September 8, 2025

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
US Department of Health & Human Services
200 Independence Avenue SW
Washington, DC 20543

Re: (CMS-1834-P) Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency

Dear Administrator Oz,

On behalf of the American College of Gastroenterology (ACG), American Gastroenterological Association (AGA) and the American Society for Gastrointestinal Endoscopy (ASGE), we appreciate the opportunity to provide comments on the CY 2026 Hospital Outpatient Prospective Payment (OPPS) and Ambulatory Surgical Center (ASC) Payment Systems proposed rule (CMS-1834-P). Together, our societies represent virtually all practicing gastroenterologists in the United States. We thank the Centers for Medicare & Medicaid Services (CMS) for its ongoing effort to engage with stakeholders to better understand the evolving healthcare environment.

There are several provisions in the proposed rule impacting practicing gastroenterologists and Medicare beneficiaries. In this letter, we offer comments on the following provisions:

- **CY2026 Proposed Hospital Outpatient Department Conversion Factor**
- **APC Specific Requests -**
    - **CPT code 43252 from APC 5302 to 5303**
    - **HCPCS code C9779 from APC 5303 to APC 5331**
    - **APC 5721 – 5724 restructuring**
    - **CPT code. 91040 from APC 5273 to APC 5274**
- **CY 2026 Proposed ASC Conversion Factor**
- **Proposed Changes to the List of ASC-Covered Surgical Procedures for CY 2026**
- **ASC device-intensive status –**
    - **Codes 4XX04, C9785 and C9901**
    - **HCPCS code C9779**
- **ASC Quality Reporting Program**

Hospital Outpatient Prospective Payment

CY2026 Proposed Hospital Outpatient Department (HOPD) Conversion Factor

We appreciate CMS' proposal to increase payment rates by 2.4% for HOPDs, reflecting a 3.2% market basket update offset by a 0.8% productivity adjustment. This update acknowledges the substantial resource needs of hospital-based services and represents an important step toward sustaining patient access to high-quality care. For gastroenterology, the HOPD remains a critical site of service for both routine and advanced procedures, including complex therapeutic interventions, cancer prevention, and urgent care for acute conditions. We thank CMS for recognizing these demands and look forward to continued collaboration to ensure that future updates fully capture the clinical complexity and resource intensity of providing GI services in the hospital outpatient setting.

APC Specific Requests -

APC Classification of CPT Code 43252 from APC 5302 to 5303

In 2024, CMS reclassified the American Medical Association (AMA) current procedural terminology (CPT) code 43252 (*Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy*) from ambulatory payment classification (APC) 5303 (*Level 3, Upper [gastrointestinal] GI Procedures*) to APC 5302 (*Level 2, Upper GI Procedures*). CMS proposes to maintain the assignment to APC 5302 for CY 2026. Our societies raised concern about this reclassification in both our CY 2024 and 2025 comment letters, and we remain concerned with the proposal to maintain its assignment to APC 5302 for CY 2026. As here is a meaningful difference in the payment for APC 5302 versus APC 5303.

Proposed CY 2026 APC Payment Rate	**APC 5302**	**APC 5303**	**$ Difference**
	$1,975.59	$4,002.57	$2,026.98

Our experts have reviewed the codes assigned to APC 5302 and APC 5303 and believe that CPT code 43252 is more appropriately aligned with APC 5303, given its clinical intensity, resource utilization, and costs. We are concerned that placement in APC 5302 does not adequately cover the true costs of performing this procedure in the hospital outpatient setting, which could negatively impact patient care.

We recognize that APC rate-setting is data-driven and based on claims data. The reclassification implemented in CY 2024—and proposed to continue in CY 2026—is based on a change in the geometric mean of reported costs for this service. However, the manufacturer has informed our societies that many hospitals have historically underreported their costs, which has significantly skewed the geometric mean. While reporting corrections have been made, they will not be fully reflected in claims data until the CY 2027 or CY 2028 reclassification cycle. In the meantime, the manufacturer has submitted supplemental data to CMS and is meeting with the agency during the comment period.

Our societies urge CMS to carefully review this supplemental data. If the evidence supports reassigning CPT code 43252 to APC 5303, we strongly recommend CMS implement this correction

for CY 2026 to ensure hospital outpatient payment more accurately reflects the complexity and costs of the service.

HCPCS code C9779 from APC 5303 to 5331

We urge CMS to reassign Healthcare Common Procedure Coding System (HCPCS) code C9779 from APC 5303 to APC 5331. Placement in APC 5303, which groups lower-acuity endoscopic procedures, does not reflect the significant clinical staff, resource use, procedure length, and overall intensity of endoscopic submucosal dissection (ESD). ESD is a technically complex, high-cost procedure that frequently requires 120–180 minutes of physician time, advanced endoscopic equipment, and specialized accessories. APC 5331, which encompasses higher-complexity surgical procedures, more accurately reflects the resource demands and clinical role of ESD as a minimally invasive alternative to colectomy or gastrectomy for early cancers and large polyps.

Proposed CY2026 APC Placement	**APC 5303**	**APC 5331**	**$ Difference**
	$4,002.57	$6,276.20	$2,273.63

Surgical comparators for similar lesions, such as laparoscopic colectomy, are reimbursed at more than three times the current payment rate for ESD, underscoring the undervaluation of this service. In addition, real-world cost modeling demonstrates that the median direct cost of ESD substantially exceeds the median costs of services currently assigned to lower-level APCs. Placement in APC 5303 therefore creates a fundamental mismatch between the clinical intensity of ESD and current payment levels.

This misalignment is further compounded by the limitations of C9779 itself. As a combined upper and lower GI ESD code, it fails to capture important differences in procedural complexity, resource use, and clinical setting. Utilization has also been relatively low, with only 826 single claims reported, and the submitted cost data show extraordinary variability—from $920.48–$37,056.37. This wide range reflects both inconsistencies in hospital cost-reporting and the challenges of relying on current data to establish an accurate geometric mean, resulting in an artificially suppressed cost profile that does not reflect the true resource demands of ESD.

For these reasons, we strongly recommend that CMS reassign C9779- ESD to the higher-level surgical APC 5331 for CY2026. Reassigning ESD (C9779) to APC 5331 would align it with comparable high-complexity therapeutic procedures, correct the current undervaluation, and calibrate payment to its true clinical complexity, device dependence, and resource intensity.

For CY2027, when distinct CPT codes for upper and lower ESD are available, CMS should establish separate prices and initially place each code into an appropriate New Technology APC to stabilize payment while accurate cost data accumulate, rather than defaulting to clinical APCs whose historical under-reporting would continue to depress rates.

Changes to Diagnostic APCs 5721 - 5724

The GI Societies urge CMS to reconsider the CY 2026 OPPS pricing for APCs 5721–5724, where the proposal reflects ~20% average reductions and large, unexplained swings year over year alongside substantial shifts in single-claim counts – see table below.

Table 1

APC	Proposed 2026 Rate	Final 2025 Rate	$ Variance	% Variance	2026 Single Claims	2025 Single Claims	Variance
5721	$132.89	$156.46	-$23.57	-15%	121,173	382,168	206,995
5722	$221.14	$311.40	-$90.26	-29%	456,969	575,000	118,031
5723	$381.96	$530.60	-$148.64	-28%	404,690	134,293	270,397
5724	$879.34	$1,017.39	-$138.05	-14%	245,349	198,001	47,348

Most diagnostic gastroenterology tests paid under the OPPS are concentrated in APCs 5721–5724, and the abrupt, unexplained payment swings proposed for CY 2026 would destabilize this entire segment. These services are inherently supply-intensive with thin operating margins; in some cases, the disposable supply cost alone approaches the proposed payment (e.g., single-use esophageal catheters), leaving little to no coverage for staff, equipment, and overhead. Such volatility is not sustainable for hospitals and ASCs, undermines budgeting and staffing, and will inevitably curtail patient access—especially in rural and safety-net settings—if finalized without a transparent rationale and appropriate adjustments. We therefore urge CMS to stabilize and clarify the methodology for APCs 5721–5724 and ensure that supply-intensive diagnostic GI testing is equitably valued to preserve access for Medicare beneficiaries.

We therefore request that CMS:

- re-run the cost modeling for APCs 5721–5724 excluding low-volume or clearly anomalous facility reports and consider volatility guards (e.g., multi-year smoothing or outlier dampening) for supply-intensive services; and

- publish a transparent explanation of the observed variance, including a claims-movement analysis, supply cost handling, and weighting methodology;

- maintain payment levels that preserve beneficiary access, including—if needed—interim adjustments or floors for high-supply procedures such as those in APCs 5721–5724, until stable, representative cost data can be established.

APC Placement of CPT code 91040

In addition, the GI Tri-Societies urge CMS to reassign CPT® 91040 (esophageal balloon distension study) from APC 5723 (Level 3 Diagnostic Tests and Related Services) to APC 5724 (Level 4 Diagnostic Tests and Related Services) for CY 2026 to improve both resource and clinical homogeneity. CPT 91040

is a clear resource outlier in APC 5723, with a geometric mean cost of $2,007—more than $1,600 above the APC 5723 mean of $388—and a device offset of 43.16%, whereas other APC 5723 procedures generally lack meaningful device costs. Its resource profile aligns far better with APC 5724 services such as CPT 95928 (device offset 67.92%; geometric mean $1,948), CPT 95938 (42.17%; $2,309; proposed for reassignment to APC 5724 in CY 2026), and CPT 95939 (16.36%; $2,076). Clinical considerations reinforce this placement: CMS proposes moving CPT 91035 (wireless esophageal pH monitoring) from APC 5723 to APC 5724, and both 91035 and 91040 involve upper endoscopy, navigation of esophageal anatomy, assessment of mucosal integrity, and precise device positioning (capsule versus balloon catheter), with 91040 additionally requiring real-time physiologic assessment (distensibility, pressure–volume curves) and dynamic adjustments comparable in complexity to accurate capsule placement for 91035.

While CMS may note limited single claims for 91040, APC assignment is driven by clinical and resource homogeneity rather than volume alone; where robust comparator anchors exist—as in APC 5724 with 95928, 95938, 95939 and the proposed 91035 reassignment—91040 should be grouped with its closest peers, with payment refined as claims mature. Accordingly, we respectfully request that CMS finalize the reassignment of CPT 91040 to APC 5724 for CY 2026 to uphold OPPS grouping principles and avert persistent underpayment that threatens patient access to essential esophageal motility diagnostics.

Hospital Outpatient Quality Reporting (OQR) Program

Adoption of the Emergency Care Access & Timeliness electronic clinical quality measures (eCQM)

We support replacing the two existing measures (Median Time to Time from ED Arrival to ED Departure for Discharged ED Patients and Left Without Being Seen) with this proposed measure. However, because hospitals will need time to map the required data elements within their electronic health record systems (EHRs) and then evaluate the validity of the resulting data, we encourage CMS to extend the voluntary reporting period from one year to two.

Modify the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography in Adults (Hospital Level – Outpatient) Measure from Mandatory Reporting to Continues Voluntary Reporting

We support extending the voluntary reporting period on this measure.

Ambulatory Surgical Center (ASC) Payment

CY 2026 Proposed ASC Conversion Factor

Updating the ASC Relative Payment Weights for CY 2026 and Future Years

CMS proposes an ASC weight scalar of 0.842, which represents a decrease from the CY 2025 final weight scalar of 0.876.

Due to the application of the secondary ASC weight scalar to maintain budget neutrality, the relative payment weights for surgical procedures in ASCs are often lower than those under the OPPS for the same procedures.

Even when procedures performed in both the HOPD and ASC settings receive the same update factor under their respective payment systems, the payment rates under the ASC payment system will increase at a slower rate compared to those in the HOPD. This is because the ASC weight scalar effectively dampens the rate of increase in ASC payments to maintain budget neutrality, creating a growing disparity between the two settings. Consequently, this disparity could discourage providers from performing certain procedures in ASCs, potentially limiting patient access to cost-effective care options.

The secondary rescaling process applied in the ASC payment system is not working appropriately and is causing an ongoing divergence in the ASC weights. The result is the further erosion of any logical link in the relationship of HOPD and ASC payments for the same set of services.

As our societies have commented in the past, we ask that CMS exercise its authority to make annual adjustments in the relative payment weights. The continued application of the separate ASC scaling factor as proposed produces payment differentials that are neither sensible nor good policy and should be eliminated.

Proposed Changes to the List of ASC-Covered Surgical Procedures for CY 2026

Our societies support CMS' proposal to revise its regulatory criteria for evaluating potential additions to the ASC covered procedures list, provided the final rule explicitly affirms that physician clinical judgment—not site designation—determines the most appropriate setting for each patient. Additionally, we thank CMS for adding CPT code 91040 to Addendum BB of the proposed rule. The following diagnostic tests in Table 2 below fall within the medicine range of CPT codes (90000 to 99999) for which separate payment is allowed under the OPPS are ASC covered ancillary services and are safely performed in the ASC setting.

Table 2

CPT Code	Long Descriptor
91010	Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report;
91013	Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report; with stimulation or perfusion (e.g., stimulant, acid or alkali perfusion) (List separately in addition to code for primary procedure)
91020	Gastric motility (manometric) studies
91022	Duodenal motility (manometric) study
91030	Esophagus, acid perfusion (Bernstein) test for esophagitis
91034	Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode(s) placement, recording, analysis and interpretation
91037	Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation;
91038	Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)
91065	Breath hydrogen or methane test (e.g., for detection of lactase deficiency, fructose intolerance, bacterial overgrowth, or oro-cecal gastrointestinal transit)
91110	Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), esophagus through ileum, with interpretation and report
91111	Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), esophagus with interpretation and report
91112	Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report
91113	Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), colon, with interpretation and report
91117	Colon motility (manometric) study, minimum 6 hours continuous recording (including provocation tests, e.g., meal, intracolonic balloon distension, pharmacologic agents, if performed), with interpretation and report
91120	Rectal sensation, tone, and compliance test (i.e., response to graded balloon distention) [Deleted for CPT 2026]
91122	Anorectal manometry [Deleted for CPT 2026]
91XX1	Rectal sensation, tone, and compliance study (e.g., barostat)
91XX2	Anorectal manometry, with rectal sensation and rectal balloon expulsion test, when performed

We ask CMS to add all the CPT codes in Table 2 to the list of ASC covered procedures because they are all safely performed in the ASC setting and doing so will lower costs to CMS since the ASC setting is lower cost than the hospital outpatient department.

Additionally, advancements in endoscopy have created opportunities to safely move procedures to the ASC setting.

We appreciate CMS is willing to show considerable deference to physicians practicing in the ASC setting and their medical judgement to determine if a procedure can be safely provided in the ASC when the entirety of circumstances is considered, including a patient's clinical profile, the availability of surgical back-up, and the ability to safely respond to unexpected complications in a timely manner.

Many endoscopic services that are clinically appropriate for ASCs still occur in HOPDs because of substantial capital and disposable supply costs (e.g., hemostatic clips, EUS needles, guidewires) and because hospital outpatient payment more accurately captures these device burdens. ASCs also lack the purchasing leverage of hospitals and are disproportionately exposed to rising manufacturer prices—especially as the market shifts toward single-use platforms—making ASC provision financially untenable in many settings. Accordingly, CMS should state clearly in the final rule that any expansion of the ASC CPL is permissive, not prescriptive: it neither signals a preference for ASCs nor limits use of HOPD/hospital sites when patient factors (comorbidities, anesthesia risk, need for rescue capability, anticipated post-procedure monitoring) warrant a higher-acuity environment.

Our societies urge CMS to recognize and appreciate that the proposal in the CY 2026 Medicare Physician Fee Schedule Proposed Rule to reduce indirect practice expense RVUs for all services provided in the facility setting, including physician-owned ASCs will significantly curb the migration of certain services to the ASC setting.

As such, if CMS wants, as stated in this proposed rule, to increase the availability of ASCs as an alternative and lower cost site of care for Medicare beneficiaries, then the agency must consider its payment policies that are either hindering migration of services to endoscopy and surgical centers or will force services back into the hospital outpatient department.

ASC device-intensive status – Codes 4XX04, C9785 and C9901

For CPT 4XX04 (endoscopic sleeve gastroplasty, ESG), HCPCS C9785 (endoscopic outlet reduction), and HCPCS C9901 (GI defect closure), physicians routinely employ multiple single-use, high-cost components—an endoscopic suturing system, tissue helix, anchors, sutures, and cinches—yielding documented acquisition costs of approximately $4,000–$7,000 per case. Early claims experience for these services remains very low volume and exhibits year-to-year volatility in measured device offsets, which makes the derived offsets statistically unstable and systematically biased downward (e.g., incomplete charge capture, inconsistent cost-center mapping, and heterogeneous hospital reporting). Reliance on these aberrant data to set ASC payment will understate device costs, compress margins below sustainable levels, and restrict patient access to minimally invasive alternatives to surgery.

To ensure appropriate, stable payment while representative data mature, the Tri-Societies request that CMS assign ASC status indicator J8 (device-intensive) to 4XX04, C9785, and C9901 and apply the default 31% device offset when calculating ASC rates, rather than using volatile offsets derived from sparse claims. We further ask CMS to commit to re-evaluating device intensity after two full

years of credible claims and to provide clear manual instructions, so MACs process these services consistently during the transition.

ASC device-intensive status—HCPCS C9779 (ESD)

Endoscopic submucosal dissection (ESD; C9779) is proposed for addition to the ASC Covered Procedures List (CPL)in CY 2026. ESD is a complex, organ-sparing alternative to segmental colectomy or gastrectomy that enables en bloc resection of early GI cancers and large lesions, reducing surgical morbidity and downstream costs. Safe performance requires specialized, single-use devices—dissection knives, injection/traction tools, caps, hemostatic accessories, and often endoscopic defect-closure systems—and typically 120–180 minutes of procedure time in experienced hands. Yet in the CY 2026 proposed rule, CMS did not designate C9779 as device-intensive in the ASC setting; as a result, payment does not reflect the true device burden, which is systematically understated in low-volume, heterogeneous claims due to inconsistent charge capture, cost-center mapping, and kit bundling. **To preserve beneficiary access as adoption grows, we respectfully request device-intensive status (J8) for C9779 and application of the default 31% device offset for ASC rate-setting, with a commitment to re-evaluate after two full years of robust ASC claims.** We also ask CMS to issue clear manual instructions to MACs to ensure consistent processing and prevent payment shortfalls that would otherwise deter ASC availability of this curative, organ-sparing therapy.

ASCQR Program

Adoption of the Information Transfer Patient-Reported Outcome-Performance Measure (PRO-PM)

We do not support inclusion of this measure in the Ambulatory Surgical Center Quality Reporting (ASCQR) program as its implementation in the Hospital OQR Program continues to be challenging. Our concerns are due to the general complexity that results from implementing PRO-PMs, the additional cost associated with administering these surveys, and the requirement that a minimum of 300 survey responses must be submitted. This minimum response rate is not realistic for lower-volume facilities (i.e., this effectively means that any site with fewer than 300 qualifying episodes must achieve a 100% response rate).

Measures Proposed for Removal from the ASC Quality Reporting Program

Our societies are collectively committed to reducing disparities in digestive disease outcomes, particularly in screening and early detection rates of colorectal cancer among racial and ethnic minorities who are less likely to have regular colorectal cancer screenings than White individuals.[1] Reducing disparities in health cannot be achieved simply through efforts to improve overall health care quality for all beneficiaries. Rather, it requires targeted investments and efforts.

[1] American Cancer Society, Colorectal Cancer Facts & Figures 2023-2025; https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/colorectal-cancer-facts-and-figures/colorectal-cancer-facts-and-figures-2023.pdf.

Our societies do, however, support CMS' proposal to remove the following measures from the ASC Quality Reporting program beginning with the CY 2025 reporting period / CY 2027 payment determination:

- **Facility Commitment to Health Equity (FCHE)**
- **Screening for Social Drivers of Health (SDOH)**
- **Screen Positive Rate for SDOH**

In comments delivered to CMS in response to the proposal to add these measures to the ASC Quality Reporting Program, our societies pointed out that free-standing ASCs (i.e., those not owned and operated by a hospital) generally do not have the infrastructure nor the resources to meet the requirements of those measures, nor do those measures reflect the functions and structure of an ASC. ACS are distinct entities that operate exclusively for the purpose of providing procedural/surgical services to patients and in which the expected duration of services would not exceed 24 hours following an admission.[2] As a result, ASCs are not designed to perform pre-operative or post-operative clinic visits. Thus, independent gastroenterologists must maintain offices and staff even when performing procedures in the ASC setting. Consequently, adding a requirement to screen patients for SDOH is beyond the role of ASCs.

Measure Concepts Under Consideration for Future Years in the Hospital OQR, REHQR, and ASCQR Programs—Request for Information (RFI): Well-Being and Nutrition

For the same reasons that our societies opposed the FCHE and SDOH measures for use in the ASCQR Program, and which are now proposed for removal, **we do not support measures that require the assessment of nutritional status and patient overall well-being in the ASC setting.** Endoscopy centers already play a critical role in the prevention and early detection of colorectal cancer and other cancers of the digestive system, including esophageal, stomach and pancreatic cancers, through the use of endoscopy. As previously stated, ASCs provide services in which the expected duration would not exceed 24 hours following an admission. ASCs also do not perform pre- or post-operative clinic visits. If a pre-or-post operative clinic visit is required, it takes place in the physician's office, not the ASC.

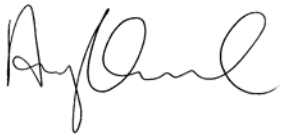
ASCs should not be subject to measures that require assessment of nutritional status, physical activity or sleep. Our societies urge CMS to abandon the consideration of any measures for the ASCQR Program that are outside the scope of services that ASCs provide.

Conclusion

We appreciate the ongoing dialogue concerning these important issues. If you have any questions about our requests, or if we may provide any additional information, please contact Brad Conway, ACG, at 301-263-9000 or bconway@gi.org; Leslie Narramore, AGA, at 410-349-7455 or Lnarramore@gastro.org; and Lakitia Mayo, ASGE, at 630-570-5641 or lmayo@asge.org.

Sincerely,

[2] U.S. Code of Federal Regulations. Title 42, Chapter IV, Subchapter B, Part 419; https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-416.



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