

September 9, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1751-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code CMS-1751-P; Medicare Program; CY 2022 Payment Policies under the Physician Payment Schedule and Other Changes to Part B Payment Policies; (July 23, 2021)

Dear Administrator Brooks-LaSure:

The Society for Vascular Surgery (SVS) is a professional medical specialty society, composed primarily of vascular surgeons, that seek to advance excellence and innovation in vascular health through education, advocacy, research and public awareness. SVS, on behalf of its 5,900 members, offers the following comments on the Centers for Medicare and Medicaid Services (CMS) Notice of Proposed Rule Making (Proposed Rule) on the revisions to Medicare payment policies under the Physician Payment Schedule for calendar year (CY) 2022, published in the July 23, 2021, *Federal Register* (Vol. 86, No. 139 FR, pages 39104-39907).

The current pandemic and subsequent public health emergency have shined a much-needed light on the disparities and inequity in access to care. We have seen many examples of patients deferring their care, resulting in a greater severity of illness when they finally reached the appropriate health care provider. While this is a complex problem without a simple solution, if finalized as currently proposed, the net effect of the CY 2022 Medicare physician fee schedule (PFS) will be even greater disparity and inequity in access to care. SVS has grave concerns that CMS' proposed PFS pay cuts will measurably reduce the ability for vascular surgeons to provide critical services to vulnerable populations.

Vascular surgeons are left asking themselves "*Where, how, and when will I be able to care for my patients?*" Burnout is real. CMS continues to ask our surgeons and their staff to do more with less. There is a breaking point. CMS' proposed MFS rule is launching us to that breaking point.

The Medicare program was designed to provide the elderly with financial protection from the cost of medical care and, in the process, to increase access to services of high quality. The guiding principles used to protect and improve the Medicare program are¹:

¹ <https://babel.hathitrust.org/cgi/pt?id=mdp.39015030280716&view=1up&seq=12&skin=2021>

- Access to care
- Quality of care
- Financial protection for beneficiaries
- Equity among physicians
- Reductions in the growth of supplemental medical insurance (SMI) outlays
- Understandability
- Orderly change
- Pluralism

This proposed rule does not provide for orderly change. Nor does it afford Medicare beneficiaries access to care or financial protections. And certainly, this proposed rule does not provide for equity among physicians.

The Protecting Access to Medicare Act (PAMA) provides that the Secretary may collect or obtain information from any eligible professional or any other source on the resources directly or indirectly related to furnishing services for which payment is made under the PFS, and that such information may be used in the determination of relative values for services under the PFS (Section 220(a)). Such information may include the time involved in furnishing services; the amounts, types and prices of practice expense (PE) inputs; overhead and accounting information for practices of physicians and other suppliers, and any other elements that would improve the valuation of services under the PFS. CMS must consider data that demonstrates CMS' proposed CY 2022 payment rates do not even approach covering the expenses incurred to perform office-based procedures that require relatively expensive single-use supplies and implantable devices.

Clinical Labor Pricing Update

CMS is proposing to update the clinical labor pricing for CY 2022, an activity the Agency has not done since CY 2002. While SVS supports a clinical labor update, our analysis comparing CY 2022 proposed policy and data with and without the clinical labor update estimates this proposal will increase unadjusted direct costs by approximately **\$4 billion** based on 2020 volume. Because CMS does not propose additional Medicare funding, the \$4 billion pay-for will be taken directly from supplies and equipment funds within the PE pool. This action is frankly unfair and fiscally unsustainable for those specialties who provide Medicare beneficiaries with important services which require resource-intensive supplies and equipment.²

By increasing the clinical labor pricing and reducing the direct PE scaling adjustment, physician services with high-cost supplies and equipment are disproportionately impacted by the direct adjustment - a type of budget neutrality mechanism within the direct practice expense component of practice expense relative values. Under the CY 2022 proposed policy and data, the vascular surgery aggregate unadjusted direct practice expenses break down is 18% clinical labor, 64% supplies and 18% equipment. This means that more than 80% of vascular surgery's direct costs are attributed to direct components that are impacted by the significant drop in the direct PE

²To estimate the increase in unadjusted direct costs resulting from the clinical labor proposal, we compared total unadjusted direct costs under 2022 proposed rule policy and data with the clinical labor update, to total unadjusted direct costs under 2022 proposed rule policy and data without the clinical labor update. Taking this approach, we estimate that the clinical labor proposal increases direct costs by ~\$4 billion.

scaling adjustment without an offsetting increase as occurs for the labor component with this clinical labor pricing update proposal. The proposed clinical labor update pay-for will result in devastating cuts to crucially important vascular services that prevent leg amputation from vascular disease, reduce beneficiary pain by treatment of venous insufficiency and provide life-saving hemodialysis access to patients with end-stage renal disease.

While the clinical labor pricing proposal provides for a long overdue and much needed update to the clinical labor rates used as inputs in the PE methodology, the burden of this proposal is being disproportionately distributed among a small number of services performed within the fee schedule. There is an inherent unfairness of an across-the-board data source update and subsequent payment correction being supported by a very small number of specialties/services. This action violates the core principle of a resource-based relative value system. When the bottom-up PE methodology was established in CY 2007, CMS stated three overarching objectives³:

1. Ensure PE reflects relative resources required to greatest extent possible, using best available data.
2. Develop an understandable, intuitive system so changes are easily predicted.
3. Stabilize RVUs to reduce fluctuations in year-to-year payments.

The proposal to update the clinical labor wage data source in the PE methodology is consistent with the first goal, however this proposal also triggers a violation of the third goal. Updating the clinical labor wage data after almost 20 years of not doing so results in significant redistribution in the system and unsustainable cuts to non-facility RVUs with high supply and equipment resource costs incurred by the physician.

If the CMS proposal goes into effect, as written, it will without a doubt limit access to care for Medicare patients and will force many Medicare beneficiaries into the facility-based system at a significantly higher cost to the Medicare program and its patients. This shift in care to the facility-based hospital settings will cause great burden on an already overwhelmed hospital system and will adversely affect physicians' ability to provide the right care to the right patient at the right time. CMS should consider the additive, multiplicative, and sometimes exponential downstream effects of a delay in care as it relates to the vascular surgery patient population. The direct effect these changes will have on hemodialysis, peripheral vascular and vein patients specifically, who are already underserved in their access to care, will be devastating and irreversible.

Hemodialysis

Patients with end stage renal disease (ESRD) undergoing hemodialysis require hemodialysis treatments three times a week in order to live with life threatening renal insufficiency. Effective hemodialysis treatments require the presence of a functioning patent hemodialysis access. Maintenance of patency of the access is therefore crucial and necessary, and maintaining a patient's hemodialysis access is much more effective than having to replace it.

³ 71 Fed. Reg. 69630 (December 1, 2006)

Maintaining hemodialysis access in the non-facility office-based setting has been identified nationally to be an effective healthcare strategy for the treatment and care of patients with ESRD for the reasons described below.

- *Non-facility office-based care is cost effective to Medicare:* Medicare reimbursement rates are often three to four times higher in the facility hospital-based setting than in the non-facility office-based setting for hemodialysis access services.
- *Non-facility office-based care is less expensive to Medicare beneficiaries:* The patient with ESRD will have a copay that is often two to three times less expensive in the non-facility office-based setting for hemodialysis access services.
- *Non-facility office-based care is more convenient for all patients with ESRD:* Non-facility office-based care provides easier access to care, and renders care closer to home and supportive family and caregivers so crucial to the care of patients with ESRD on hemodialysis. Furthermore, the non-facility office setting is vastly easier to navigate than the large medical center for the patient, families and caregivers of all socioeconomic status, race, or gender.
- *Non-facility office-based care is timely:* Scheduling is easier to adjust, resulting in more immediate access to care. Clinically dangerous delays in care so frequent in facility hospital-based care for patients with ESRD are avoided. Prompt site-of-service value-based care in the non-facility office is the norm rather than the exception.
- *Non-facility office-based care offers continuity of care:* The patient-practice and patient-doctor relationship is maintained and emphasized in non-facility office-based care.
- *Non-facility office-based care prioritizes the patient with ESRD on hemodialysis:* Treatment of patients on hemodialysis is the primary healthcare mission of the non-facility office-based hemodialysis practice.
- *Non-facility office-based care is safe and time efficient:* Office-based care is clinically efficient and avoids unnecessary interactions with medical and nonmedical personnel so often associated with extended delays typically seen with facility hospital-based care; thus minimizing exposure to COVID and other aerosol or contact-based diseases because of decreased actual time spent in the non-facility setting.
- *Non-facility office-based care helps facility hospital-based care achieve its primary mission:* By treating patients with ESRD with non-facility office-based care rather than facility hospital-based settings, hospitals are allowed to focus on sicker patients, including COVID pandemic patients.

Regardless of the well-documented advantages of treating ESRD patients in the non-facility setting, in its present form, CMS' proposed rule will result in greater than 20% cuts to these critical non-facility office-based hemodialysis services. The negative consequences of this proposal are going to be felt by the exceedingly fragile hemodialysis patients.

Peripheral Arterial Disease (PAD)

Intervening on a patient's arterial tree to treat disabling symptoms will not only alleviate the patient's suffering, but also prevent the patient from progressing to major limb amputation, which is a devastating outcome both physically, emotionally, and financially.

PAD is a progressive disease process that results in narrowing or complete blockage of large and medium-sized arteries. Vascular specialists provide care for these patients to reduce the risk of PAD-related complications including chronic ulceration, limb amputation and death.

PAD affects approximately 10% of the American population and is a marker for a systemic disease process that increases one's risk of cardiovascular mortality (Int J Angiol, 2007 Summer 16(2): 36-44). The risk of PAD increases substantially with age and patients with diabetes and renal failure have a significantly higher incidence.

The femoral and popliteal arteries are affected in 80-90% of symptomatic patients (Atherosclerosis. 2018 Aug; 275: 379-81). Approximately 50% of patients have mild disease with no symptoms. Moderate disease may have symptoms that include leg pain with activity known as intermittent claudication. Claudication is treated medically, with a walking program, antiplatelet medications and cholesterol lowering medications. Should the claudication worsen or fail to improve with risk factor modification and medical treatment, it can affect the activities of daily living and require vascular intervention. More severe PAD, known as critical limb ischemia (CLI) may have symptoms of debilitating pain, ulcerations and skin necrosis. CLI poses the threat of imminent leg amputation, and urgent, effective vascular specialist care is required.

Non-facility office-based care allows vascular surgeons to avoid hospital-related delays in providing needed patient care. Office-based care provides the ability to improve access to the vulnerable populations. It also provides more effective time management for our vascular specialists. It is clear that provision of appropriate and timely office-based care ultimately benefits our patients and CMS as well.

Vein Disease

Treating a patient's leg swelling prospectively is much more effective than having to deal with and debride a venous leg ulcer retrospectively.

Venous disease becomes increasingly common and increases in severity with advancing age. In addition, the severity of venous disease increases with age. Patients with advanced venous disease have severe leg swelling and ulcers. Venous leg ulcers can be painful,

debilitating, and lead to infection. Effective surgical and non-surgical treatments are available. Key to the success of these treatments is early intervention. Delays in treatment result in unnecessary pain, swelling, wound drainage and infection. These adverse medical outcomes, including delayed wound healing, can ultimately increase the cost of care.

Patients with venous leg ulcers require regular wound care including painful debridement's. They typically have significant drainage, a high risk of infection, and once healed have a high risk of recurrence. While non-operative care including dressing care and compression wraps show clear benefit in patients with venous disease, there is also significant added benefit when the underlying venous pathology is treated with minimally invasive surgical procedures. Most venous disease can be divided into problems related to venous reflux resulting from poorly functional or absent vein valves or from obstruction to venous flow from venous compression or prior clots. In either case, the result is increased venous pressure, stagnant flow, and all other pathology described above. Common treatments for these debilitating diseases address one or both problems.

Data reveal that early intervention (i.e., scheduled within 2 weeks) results in faster healing than delayed surgery. Office procedures are uniformly easier to schedule. In many practices scheduling time for hospital-based surgery can be up to 2 months whereas office-based procedures are commonly accomplished within 1-2 weeks of approval.

In 2019 in the US, these venous procedures were performed 170,260 times in Medicare patients. Among the "vein ablation" procedures more than 90% were performed in the office setting. While excellent outcomes can be achieved in any approved site of service, the overwhelming predominance of office-based procedures for vein ablations is a testament to the excellent patient experience and effective resource utilization of this system.

Unfortunately, many of the offices where these procedures are currently performed are at risk of closing if the proposed PFS is enacted as written. If that were to occur and the patients were to seek care in hospital outpatient facilities, access to hospital-based surgeons and operating rooms which is already delayed would certainly become much worse. In addition, the cost to Medicare and to our patients (co-pays) would increase dramatically. Using the 2021 rates and looking at radiofrequency ablation treatment, the office(non-facility) CMS payment is \$1,317 whereas the hospital outpatient payment for the facility + physician = \$3,145. With many patients responsible for 20% of Medicare charges, we would have nearly tripled the cost to Medicare and to the patients. Additionally, the patients have to receive a service at a hospital facility that turns out to be less convenient and less accessible. This all assumes that our patients are able to eventually access this important, if more expensive, care at their local hospital. The reality is that a significant though undefined portion of patients would not get the care they need and would suffer unnecessarily and experience progressive disease.

There are approximately 700 non-facility offices in this country providing excellent vascular care at a fraction of the cost for procedures performed in the outpatient hospital setting. Most offices are run by private individuals who have signed forward looking, long term agreements (leases, loans, build outs, etc.) that cannot be restructured in such a short period of time as the cuts go into effect. These business commitments were made assuming reasonably consistent and slightly increasing costs over time, as is the fashion of literally every other government contract. Dramatic changes in payment policy will likely lead to default on various financial instruments associated with these endeavors and cause rapid closing of practices as they are forced to comply with loan and lease agreements, among other financial hardship. In short, the financial consequences will be IMMEDIATE for small businesses and will not be absorbed by physician salaries as we suspect CMS thinks will happen. A flood of practice, and potentially personal, bankruptcies will follow early next year. Each year, approximately 25% of non-facility offices fail due to the inability to remain financially solvent. If the CMS proposal goes into effect 1/1/2022 it will lead to many more physician offices to fail. This will limit access to our patients, lead to a loss of jobs in the office-based health care arena and force patients into an inefficient hospital-based system at a significantly higher cost to the health care system.

In the proposed rule, CMS displayed the isolated anticipated effects of the clinical labor pricing update on specialty payment impacts in Table 6. The negative impact to vascular surgery is estimated at -4%. CMS highlights in the text that specialties with a substantially lower or higher than average share of direct costs attributable to labor would experience significant declines or increases, respectively, if this proposal is finalized. They go on to say that the Table 6 impacts do not include complete impacts of all the policies the Agency is proposing for CY 2022, only the anticipated effect of the isolated clinical labor pricing update. The anticipated payment impact to vascular surgery if all the payment policies contained in the proposed rule are finalized is -8% (Table 123). The impacts published in Table 6 and Table 123 are misleading. First, the tables do not reflect the 3.75% decrease in the conversion factor from 2021 to 2022 due to the expiration of the one-time update enacted in the Consolidated Appropriations Act of 2021. Second, while the aggregate specialty impact shown in Table 123 shows vascular surgery decreasing by -8%, in reality, the negative impact is much greater for many vascular services that will see reductions greater than -20%. This causes significant fluctuations in year-to-year payments for office-based services.

While SVS understands the impact tables are for illustrative purposes for aggregate impacts on specialties, and not meant to be code specific, it is disingenuous to withhold actual impacts when they are so devastating to providers of office-based procedures with high supply and equipment costs. Our estimates suggest that the aggregate impact to non-facility vascular surgery is -12% before taking the CF reduction into account. **CMS should publish a cost estimate for the clinical labor proposal as well as impacts to illustrate how the proposal is impacting non-facility reimbursement rates.**

Budget Neutrality

Section 1848(c)(2)(B)(ii)(II) of the Act requires that increases or decreases in RVUs may not cause the amount of expenditures for the year to differ by more than \$20 million from what

expenditures would have been in the absence of these changes. If this threshold is exceeded, CMS makes adjustments to preserve budget neutrality. It is important to note that this \$20 million "threshold" has been the same since the inception of the MPFS in 1992. No adjustments to this threshold have been made to account for new technology that has revolutionized health care over the past 30 years.

As stated previously, the clinical labor pricing update results in unadjusted direct (real dollar) costs of approximately **\$4 billion**. It is unreasonable to think that such an enormous proposal should be implemented without additional funding. Recognizing that additional funding would need to be directed by Congress, SVS questions CMS' intentions of the clinical labor proposal. Was the intent of the proposal to cause chaos within the provider community in the hopes of those stakeholders going to Congress to seek additional funding? There are many more responsible ways a proposal with such magnitude could have been rolled out.

CMS should analyze the effects of implementing the clinical labor rates as they have proposed, after no change for 20 years, versus having implemented those updates more regularly. CMS should publish how the annual \$20 million restriction on changes to expenditures could have played a role in the clinical labor updates. CMS should also consider all the ways budget neutrality can be accounted for in the practice expense methodology, as there are several steps in the formula where concepts consistent with budget neutrality are applied.

Scaling Factors

In order to account for the dramatic rise in direct practice expense costs from the clinical labor proposal, CMS is proposing to decrease the CY2022 direct scaling factor by -24% from 0.5916 in 2021 to 0.4468. Stated another way, Medicare will now reimburse ~45 cents on the dollar instead of 59 cents on the dollar for direct cost inputs.

The practice expense component of the MPFS comprises approximately 45% of the total physician payment and that percentage is fixed. Therefore, an increase in the clinical labor rates results in a shift of RVUs that were previously directed to supplies and equipment. Many of the vascular services proposed to receive dramatic reductions require the use of expensive supplies that need to be stocked and readily available.

In CY 2021, clinical labor reflects ~44% of total unadjusted direct costs in the PFS.³ Under CY 2022 proposed rule policy and data with the clinical labor update taken into account, non-physician labor represents ~53% of total direct costs. Practice Expense is budget neutralized within the rate setting methodology. In this instance, the increase in clinical labor costs is offset by a reduction in the direct PE scaling adjustment to maintain the aggregate pool of direct PE RVUs. This decrease in the direct adjustment factor results in disproportionate impacts on specialties with substantially more direct costs attributed to supplies and equipment relative to labor.

⁴ Using 2019 volume and unadjusted direct inputs published with the 2021 final rule.

It is within CMS' regulatory authority to make accommodations within the practice expense formula to more evenly distribute the increase associated with this clinical labor proposal, allow for a more appropriate reimbursement of real dollar direct practice expenses and dampen the negative effect on specialties with high supply and equipment direct expenses compared to labor. **CMS should explore options to adjust the scaling factor(s) or budget neutralize this proposal within PE rate setting in an alternative manner in order to more appropriately reimburse for expenses incurred to treat Medicare beneficiaries.**

Utilization Data

CMS uses 2020 utilization data in PFS rate setting for CY 2022. Service utilization was significantly impacted by the public health emergency and this decline is reflected in the 2020 utilization data. CMS seeks comment on use of 2019 utilization data in rate setting as an alternative to using 2020 data. CMS should further explain where utilization is applied in the methodology and how lower 2020 volume effects the steps in the methodology and calculation of PE RVUs. For example, pools within the PE methodology are aggregated using utilization data. Likewise, CMS sets the aggregate pool of PE costs in the methodology in relation to the current and proposed aggregate pools of work RVUs. Prior to implementing any proposed changes, **CMS should explain in more detail the relationship between the choice of the year of utilization data and the PE methodology. CMS should consider adjusting the work pools to account for the volume decrease in 2020 due to the PHE.**

Understanding that CMS cites a slight improvement (from -8% in Table 123 to -7% in Table 134) in the impact of changes in RVUs on the specialty of vascular surgery when CY 2019 data is applied in rate setting, we support that alternative. The change of an impact reduced by 1%, while on the surface may be perceived as minor, could represent a difference of more than \$11 million in total allowed charges for vascular services.

Clinical Labor Rates – BLS Data

CMS believes it is important to update the clinical labor pricing to maintain relativity with the recent supply and equipment pricing updates. CMS is proposing to use the methodology outlined in the CY 2002 PFS final rule, which draws primarily from United States Bureau of Labor Statistics (BLS) wage data. CMS believes that the BLS wage data continues to be the most accurate source to use as a basis for clinical labor pricing and this data will appropriately reflect changes in clinical labor resource inputs for purposes of setting PE RVUs under the PFS.

The clinical labor rates were last updated in CY 2002 using Bureau of Labor Statistics (BLS) data and other supplementary sources where BLS data were not available. In the clinical labor rate update proposal, 12 of the 32 staff types used "other sources" instead of BLS data for pricing. These 2002 "other sources" data were not readily available for public review. For CY 2022, 14 of the 32 staff types are being updated using a BLS crosswalk because an exact match was not available. To maintain transparency, **CMS should publish the 'other sources' wage data details. In addition, CMS should update specific clinical labor wage rates based on stakeholder comments and data.**

Angio Tech

An angiography technician, often referred to as a vascular interventional radiographer, assists physicians with minimally invasive, image-guided vascular procedures, including angioplasty, stenting, thrombolysis, and more. Using sophisticated fluoroscopic equipment, they are responsible for capturing images of the blood vessels. To earn the certification in vascular interventional radiography, you must complete a post primary eligibility pathway. This requires, among other things, that the individual already holds a primary credential (i.e. radiologic technologist). The magnetic resonance imaging (MRI) technologist also requires a post primary pathway.

Angio Tech does not have a direct BLS labor category. As such, CMS is proposing to use BLS category 29-9000 Other Healthcare Practitioners and Technical Occupations as the proxy BLS wage rate. Both the angiography technician and MRI technologist require a post-primary pathway to certification (after primary credentialing such as radiologic technologist), therefore, **SVS recommends using 29-2035 Magnetic Resonance Imaging (MRI) Technologist as the proxy BLS wage rate for an angiography technician.**

Vascular Tech

Vascular Technologists, like other ultrasound sonographers, provide a direct role in obtaining ultrasound images. Unlike other sonographers, they also employ physiologic methods that require specialized skill sets and training. This is what makes their labor code separate and distinct. A skilled vascular technologist undergoes between 2 and 4 years of didactic and clinical post-secondary education as evidenced by the presence of a baccalaureate degree program in vascular technology.

Vascular Technologist does not have a direct BLS labor category. As such, CMS is proposing to use BLS category 19-1040 Medical Scientist as the proxy BLS wage rate. CMS is proposing to use the same BLS category as the proxy BLS wage rate for a medical dosimetrist. SVS agrees that both vascular technologists and medical dosimetrists play critical roles in independently providing clinically accurate, reproducible and high-quality data for physician decision making. When the updated clinical labor rates go into effect, **SVS recommends using 19-1040 Medical Scientist as the proxy BLS wage rate for the vascular tech, as proposed.**

Data Elements in Wage Rates

The BLS data includes several data elements for consideration. In the clinical labor pricing update proposal, CMS utilizes the mean wage data to establish updated clinical labor rates, while the majority of the MPFS data inputs are based on the median. For example, when developing RUC recommendations (work and practice expense) the physician times, work RVUs, clinical staff times and clinical staff types all use medians (ie, "typical"). The BLS survey data also include wage rates for a variety of sites of service (eg, hospitals, physician offices, farms) and wage data from a variety of industries. **We urge CMS to use the median wage data, instead of mean wage data, to more accurately capture "typical" wage rates and to be consistent with the median statistic used for clinical staff time.**

Fringe Benefit Multiplier

To account for employers' cost of providing fringe benefits, such as sick leave, CMS proposes to use the same benefits multiplier of 1.366 that was utilized in CY 2002. Using the fringe benefits multiplier rate from 20 years ago (2002) is not consistent with CMS' premise for updating the clinical labor pricing which was to "maintain relativity with the recent supply and equipment pricing updates". BLS publishes benefits data routinely. **CMS should use a current fringe benefits multiplier (1.296 BLS).**⁵

Timeline

The current clinical labor proposal requires additional analysis and modifications prior to implementation. There is further work to be done by both the Agency and stakeholders to ensure accurate data is used and appropriate methodological steps are taken for implementation. It is important to note that CY2022 will be the 4th and final transition year of the update to supply and equipment items, which also results in significant shifts in payment rates.

Summary of Clinical Labor Recommendations

The clinical labor proposal, as written, if implemented, will jeopardize the delivery of care to Medicare beneficiaries. We recommend CMS take the following steps regarding the clinical labor proposal:

1. CMS should encourage Congress to approve additional funding to pay for the clinical labor update
2. Utilize 2019 data as an alternative to 2020 data consistent with the impacts presented by CMS in Table 134
3. Use BLS wage category 29-2035 Magnetic Resonance Imaging (MRI) Technologist as the proxy BLS wage rate for the angio tech
4. Use BLS wage category 19-1040 Medical Scientist as the proxy BLS wage rate for the vascular tech, as proposed
5. Use BLS median wage rates
6. Apply a more current fringe benefits multiplier
7. Publish non-BLS 'other sources' wage data
8. Analyze and publish codes with the most significant impacts
9. Explore adjustments to the scaling factor(s)
10. Analyze the budget neutrality options

Conversion Factor

There is growing financial uncertainty within the Medicare payment system. The PFS has failed to keep up with inflation and increases to some providers must be offset by cuts to other providers, even if there is no evidence of overpayment, due to an unrealistic budget neutrality provision in statute, further contributing to the financial pressure on health care professionals. Initiatives to increase reimbursement rates for primary care services must not result in unintended consequences for specialty care.

⁵https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwirzqnMrN_yAhVMQ80KHdGWAY0QFnoECAIQAAQ&url=https%3A%2F%2Fwww.bls.gov%2Fnews.release%2Fpdf%2Feccec.pdf&usg=AOvVaw3vUaOmShjJDbWvVa_tJi6u

The profound exhaustion from the pandemic combined with the stress of uncertainty in payments may lead to further retirements, office closures, or reduced staffing, ultimately limiting patient access to care. **SVS calls on CMS to urge Congress to provide a positive update to the Medicare conversion factor in 2022 and all future years.**

Office Visits Included in Codes with a Surgical Global Period

This proposed rule does not include any new proposals to apply the office visit incremental RVU and time increases to the visits bundled into the global surgery codes. The SVS strongly rejects CMS' establishment of a two-tiered system for evaluation and management services. We are insulted by CMS' ongoing argument that they do not believe physicians are performing follow-up care with their patients. Stakeholders have articulated in great detail the fatal flaws with the RAND study, which CMS uses to defend their position that physicians are not seeing patients for follow-up care. We reiterate that it is inappropriate for CMS to not apply the RUC-recommended CY 2021 office visit RVU and time changes to global codes. **SVS continues to strongly recommend that CMS apply the office E/M visit increases to the office visits included in surgical global payment, as it has done historically.**

Valuation of Specific Codes

CMS continues to use flawed methodologies to arrive at valuations such as time ratios, reverse building block adjustments and incremental adjustments in the valuation of specific codes. While CMS sometimes provides crosswalk codes and other reference codes with similar times in support of their proposed values, CMS' selection process has the appearance of seeking an arbitrary value from the vast array of possible mathematical calculations, rather than seeking a valid, clinically relevant relationship that would preserve relativity. CMS' comparison codes often seem to have been selected solely for their work RVUs to the Agency's desired reduction and to justify similarly chosen time ratio comparisons. Significant clinical expertise of all medical specialties (including primary care) goes into developing RUC recommendations. **SVS urges the Agency to thoughtfully consider all aspects that go into developing RUC recommendations (i.e. time, intensity, magnitude estimation, etc) instead of relying solely on simple mathematical computations.**

Refinement Process/Appeals Process

In 2016, CMS permanently eliminated its Refinement Panel process by making the nomination requirements so specific that no services could be eligible going forward. For two decades, the CMS Refinement Panel Process was considered by specialties like SVS to be an appeals process. The complete elimination of the Refinement Panel discontinued CMS' reliance on outside stakeholders to provide accountability through a transparent appeals process. **SVS recommends that CMS create an objective, transparent and consistently applied formal appeals process that can act as a peer-review to the work / time changes the Agency proposes.**

Clinical Staff Pre-Time Package for Major Surgical Procedures (New 000 or Conversion from 090 to 000 day global)

There is a misguided presumption that services with 000 global periods are “minor” procedures. CMS’ reassignment of global periods for select codes does not change a major procedure to a minor procedure. The original establishment of a global period for postoperative care bundling has changed over time. Appropriate pre-service time for any service, regardless of the assigned postoperative global period must be recognized. The RUC PE Subcommittee deliberates on each code that is presented to determine the appropriate preservice clinical staff time. **SVS urges CMS to adopt the recommendations from the RUC for preservice clinical staff time and not impose a bias due to postoperative global period assignment.**

Split (or Shared) Visits

CMS is proposing to revise the policies related to split (or shared) E/M visits and the conditions of payment that must be met to bill Medicare for these services. In the CY 2022 PFS proposed rule, CMS is proposing the following:

- Definition of split (or shared) E/M visits as evaluation and management (E/M) visits provided in the facility setting by a physician and an NPP in the same group.
- The practitioner who provides the substantive portion of the visit (more than half of the total time spent) would bill for the visit.
- Split (or shared) visits could be reported for new as well as established patients, and initial and subsequent visits, as well as prolonged services.
- Requiring reporting of a modifier on the claim to help ensure program integrity.
- Documentation in the medical record that would identify the two individuals who performed the visit. The individual providing the substantive portion must sign and date the medical record.

SVS urges CMS to delay the split/shared E/M proposal. The AMA CPT Editorial Panel has approved several revised code descriptors and guidelines for CPT 2023 that will impact CMS’ split (or shared) visits proposal. SVS believes CMS’ definition of “substantive portion” of the visit using time will be problematic when the code level selection is based on Medical Decision Making (MDM) and not time.

SVS appreciates the opportunity to provide feedback on the proposed rule. If additional information is required, please contact trishacrishock@gmail.com.

Sincerely,



Ali AbuRahma, MD, DFSVS
President, SVS



Matthew Sideman, MD
Chair, SVS Advocacy Council

The Honorable Chiquita Brooks-LaSure

September 9, 2021

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cc: Edith Hambrick, MD
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