 DGN	K29	Gastritis and duodenitis	Rule A3 is satisfied if code(s) in this row occur on PB claims during the trigger event	Rule A3 is satisfied if code(s) in this row occur ~~on PB claims~~ during the trigger event
Rule A3	ICD-10 DGN	K3181	Angiodysplasia of stomach and duodenum	Rule A3 is satisfied if code(s) in this row occur on PB claims during the trigger event	Rule A3 is satisfied if code(s) in this row occur ~~on PB claims~~ during the trigger event

Trigger Exclusion Name	Code Type	Code	Code Description	Current Logic Notes	Revised Logic Notes
Rule A3	ICD-10 DGN	K3182	Dieulafoy lesion (hemorrhagic) of stomach and duodenum	Rule A3 is satisfied if code(s) in this row occur on PB claims during the trigger event	Rule A3 is satisfied if code(s) in this row occur ~~on PB claims~~ during the trigger event
Rule A3	ICD-10 DGN	K920	Hematemesis	Rule A3 is satisfied if code(s) in this row occur on PB claims during the trigger event	Rule A3 is satisfied if code(s) in this row occur ~~on PB claims~~ during the trigger event
New! Rule A3	ICD-10 DGN	K5501	Acute (reversible) ischemia of small intestine		Rule A3 is satisfied if code(s) in this row occur during the trigger event (Excludes acute vascular disorders affecting the small intestine)
New! Rule A3	ICD-10 DGN	K5502	Acute infarction of small intestine		Rule A3 is satisfied if code(s) in this row occur during the trigger event (Excludes acute vascular disorders affecting the small intestine)
New! Rule A3	ICD-10 DGN	K221	Ulcer of esophagus		Rule A3 is satisfied if code(s) in this row occur during the trigger event (Excludes upper GI bleeding from an ulcer of the esophagus)
New! Rule A3	ICD-10 DGN	K20	Esophagitis		Rule A3 is satisfied if code(s) in this row occur during the trigger event (Excludes upper GI bleeding from esophagitis)

Trigger Exclusion Name	Code Type	Code	Code Description	Current Logic Notes	Revised Logic Notes
New! Rule A3	ICD-10 DGN	K319	Disease of stomach and duodenum, unspecified (Diagnosis code used to describe gastropathy and duodenopathy)		Rule A3 is satisfied if code(s) in this row occur during the trigger event (Excludes upper GI bleeding from gastropathy and duodenopathy)
New! Rule A3	ICD-10 DGN	K3189	Other disease of stomach and duodenum (Diagnosis code used to describe portal hypertensive gastropathy)		Rule A3 is satisfied if code(s) in this row occur during the trigger event (Excludes upper GI bleeding from portal hypertensive gastropathy)
New! Rule A3	ICD-10 DGN	I85	Esophageal varices		Rule A3 is satisfied if code(s) in this row occur during the trigger event (Excludes upper GI bleeding from esophageal varices)
New! Rule A3	ICD-10 DGN	I864	Gastric varices		Rule A3 is satisfied if code(s) in this row occur during the trigger event (Excludes upper GI bleeding from gastric varices)
New! Rule A3	ICD-10 DGN	K228	Other specified diseases of esophagus (Code used to describe dieulafoy lesion of the esophagus)		Rule A3 is satisfied if code(s) in this row occur during the trigger event (Excludes upper GI bleeding from a dieulafoy lesion of the esophagus)

Trigger Exclusion Name	Code Type	Code	Code Description	Current Logic Notes	Revised Logic Notes
New! Rule A3	ICD-10 DGN	K226	Gastro-esophageal laceration-syndrome (Code used to describe Mallory-Weiss Syndrome)		Rule A3 is satisfied if code(s) in this row occur during the trigger event (Excludes upper GI bleeding from a dieulafoy lesion of the esophagus)
New! Rule A3	ICD-10 DGN	K838	Other specified diseases of biliary tract (Code used to describe hematobilia)		Rule A3 is satisfied if code(s) in this row occur during the trigger event (Excludes upper GI bleeding from hematobilia)
New! Rule A3	ICD-10 DGN	K8689	Other specified diseases of pancreas (Code used to describe hemosuccus pancreaticus or pseudo hematobilia)		Rule A3 is satisfied if code(s) in this row occur during the trigger event (Excludes upper GI bleeding from hemosuccus pancreaticus or pseudo hematobilia)

In addition to revising Trigger Exclusion Logic Set A, our societies recommend creating an exclusion logic set for the surgical episodes.

Below in Table 7 Table 6**, our societies propose a new trigger exclusion logic set to ensure exclusion of episodes that include upper GI bleeding.**

Table 7

Trigger Exclusion Name	Code Type	Code	Code Description	Proposed Logic Notes
Rule 1	MS-DRG	356	Other Digestive System O.R. Procedures W MCC	Rule 1 is satisfied if code(s) in this row occur on the IP trigger claim
Rule 1	MS-DRG	357	Other Digestive System O.R. Procedures W CC	Rule 1 is satisfied if code(s) in this row occur on the IP trigger claim
Rule 1	MS-DRG	358	Other Digestive System O.R. Procedures W/O CC/MCC	Rule 1 is satisfied if code(s) in this row occur on the IP trigger claim
Rule 2	ICD-10 DGN	K25	Gastric ulcer	Rule 2 is satisfied if code(s) in this row occur during the trigger event
Rule 2	ICD-10 DGN	K26	Duodenal ulcer	Rule 2 is satisfied if code(s) in this row occur during the trigger event
Rule 2	ICD-10 DGN	K27	Peptic ulcer, site unspecified	Rule 2 is satisfied if code(s) in this row occur during the trigger event
Rule 2	ICD-10 DGN	K28	Gastrojejunal ulcer	Rule 2 is satisfied if code(s) in this row occur during the trigger event
Rule 2	ICD-10 DGN	K29	Gastritis and duodenitis	Rule 2 is satisfied if code(s) in this row occur during the trigger event
Rule 2	ICD-10 DGN	K3181	Angiodysplasia of stomach and duodenum	Rule 2 is satisfied if code(s) in this row occur during the trigger event
Rule 2	ICD-10 DGN	K3182	Dieulafoy lesion (hemorrhagic) of stomach and duodenum	Rule 2 is satisfied if code(s) in this row occur during the trigger event
Rule 2	ICD-10 DGN	K920	Hematemesis	Rule 2 is satisfied if code(s) in this row occur during the trigger event

Trigger Exclusion Name	Code Type	Code	Code Description	Proposed Logic Notes
Rule 2	ICD-10 DGN	K5501	Acute (reversible) ischemia of small intestine	Rule 2 is satisfied if code(s) in this row occur during the trigger event
Rule 2	ICD-10 DGN	K5502	Acute infarction of small intestine	Rule 2 is satisfied if code(s) in this row occur during the trigger event
Rule 2	ICD-10 DGN	K221	Ulcer of esophagus	Rule 2 is satisfied if code(s) in this row occur during the trigger event
Rule 2	ICD-10 DGN	K20	Esophagitis	Rule 2 is satisfied if code(s) in this row occur during the trigger event
Rule 2	ICD-10 DGN	K319	Disease of stomach and duodenum, unspecified (Diagnosis code used to describe gastropathy and duodenopathy)	Rule 2 is satisfied if code(s) in this row occur during the trigger event
Rule 2	ICD-10 DGN	K3189	Other disease of stomach and duodenum (Diagnosis code used to describe portal hypertensive gastropathy)	Rule 2 is satisfied if code(s) in this row occur during the trigger event
Rule 2	ICD-10 DGN	I85	Esophageal varices	Rule 2 is satisfied if code(s) in this row occur during the trigger event
Rule 2	ICD-10 DGN	I864	Gastric varices	Rule 2 is satisfied if code(s) in this row occur during the trigger event
Rule 2	ICD-10 DGN	K228	Other specified diseases of esophagus (Code used to describe dieulafoy lesion of the esophagus)	Rule 2 is satisfied if code(s) in this row occur during the trigger event

Trigger Exclusion Name	Code Type	Code	Code Description	Proposed Logic Notes
Rule 2	ICD-10 DGN	K226	Gastro-esophageal laceration-syndrome (Code used to describe Mallory-Weiss Syndrome)	Rule 2 is satisfied if code(s) in this row occur during the trigger event
Rule 2	ICD-10 DGN	K838	Other specified diseases of biliary tract (Code used to describe hematobilia)	Rule 2 is satisfied if code(s) in this row occur during the trigger event
Rule 2	ICD-10 DGN	K8689	Other specified diseases of pancreas (Code used to describe hemosuccus pancreaticus or pseudo hematobilia)	Rule 2 is satisfied if code(s) in this row occur during the trigger event

Additionally, ACG, AGA and ASGE suggest that all gastrointestinal malignancies be included as trigger exclusions. Currently the list is limited to primary malignant neoplasms of the anus and anal canal, colon, jejunum, rectosigmoid junction, and rectum. Not only does the list not include all GI malignancies, it doesn't include secondary malignant neoplasms, carcinoma in situ, or uncertain and unspecified neoplasms. The current list should be expanded to include all GI malignancies (by both location and type).

Attribution

A gastroenterologist (or other clinician) may be attributed a lower GI hemorrhage episode, if the physician's group billed at least 30 percent of the inpatient E/M services provided during the hospital stay AND the physician bills a **single** inpatient E/M service during the beneficiary's hospital stay. This attribution method allows for an episode to attributed to up to three groups and multiple physicians within a group. ACG, AGA and ASGE agree that methods should allow an episode to be attributed to multiple groups and physicians and we support the 30 percent threshold used to attribute episodes to physician groups. However, **our societies are concerned that an episode may be assigned to a physician (or other clinician) that bills only a single E/M service during the hospital stay.**

As discussed above, the volume weighted arithmetic mean length of stay (ALOS) for the three surgical Medicare Severity Diagnosis Related Groups (MS-DRGs or DRGs) 356, 357 and 358 is 7.77 days and the volume weighted ALOS for the three medical DRGs 377, 378 and 379 is 4.12 days. While a single E/M service may be an appropriate attribution threshold for episodes with short lengths of stay, it is unlikely to be an appropriate threshold for episodes with longer lengths of stay. For example, for an episode with a length of stay of 7 days in which a physician group bills an E/M service every day, one E/M service represents only 14 percent of the E/M service provided by the group. If the remaining six E/M services are provided by a single other physician, it would be inappropriate to attribute the episode to both physicians. Instead of attributing episodes to individual clinicians who provide a single E/M service, **our societies recommend that episodes be assigned to a physician (or other clinician) that bills at least 30 percent of the group's E/M services for the hospital stay.**

Assigned Services

The Lower GI Hemorrhage Measure Codes List identifies services assigned to an episode if they occur in the post trigger period. For the Lower GI Hemorrhage cost measure, post-trigger services are assigned to one of seven categories – (1) Emergency Room, (2) Outpatient (OP) Facility and Clinician Services, (3) Inpatient (IP) Medical, (4) IP Surgical, and (5) Inpatient Rehabilitation Facility (IRF) – Medical, (6) Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DME) and (7) Home Health.

In general, the services assigned seem appropriate. However, concerns were raised that the assignment window for certain services and/or diagnoses are too long. **Consistent with our recommendation that the post-trigger period be shortened to 35 days, ACG, AGA and ASGE recommend that the service assignment window for any assigned services not exceed 35 days.**

Total Per Capita Cost Measure

Service Category Exclusions

The TPCC measure is intended to identify physicians (and other clinicians) who are responsible for providing primary care management to Medicare beneficiaries and then measure how effective they are at doing so. Although certain gastroenterologists may provide primary care management to Medicare beneficiaries who have chronic digestive diseases, in general gastroenterologists do not provide primary care management. Rather gastroenterologists mainly provide specialized diagnostic and therapeutic services to beneficiaries presenting with

gastrointestinal signs and symptoms that primary care physicians are ill-equipped to diagnose and treat. **ACG, AGA and ASGE are concerned that the re-evaluated TPCC measure is identifying as primary care management highly specialized gastroenterology services.**

The current TPCC measure methodology does acknowledge that certain service categories should be excluded from the measure, because the services do not represent primary care management. **ACG, AGA and ASGE urges CMS to consider an additional service category exclusion related to therapeutic and diagnostic endoscopy services.** Consistent with how the exclusions for therapeutic radiation and chemotherapy services are structure, **our societies recommend the following service category exclusion for therapeutic and diagnostic endoscopy**:

> *Clinicians are excluded from attribution if they performed at least one therapeutic/diagnostic endoscopy service in the calendar years overlapping the measurement period; and 5 percent or more of a clinician's candidate events had a therapeutic/diagnostic endoscopy service with the same beneficiary and were performed by the same clinician within +/- 180 days of the candidate event.*

Appendix A provides a list of the CPT/HCPCS codes that identify therapeutic and diagnostic endoscopy.

Overall Concerns

In general, our members find that the TPCC measure methodology materials lack specificity. This lack of specificity makes it nearly impossible to identify, and therefore understand, how beneficiaries are attributed, and costs are assigned. As our members have reviewed the methodology materials and field test reports, the following questions remain.

- What constitutes an episode? What constitutes the measurement period?
  The measure methodology materials state that the denominator is the number of episodes attributed to the TIN or TIN-NPI during the measurement period, but it is not clear what constitutes an episode or the measurement period.

  Including in the methodology materials a clear list of definition for key terms related to the measure would facilitate better understanding.

- Do candidate events occur before or during the measurement period? If before, what is the lookback period?

  Figure 1 in the methodology materials suggest that candidate events may occur before the measurement period.

- Does the candidate event include days outside of the measurement period? If yes, what is included or excluded?

- What is the rationale to allow a non-E/M primary care service provided **by any TIN** within 3 days of the E/M service to serve as the second criteria to attribute a beneficiary to a TIN-NPI?

  The lack of a clear connection between the primary care E/M services with a non-E/M service provided by another physician/TIN increases the potential to compromise the validity of the attribution model.

- Does a second candidate event for the same beneficiary/TIN-NPI combination trigger a new risk window? Or is a new risk window not triggered until the current risk window or current measurement period ends?

  It is not clear whether a beneficiary may be attributed to the same TIN-NPI more than once during a measurement period.

In addition to these outstanding questions, **our members also urge CMS to include in field test reports the date of the candidate event for each attributed beneficiary**. The current field test report makes it nearly impossible to identify the attributed beneficiaries. And as stated already, the inability to identify attributed beneficiaries makes it nearly impossible for physicians to understand the measure.

Medicare Spending Per Beneficiary Measure

Overall Concerns

With the introduction of the Screening/Surveillance Colonoscopy cost measure and the development of the Lower GI hemorrhage cost measure, there are now two specialty specific cost measures for gastroenterology. Specialty-specific measures are better suited to evaluate how gastroenterologists perform on costs. However, their introduction creates the potential for the same cost episodes to be captured by multiple cost measures. For example, episodes captured by the Lower GI Hemorrhage cost measure are also likely to be captured by the MSPB measure. ACG, AGA and ASGE are concerned about this overlap and the potential for lower GI bleeding episodes to be "double counted." Lower GI bleeding episodes captured by the Lower GI Hemorrhage measure should be excluded from the MSPB measure for the attributed

physician. The Lower GI Hemorrhage measure better captures the costs specific to these episodes and those costs should count towards that measure alone. Thus, **our societies request that lower GI bleeding episodes captured by the Lower GI Hemorrhage measure be excluded from the MSPB measure for the same attributed physician**.

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Thank you for the opportunity to provide feedback on the on the draft materials for the Lower GI Hemorrhage cost measure. Should you have any questions or require additional information, please contact Brad Conway, Vice President of Public Policy, ACG at 301.263.9000 or bconway@gi.org; Jessica Roth, Director of Regulatory Affairs, AGA at 240.482.3230 or jroth@gastro.org; or Lakitia Mayo, Senior Director of Health Policy, Quality and Practice Operations, ASGE at 630.570.5641 or lmayo@asge.org.

Sincerely,

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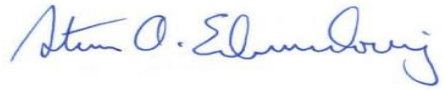

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Appendix A: Codes to Identify Therapeutic/Diagnostic Endoscopy Services

The table below lists the CPT/HCPCS codes that identify therapeutic/diagnostic endoscopy services.

CPT/HCPCS Code	HCPCS Code Description
43200	Esophagoscopy flexible brush
43201	Esoph scope w/submucous inj
43202	Esophagoscopy flex biopsy
43204	Esoph scope w/sclerosis inj
43205	Esophagus endoscopy/ligation
43206	Esoph optical endomicroscopy
43210	Egd esophagogastrc fndoplsty
43211	Esophagoscop mucosal resect
43212	Esophagoscop stent placement
43213	Esophagoscopy retro balloon
43214	Esophagosc dilate balloon 30
43215	Esophagoscopy flex remove fb
43216	Esophagoscopy lesion removal
43217	Esophagoscopy snare les remv
43220	Esophagoscopy balloon <30mm
43226	Esoph endoscopy dilation
43227	Esophagoscopy control bleed
43229	Esophagoscopy lesion ablate
43231	Esophagoscop ultrasound exam
43232	Esophagoscopy w/us needle bx
43233	Egd balloon dil esoph30 mm/>
43235	Egd diagnostic brush wash
43236	Uppr gi scope w/submuc inj
43237	Endoscopic us exam esoph
43238	Egd us fine needle bx/aspir
43239	Egd biopsy single/multiple
43240	Egd w/transmural drain cyst
43241	Egd tube/cath insertion
43242	Egd us fine needle bx/aspir
43243	Egd injection varices
43244	Egd varices ligation
43245	Egd dilate stricture
43246	Egd place gastrostomy tube
43247	Egd remove foreign body
43248	Egd guide wire insertion
43249	Esoph egd dilation <30 mm

43250	Egd cautery tumor polyp
43251	Egd remove lesion snare
43252	Egd optical endomicroscopy
43253	Egd us transmural injxn/mark
43254	Egd endo mucosal resection
43255	Egd control bleeding any
43257	Egd w/thrml txmnt gerd
43259	Egd us exam duodenum/jejunum
43260	Ercp w/specimen collection
43261	Endo cholangiopancreatograph
43262	Endo cholangiopancreatograph
43263	Ercp sphincter pressure meas
43264	Ercp remove duct calculi
43265	Ercp lithotripsy calculi
43266	Egd endoscopic stent place
43270	Egd lesion ablation
43273	Endoscopic pancreatoscopy
43274	Ercp duct stent placement
43275	Ercp remove forgn body duct
43276	Ercp stent exchange w/dilate
43277	Ercp ea duct/ampulla dilate
43278	Ercp lesion ablate w/dilate
44360	Small bowel endoscopy
44361	Small bowel endoscopy/biopsy
44363	S bowel endoscope/foreign body
44364	Small bowel endoscopy/snare
44365	S bowel endoscope/hot biopsy
44366	S bowel endoscope/ctrl bleeding
44369	Small bowel endoscopy/ablate
44370	Small bowel endoscopy/stent
44372	S bowel endoscope/place J-tube
44373	S bowel endoscope/convert J-tube
44376	S bowel endoscopy, enteroscopy
44377	S bowel endoscopy, enteroscopy/bx
44378	S bowel endoscopy, enteroscopy/ctrl bleeding
44379	S bowel endoscope, enteroscopy/stent
44380	Ileoscopy thru stoma
44381	Small bowel endoscopy br/wa
44382	Ileoscopy thru stoma/biopsy
44384	Small bowel endoscopy
44385	Endoscopy of bowel pouch
44386	Endoscopy bowel pouch/biop
44388	C-stoma
44389	C-stoma with biopsy
44390	C-stoma for foreign body
44391	C-stoma for bleeding

44392	C-stoma & polypectomy
44394	C-stoma w/snare
44401	C-stoma with ablation
44402	C-stoma w/stent plcmt
44403	C-stoma w/resection
44404	C-stoma w/injection
44405	C-stoma w/dilation
44406	C-stoma w/ultrasound
44407	C-stoma w/ndl aspir/bx
44408	C-stoma w/decompression
45330	Diagnostic sigmoidoscopy
45331	Sigmoidoscopy and biopsy
45332	Sigmoidoscopy w/fb removal
45333	Sigmoidoscopy & polypectomy
45334	Sigmoidoscopy for bleeding
45335	Sigmoidoscopy w/submuc inj
45337	Sigmoidoscopy & decompress
45338	Sigmoidoscopy w/tumr remove
45340	Sig w/balloon dilation
45341	Sigmoidoscopy w/ultrasound
45342	Sigmoidoscopy w/us guide bx
45346	Sigmoidoscopy w/ablation
45347	Sigmoidoscopy w/plcmt stent
45349	Sigmoidoscopy w/resection
45350	Sgmdsc w/band ligation
45378	Diagnostic colonoscopy
45379	Colonoscopy w/fb removal
45380	Colonoscopy and biopsy
45381	Colonoscopy submucous inj
45382	Colonoscopy/control bleeding
45384	Lesion remove colonoscopy
45385	Lesion removal colonoscopy
45386	Colonoscopy dilate stricture
45388	Colonoscopy w/ablation
45389	Colonoscopy w/stent plcmt
45390	Colonoscopy w/resection
45391	Colonoscopy w/endoscope us
45392	Colonoscopy w/endoscopic fnb
45393	Colonoscopy w/decompression
45398	Colonoscopy w/band ligation
91110	Gi tract capsule endoscopy
91111	Esophageal capsule endoscopy
91112	Gi wireless capsule measure