American Society of Regional Anesthesia and Pain Medicine
Advancing the science and practice of regional anesthesiology and pain medicine to improve patient outcomes through research, education, and advocacy
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September 13, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1751-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted Electronically to http://www.regulations.gov

Re: ***Medicare Program; Calendar Year (CY) 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-payment Medicare Review Requirements***

Dear Administrator Brooks-LaSure:

The American Society of Regional Anesthesia and Pain Medicine (ASRA) is a voluntary organization representing chronic and acute pain medicine physicians both nationally and internationally. In particular, we are highly dedicated to the use of evidence-based, medical therapies in treating patients with chronic and acute pain when appropriate. Our membership, of over 5,000 practitioners, includes solo practitioners, small group practice members, and practitioners in large private and academic healthcare systems. We strongly support the efforts of the Centers for Medicare and Medicaid Services (CMS) to improve quality of care and patient outcomes.

We welcome the opportunity to offer comments on the proposed rule referenced above, which include the following recommendations:

- *Work with Congress to mitigate the reduction in Physician Fee Schedule (PFS) payment for 2022.*
- *Implement updates to clinical labor pricing using a 4-year transition, and update pricing data more frequently to more accurately reflect clinical labor costs.*
- *Work with Congress to eliminate the statutory geographic restrictions and originating site requirements that apply to Medicare telehealth services.*
- *Finalize the proposal to retain all Category 3 services on the Medicare telehealth services list until the end of CY 2023.*
- *Add CPT codes 95970 through 95972 to the Medicare telehealth services list on a Category 3 basis.*
- *Expand the definition of interactive telecommunications system to include audio-only communications technology when used to furnish evaluation and management (E/M) services.*
- *Adopt the values recommended by the American Medical Association/Specialty Society RVS Update Committee (RUC) for Current Procedural Terminology (CPT) codes for destruction of*

neurolytic agent (CPT codes 64633 through 64636) and destruction of intraosseous basivertebral nerve (CPT codes 646X0 and 646X1).

- *Move forward with efforts to provide separate or add-on coding and payment for chronic pain management services.*
- *Demonstrate the value of the Merit-based Incentive Payment System (MIPS) on improving quality and controlling costs under the Medicare program before implementing substantive changes.*

ASRA's comments reflect our strong desire to partner effectively with CMS to provide high-quality care to Medicare beneficiaries.

Impact of the Conversion Factor Reduction on Physician Practices

<u>Recommendation:</u> ASRA urges CMS to work with Congress to mitigate the reduction in the PFS conversion factor for 2022 and to eliminate payment reductions associated with sequestration of Medicare payments.

CMS estimates that the PFS conversion factor will decrease by 3.75 percent for 2022, largely as a result of the expiration of payment increase for PFS services that Congress provided under the Consolidated Appropriations Act, 2021 (CAA) that applied for services furnished in 2021. As a result, physicians across the country will see significant reductions in their Medicare payments for 2022 absent action by policymakers to mitigate the cuts. Such reductions, if effectuated, will result in serious financial harm for physician practices at a time that they are continuing to struggle with increased costs and uncertainty associated with the public health emergency (PHE) for COVID-19. Solo practitioners and small practices, in particular, are likely to face challenges, which may contribute to the shift away from physician ownership documented by the American Medical Association, whose 2020 Physician Practice Benchmark survey showed that, for the first time, the majority of physicians worked outside of physician-owned medical practices in 2020.[1] Moreover, persistent uncertainty regarding Medicare payments may increase the risk of accelerating physician movement away from participation in the Medicare program, thereby reducing beneficiaries' access to care. These impacts are expected even without further payment reductions associated with the 2 percent sequestration of Medicare payments that are expected to return in January, as well as additional sequestration reductions of 4 percent that are also scheduled to take effect under the Statutory Pay-As-You-Go Act. Relief from the full slate of payment cuts is critical for physician practices to remain solvent and available to meet Medicare patients' healthcare needs.

Clinical Labor Pricing Update

<u>Recommendation</u>: ASRA recommends that CMS implement updates to clinical labor pricing using a 4-year transition, and that CMS update pricing data more frequently.

CMS proposes to update clinical labor pricing for CY 2022 using the methodology outlined in the CY 2002 PFS final rule, which draws primarily from wage data from the Bureau of Labor Statistics, to calculate

[1] Kane CK. Policy Research Perspectives. Recent Changes in Physician Practice Arrangements: Private Practice Dropped to Less than 50 Percent of Physicians in 2020. American Medical Association. https://www.ama-assn.org/system/files/2021-05/2020-prp-physician-practice-arrangements.pdf. Accessed August 18, 2021.

updated clinical labor pricing. The last time CMS updated clinical labor pricing was for CY 2002. While ASRA agrees that updating clinical labor pricing is appropriate and necessary to improve valuation and relativity of services, the proposed update will have a significant effect on the valuation of many services, including services that ASRA members commonly furnish, due to budget neutrality requirements. Implementing the updates over a four-year period will mitigate the excessive swings in valuation and provide additional time for practices to adjust to pricing changes. More frequent updates to clinical labor costs in the future will also likely help to prevent large adjustments.

Telehealth and Other Services Involving Communications Technology

Recommendation: ASRA recommends that CMS work with Congress to eliminate the statutory geographic restrictions and originating site requirements that apply to Medicare telehealth services.

ASRA appreciates the broad flexibility that CMS and its federal agency partners have provided to clinicians in the delivery of virtual care and telehealth services in response to the PHE for COVID-19. As we have previously noted, we believe that these changes have resulted in positive outcomes for both patients and providers that should be maintained beyond the PHE. In particular, the flexibility for patients to receive telehealth services regardless of where they are located in the country – including in their homes – has been invaluable, and reverting to the statutory geographic and originating site restrictions that apply to telehealth services outside of the PHE will eliminate an important tool for engaging with patients and increasing access to medically necessary care for a substantial proportion of the Medicare population. Such an outcome would be troubling, particularly as telehealth has the potential to increase the efficiency of health care delivery, including through reductions in no-show rates, as well as to reduce overall healthcare costs relative to in-person care if telehealth services replace in-person care.

Recommendation: ASRA supports CMS' proposal to retain all Category 3 services on the Medicare telehealth services list until the end of CY 2023.

ASRA appreciates CMS' proposal to extend the availability of Category 3 services through the end of CY 2023. This policy will increase the likelihood that there will be sufficient time to compile and submit evidence to support the permanent addition of these codes to the Medicare telehealth services list, and will help to provide greater certainty regarding the ability to furnish these services via telehealth given the ongoing impact of the PHE for COVID-19.

Recommendation: ASRA recommends that CMS add CPT codes 95970 through 95972 to the Medicare telehealth services list on a Category 3 basis.

ASRA disagrees with CMS' decision not to propose the addition of neurostimulator codes (CPT codes 95970 through 95972) to the Medicare telehealth services on a Category 3 basis. Our members report numerous benefits to patients associated with furnishing these services via telehealth. For example, remote analysis can improve outcomes through increased patient compliance. This is because in-person delivery of these services can often be time-consuming and burdensome for patients, and services may be required relatively frequently, for example each time the patient's stimulation needs change, particularly early after device implantation. By allowing these services to be furnished via telehealth, patients may be more likely to undergo timely monitoring and analysis to ensure proper neurostimulator programming. Additionally, ongoing availability of telehealth for these services will

enable patients to continue to benefit from increased flexibility and access to care, while minimizing risks of exposure to infectious diseases like COVID-19.

<u>Recommendation</u>: ASRA urges CMS to expand the definition of interactive telecommunications system to include audio-only communications technology when used to furnish evaluation and management (E/M) services.

ASRA appreciates that CMS is exercising the flexibility included in statute to allow for delivery of telehealth services via audio-only communications technology following the PHE for COVID-19. However, we continue to believe that the use of audio-only communications technology should be permitted to furnish evaluation and management services, similar to the availability of audio-only E/M services during the PHE – rather than just limiting this flexibility to mental health services. The ability to furnish services via audio-only communication technology has eliminated a significant barrier to virtual care, particularly as many Medicare patients may lack access to broadband services or may experience difficulty utilizing both audio and video capabilities on their communications devices. In many cases, our members have also reported that patients are unwilling to utilize audio-visual capabilities. Furthermore, allowing audio-only E/M services will help to address a disparity that contributes to a health equity gap, as patients in underserved rural areas and those with lower socioeconomic status often have the most difficulty utilizing video technology.

Valuation of Specific Codes

Recommendation: ASRA recommends that CMS adopt the RUC-recommended values for the following CPT codes:

- **Destruction by neurolytic agent (CPT codes 64633, 64634, 64635, and 64636)**
- **Destruction of Intraosseous Basivertebral Nerve (CPT codes 646X0 and 646X1)**

ASRA appreciates that CMS is proposing to adopt the RUC-recommended values for CPT codes 64634 and 64636, and we recommend that CMS finalize those values as proposed. However, we disagree with CMS' proposals to adopt lower values for the two additional codes in the same family (CPT codes 64633 and 64635), as well for the two destruction of intraosseous basivertebral nerve codes (CPT codes 646X0 and 646X1). The RUC process uses valid surveys and rigorous review by specialty society committees to inform the RUC's recommendations on the resources required to furnish these services; as such, we believe CMS' proposals would not accurately reimburse physicians for the work involved.

Comment Solicitation on Separate PFS Coding and Payment for Chronic Pain Management

<u>Recommendation</u>: ASRA supports CMS' efforts to provide separate or add-on coding and payment for chronic pain management services.

ASRA appreciates CMS' interest in improving payment for chronic pain management, including through establishment of separate or add-on coding and payment under the PFS. As CMS notes, there are numerous challenges to adequately treating chronic pain, including through the use of multi-modal therapies. New coding and payment would dedicate resources to furnishing chronic pain management that could help to overcome challenges – including by supporting pain care among primary care practitioners as well as pain specialists – while also improving patient outcomes. ASRA believes that the

list of services CMS identified offers a fairly comprehensive starting point for contemplating the types of activities that should be included under a chronic pain management code. Additionally, we believe an add-on code billed with an E/M visit may be most practical in the short-term.

MIPS Value Pathways (MVPs)

Recommendation: ASRA requests that CMS demonstrate the value of the Merit-based Incentive Payment System (MIPS) on improving quality and controlling costs under the Medicare program, including as envisioned under its MVP proposals, before implementing substantive changes.

While ASRA appreciates CMS' aims to streamline MIPS reporting and make the program more clinically meaningful through transitioning to MVPs, we have significant concerns that the MIPS program creates more complexity and burden than benefit, and that movement to MVPs would have minimal effect on burden reduction, quality improvement, or cost containment. Our members report that the MIPS program has not resulted in changes that improve care; rather, the most salient outcomes associated with the program from their perspective include provider burden and physician and staff burnout. Indeed, a recently published article by Glance et al[2] found only the slightest relationship between better performance in the MIPS quality performance category and surgical outcomes, and only for certain specialties. For example – for vascular surgeons, MIPS quality scores for surgeons in the 11th to 25th percentile, relative to those in the 51st to 100th percentile, were associated with a mere 0.55-percentage point higher hospital rate of failure to rescue. And while these findings are based on the first year of the MIPS program – suggesting that stronger relationships between physician quality performance under MIPS and surgical outcomes could develop – we note that even the Medicare Payment Advisory Commission (MedPAC) has concluded that MIPS will not be successful in incentivizing improvements in clinician practice patterns,[3] leading the Commission to recommend the elimination of MIPS.

ASRA is likewise concerned that MIPS is not achieving its intended outcomes, and that ongoing modifications to the program – including CMS' planned transition to MVPs – too often result in disruption and added complexity that does not benefit patients, providers, or the Medicare program. We would welcome evidence to the contrary, and recommend that CMS present data demonstrating how MIPS has contributed to higher quality, higher-value care that is commensurate with the costs it has imposed. We would also appreciate data showing that CMS' plans to transition to MVPs will result in meaningful improvements relative to traditional MIPS. And while we recognize that CMS is bound by statutory requirements for MIPS, we believe such evidence is necessary to support ongoing demands on Medicare physicians and other eligible professionals to continue to meet the complex, burdensome, and fragmented requirements of the MIPS program.

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Conclusion

[2] Glance LG, Thirukumaran CP, Feng C, et al. Association between the Physician Quality Score in the Merit-Based Incentive Payment System and Hospital Performance in Hospital Compare in the First Year of the Program. *JAMA Netw Open.* 2021;4(8):e2118449. doi:10.1001/jamanetworkopen.2021.18449.

[3] Medicare Payment Advisory Commission. Report to the Congress: Medicare Payment Policy. March 2018. http://www.medpac.gov/docs/default-source/reports/mar18_medpac_entirereport_sec.pdf. Accessed August 18, 2021.

In conclusion, ASRA appreciates your consideration of our comments on the updates to the aformentioned proposed rule. We look forward to working with CMS so we can achieve our shared goals of advancing high-quality of care and improving health outcomes for Medicare beneficiaries. As part of this important work, we will continue our commitment to promote use of evidence-based, non-opioid pain management techniques in the treatment of acute and chronic pain and safe use of opioids according to evidence-based guidelines in patients for whom it is medically appropriate. If you have any questions about these comments or other issues of concern, please do not hesitate to contact Angela Stengel at 412-471-2718 or astengel@asra.com.

Sincerely,

Samer Narouze, MD, PhD
ASRA President