INTERNATIONAL SOCIETY for the ADVANCEMENT of SPINE SURGERY

September 6, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1770-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code CMS-1770-P; Medicare Program; CY 2023 Payment Policies Under the Physician Payment Schedule and Other Changes to Part B Payment Policies; (July 29, 2022)

Dear Administrator Brooks-LaSure:

The International Society for Advancement of Spine Surgery (ISASS) appreciates the opportunity to comment on the Centers for Medicare & 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) 2023.

ISASS is a multi-specialty association dedicated to the development and promotion of the must current surgical standards, as well as the highest quality, most cost-efficient, patient-centric, and proven cutting-edge technology for the diagnosis and treatment of spine and low back pain. The *Proposed Rule* includes several policy and technical modifications within the Resource-Based Relative Value Scale (RBRVS).

This letter includes ISASS recommendations and comments regarding the following:

- **CY 2023 Conversion Factor**
- **Practice Expense Relative Value Units**
    - **Clinical Labor Pricing Update**
- **Improving Global Surgical Package Valuation**
- **Payment for Medicare Telehealth Services**
- **Valuation of Specific Codes**

- Physician Work and Practice Expense Relative Value Unit Recommendations
    - CPT codes 22867
    - CPT codes 22630, 22632, 22634, 22636, 63052 and 63053
    - CPT codes 63020, 63030, and 63035
        - **E/M Payment**
            - **Split/Shared Visits**
            - **Office Visits in Global Periods**
- **Potentially Underutilized Physician Services**
- **Rebasing and Revising the Medicare Economic Index (MEI)**

2023 Medicare Conversion Factor

If the proposed conversion factor changes are implemented, most pain interventions would see dramatic reductions in total Medicare reimbursement. These procedures are critically important alternatives to opioid based treatment plans which have led to the tragic opioid epidemic that continues to devastate our country. Several efficacious and cost-effective pain treatments which currently are reimbursed at marginal levels that barely cover overhead face drastic reductions if the conversion factor were to be implemented as proposed. These collective reductions would represent a tremendous setback in the efforts by CMS and HHS to effectively address the opioid crisis in the United States and may inadvertently cause a resurgence of opioid prescribing.

CMS has done an admirable job in adjusting rules, regulations, and payment rates in response to the current Public Health Emergency (PHE) due to the Covid-19 crisis. Yet, despite this recognition and all the efforts by CMS to increase access to care for Medicare patients, CMS is proposing the largest single reduction in payment rates to physicians and providers in many years at the same time that the economy is experiencing the highest levels of inflations in the past 45 years. This is directly contrary to the efforts and the messaging by CMS and if implemented for CY 2023 would completely undo much of the success CMS and physician stakeholders have had in navigating this unprecedented health crisis. If implemented in the final rule, a -4% reduction would cause massive shortage of access as practices reduce staff and hours to absorb the impact. This would result in less access at a time that greater access and greater flexibility is needed in caring for Medicare patients. Even if the conversion rate were to stay at the same rate as CY 2022, physicians would be confronted with a real-dollar loss in the 7-8% range due to inflation. Practices and hospitals have already incurred significant deficits in 2022 and further reducing physician payments will lead to even greater practice and hospital deficits. Practices will either be forced to lay off staff or reduce services, or both; thus, negatively impacting access for patients at a time of critical health care needs for Medicare patients.

The reduced conversion factor also represents a breaking of trust between physicians, CMS, and patients. Our collaboration and cooperation in overcoming these unprecedented times has

been one of the few bright spots in the PHE. Reducing payments to physicians is an unfair and unacceptable response to this collaboration and risks future opportunities for cooperation. CMS should maintain their cooperation and collaboration by maintaining conversion factors and waiving budget neutrality in the fee schedule for all physicians and providers under the Medicare Physician Fee Schedule for CY 2023. CMS could offset the conversion factor reduction by overriding the 2% sequester cut from the ACA and the statutory 4% decrease from the American Rescue Plan Act. This 6% is on top of the conversion factor reduction and with the aforementioned increasing costs, represents an unmanageable combination of significant reductions in reimbursement with a significant increase in costs. Many practices will be forced to close their doors and Medicare patients will suffer significantly negative impacts to the health as a result. CMS must act through the proposed rule to ensure access for Medicare patients and assist their physician partners in providing high quality, accessible care to Medicare beneficiaries by waiving all proposed physician payment reductions and instead offsetting the 6-8% real dollar loss to practices from inflation by increasing payments accordingly.

Practice Expense Relative Value Units (PE RVUs)

Clinical Labor Pricing Update

CY 2023 marks the second year of a four-year transition to the new clinical labor cost data that will be completed in CY 2025, much like the transition used in updating the supply and equipment price updates that were completed in CY 2022. In the future, CMS should update pricing data on a more frequent basis for all direct PE inputs, so adjustments will not be so dramatic. ISASS understands the underlying unfairness that the real increase in clinical labor costs for physician practices is not recognized through a single update to the conversion factor and calls on CMS to urge Congress to provide a positive update to the Medicare conversion factor in 2023 and all future years.

ISASS also reiterates that the total direct practice expense pool increases by 30% under this proposal, resulting in a significant budget neutrality adjustment. Practice expense comprises 44.8% of the physician payment and the pool of this payment is fixed by statute. Therefore, increasing payment for clinical labor shifts funds that were previously directed to supplies and equipment. Since the overall size of the practice expense component is static, a larger proportion of that 44.8% is now clinical labor, relative to before the proposed wage rate update. By increasing the clinical labor pricing, physician services with high-cost supplies and equipment are disproportionately impacted by the budget neutrality component within the practice expense relative values. The scaling of direct expenses, to 50 cents on every dollar fully recognized as direct costs, puts a huge and unfair burden on specialties that require expensive supplies and other direct costs to care for their patients. While the increase in clinical labor is appropriate, it is not appropriate that physicians and other qualified health care professionals, notably from a few small specialties, are negatively impacted by the change.

New Clinical Staff Pre-Time Package for Major Surgical Procedures
The RUC recently determined that the addition of a pre-service clinical staff time package is warranted for major surgical procedures that are 000 or 010-day global periods yet require greater time than provided by the standard extensive clinical staff times package. The RUC considered CMS' action in the Final Rule for the 2022 Medicare Physician Payment Schedule for CPT codes 28820, 28825, 46020, 61736 and 61737 where the RUC-recommended pre-service clinical staff times were reduced from 60 minutes to 30 minutes. CMS stated, "We continue to believe that setting and maintaining clinical labor standards provides greater consistency among codes that share the same clinical labor tasks and could improve relativity of values among codes." While acknowledging that the RUC process of handling the pre-service time for code conversions on a case-by-case basis is effective and allows for the specialties to advocate for the most appropriate times for their procedures, the ISASS also understands the value in establishing an additional 000 and 010-day global period pre-service time package as an option for those procedures in the facility-setting that require pre-service clinical staff time corresponding with a 090-day procedure. The RUC concurred that a new "comprehensive" category reasonably follows "extensive use" and appropriately accounts for the comprehensive care required for the patients involved in these major surgical procedures. The new pre-service package would also encompass the global conversions from 090-day to 000 or 010-day global periods. Therefore, the RUC has established an additional pre-service clinical staff time package, "Comprehensive Use of Clinical Staff" as an option for those procedures in the facility-setting that are assigned 000 or 010-day global periods yet require pre-service clinical staff time commensurate with a 090-day procedure.

ISASS strongly encourages CMS to recognize and utilize this new package as appropriate.

Soliciting Public Comment on Strategies for Improving Global Surgical Package Valuation

In preparation for future rulemaking, CMS is seeking public comment on strategies to improve the accuracy of payment for the global surgical packages.

CMS continues to project broad assumptions that proceduralists are not providing the post-operative visits that are included in the global periods. However, the most common surgical procedure, cataract surgery, illustrates the flaw in conflating the valuation of the individual visits with the RAND reports on the ongoing claims reporting of 99024 Postoperative follow-up visits, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure. The RUC's recent recommendation included three office visits in the post-operative work for cataract surgery is supported by claims reporting of 99024 and other extant data and studies. The ophthalmology survey data for the recent office visit (99202-99215) survey reflect similar time and work as the primary care data and RUC submitted overall data. It is, therefore, not appropriate to distort the relativity of the post-operative visits for cataract surgery. As the most frequently performed surgery to Medicare patients, this example should lead as an example for other surgical procedures.

Post-operative visits are a proxy for work, but CMS is punitive with how it applies this work. For example, if a patient is staying less than 23-hours in the hospital, CMS is applying a lower intensity of work to that service even though the service provided is the same as an inpatient hospital visit.

CMS and the RUC have a longstanding process to identify potentially misvalued services, including the global service period. To date, CMS and the RUC have conducted the following objective screens to identify potentially misvalues services related to global periods:

- Post-Operative Visits Screen – In 2014 and 2019, the RUC identified 010-day global period services with more than 1.5 office visits and Medicare utilization over 1,000 and 090-day global period services that include more than 6 office visits and Medicare utilization over 1,000. The RUC has conducted this screen two times, reviewed and provided recommendations on 62 services for the 2015-2017 and 2021-2022 Medicare Physician Payment Schedules.
- High Level E/M in Global Period – In 2015, the RUC identified services that have Medicare utilization over 10,000 and include a 99214 or 99215 office visit in the global period. The RUC reviewed and provided recommendations for 10 services for the 2017-2018 Medicare Physician Payment Schedules.
- 000-Day Global Services Reported with an E/M with Modifier 25 screen - CMS developed this screen in the NPRM for 2017. This included services with a 000-day global period reported with an E/M 50 percent of the time or more, on the same day of service, same patient, by the same physician, and were not reviewed in the last five years with Medicare utilization greater than 20,000. The RUC reviewed 22 services (CPT deleted one) and provided recommendations for the 2019 Medicare Physician Payment Schedule.

ISASS believes that the misvalued services process is the appropriate avenue to address any services that may have incorrect post-operative visits in its global period. A blanket approach to address all 010-day and 090-day services only targets physicians performing surgery.

ISASS urges CMS to continue to rely on the Relativity Assessment Workgroup process, utilizing objective screens to identify any potential misvaluation of services with global periods. The CMS public comment process may also be utilized to identify potential misvaluations, as it has been successfully utilized for this purpose.

Payment for Medicare Telehealth Services

CMS is proposing several policies related to Medicare telehealth services under the MFS including making several services that are temporarily available as telehealth services for the public health emergency (PHE), available through 2023 on a Category III basis, to allow more time for collection of data that could support their eventual inclusion as permanent additions to the list. CMS is proposing to extend the duration of time that services will be temporarily available for the PHE for a period of 151 days following the end of the PHE to align with the

timeframe of flexibilities according to the Consolidated Appropriations Act (CAA) 2022. CMS is proposing that telehealth claims will require the appropriate place of service (POS) indicator to be included on the claim, rather than modifier "95," after a period of 151 days following the end of the PHE. As finalized in CY 2022, mental health services will be available to be furnished through audio-only technology in certain circumstances after the end of the PHE. Additionally, CMS is proposing to continue to make payments for services on the Medicare Telehealth List that use audio-only telecommunications systems for 151-days following the PHE. CMS proposes to delay the requirement for an in-person visit with the physician or practitioner within six months prior to the initial mental health telehealth service for 151 days following the PHE. CMS also proposes to pay audio-visual services at the facility rate, following the PHE.

ISASS supports these efforts by CMS and the proposals to maintain access to telehealth for Medicare patients. These policies have been effective in the last three years and should remain in place even beyond the end of the PHE.

Valuation of Specific Codes

While CMS accepted 75 percent of the RUC's work relative value recommendations submitted for 2023, ISASS urges acceptance of all its recommendations, in general. Significant clinical expertise was contributed to developing these recommendations, many of which were unanimously supported by the 29 voting members of the RUC. ISASS is concerned about the use by CMS of flawed methodologies to arrive at valuations such as time ratios, reverse building block adjustments and incremental adjustments. Often, these systematic changes involve comparing the ISASS recommended physician times to the existing CMS physician times that are proxy data and not reflective of any surveyed data from practicing physicians. The CMS/Other source of data was one CMS staffer decades ago assigning a time and should never be used as a source of "truth" when comparing actual survey data from practicing physicians.

In many scenarios, CMS selects an arbitrary combination of inputs to apply, including total physician time, intra-service physician time, "CMS/Other" physician times, Harvard study physician times, existing work RVUs, RUC recommended work RVUs, work RVUs from CMS-selected crosswalks, work RVUs from a base code, etc. This selection process has the appearance of seeking an arbitrary value from the vast array of possible mathematical calculations, rather than seeking a consistent valid, clinically relevant relationship that would preserve relativity.

ISASS would like to remind CMS of both the Agency's and the RUC's longstanding position that treating all components of physician time (pre-service, intra-service, post-service and post-operative visits) as having identical intensity is incorrect and inconsistently applying it to only certain services under review creates inherent payment disparities in a payment system based on relative valuation. When physician service period times are updated in the Medicare payment schedule, the ratio of intra-service time to total time, the number and level of bundled

post-operative visits, the length of preservice and the length of immediate post-service time may all potentially change for the same service. These changing components of physician time result in the physician work intensity per minute often changing when physician time also changes. ISASS recommends that CMS always account for these nuanced variables. The underlying principle of the RBRVS is magnitude estimation, and we implore CMS to use that long-standing methodology instead of inconsistent mathematical computations.

CMS provides crosswalk codes and other reference codes with similar times in support of their proposed values. However, it appears most of these comparison codes were arbitrarily selected as CMS does not provide any clinical foundation for the comparison of the surveyed codes to the crosswalk codes. Furthermore, these comparison codes often seem to have been selected solely for their similar work RVUs or service period times to the Agency's desired reduction and to justify similarly chosen time ratio comparisons. ISASS recommends that CMS embrace the clinical input from practicing physicians when valid surveys were conducted, rigorous review by the specialty society committees was performed, and a review of magnitude estimation and cross-specialty comparison has been conducted by the RUC.

Physician Work and Practice Expense Relative Value Unit Recommendations

CPT code 22867

In the 2022 Proposed Rule, CMS recommended adjustments to work RVUS for CPT® code 22867, *Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with* ***open*** *decompression, lumbar; single level.* 22867 was nominated by CMS as potentially misvalued in the 2021 Medicare Physician Fee Schedule Final Rule and was reviewed by the RUC at the January 2021 AMA RUC meeting. ISASS agreed with the agency that 22867 was misvalued and worked with other stakeholders in advising the RUC on a proposed update in value. While we appreciate the acceptance by CMS of a new, higher value for 22867 of 15.00 work RVU from the current work RVU of 13.50, we request that CMS consider adding additional work RVUs to the adjusted value to correctly represent the physician work and intensity involved in performing 22867.

All stakeholders, including CMS agree the current work RVU of 13.50 to be incorrect and the RUC recommendation of 15.00 work RVUs was appropriate from a RUC perspective only, based on RUC methodology alone. However, ISASS encourages CMS to consider input beyond the RUC's recommendation given the evidence of incorrect valuation. ISASS has presented information and feedback on the clinical work necessary to perform this complex procedure and believes that even at 15.00 the work RVUs undervalue the work. The procedure itself includes the work of a Laminectomy, which is coded as 63047. 63047 has a work RVU of 15.37 as a stand-alone procedure which means that valuation at 15.00 for 22867 represents a clear rank order anomaly.

Therefore, we recommend the agency use a building block approach to valuing 22867 which takes the 15.37 work RVU of 63047 and adds the additional work for implantation of the interlaminar/interspinous stabilization device after the decompression laminectomy. Other lumbar spine device implant add-on codes such as 22853 have a work RVU of 4.25. When added to 63047 this would result in a work RVU of 19.62 which is also close in value to many other spinal surgery codes such as 22612 and 22630 and more appropriately places the work of 22867 relative to other similar spine surgery services.

ISASS has presented its recommendations and information that support higher work RVUs for CPT 22867. Based on these materials, ISASS recommends that CMS rely on the detailed analysis of physician work associated with the procedure, published in the *International Journal of Spine Surgery.*[1] This recently published analysis of the work involved with CPT 22867 was based on an independent survey of 58 surgeons with experience performing open decompression with interlaminar stabilization (ILS) as described by CPT 22867 and with experience performing open decompression laminectomy described by CPT 63047 open laminectomy. Twenty-eight surgeons responded to the survey. The survey results were there used to compare the physician work involved in the procedure with the five most common comparable procedures. A multi-linear regression analysis was then completed with comparator work RVUs as the dependent variable and estimated complexity difference as the independent variable.
"In the spirit of the Rasch analysis, the comparator CPT® code wRVUs and calculated differences were analyzed by multiple linear regression that adjusts for five relative difficulties (complexity) variables captured during the survey (mental effort, technical effort, physical effort, risk, and overall intensity). In other words, the wRVUs for CPT 22867 were predicted by using the relative difficulty of the surveyed procedure to the most comparable procedure. The regression analysis of comparator code wRVUs (dependent variable) on the calculated differences (independent variable) estimated an intercept of 20.95."[2]

The **new regression analysis** demonstrates that not only are the current work RVUs for CPT 22867 undervalued but that the work RVUs for CPT 22867 should be increased to 20.95 to correctly value the physician work. See Figure 1 below showing the regression analysis results with the 0-value falling well above 20 work RVUS for the value of the physician time and effort involved in the procedure 22867 (see Figure 1 embedded below).

[1] Lorio D et al. Determination of Work Relative Value Units for Management of Lumbar Spinal Stenosis by Open Decompression and Interlaminar Stabilization. *Int J Spine Surg*. 2021;15(1):1-11. doi:10.14444/8026.
[2] Lorio D et al. Determination of Work Relative Value Units for Management of Lumbar Spinal Stenosis by Open Decompression and Interlaminar Stabilization. *Int J Spine Surg*. 2021;15(1):1-11. doi:10.14444/8026.

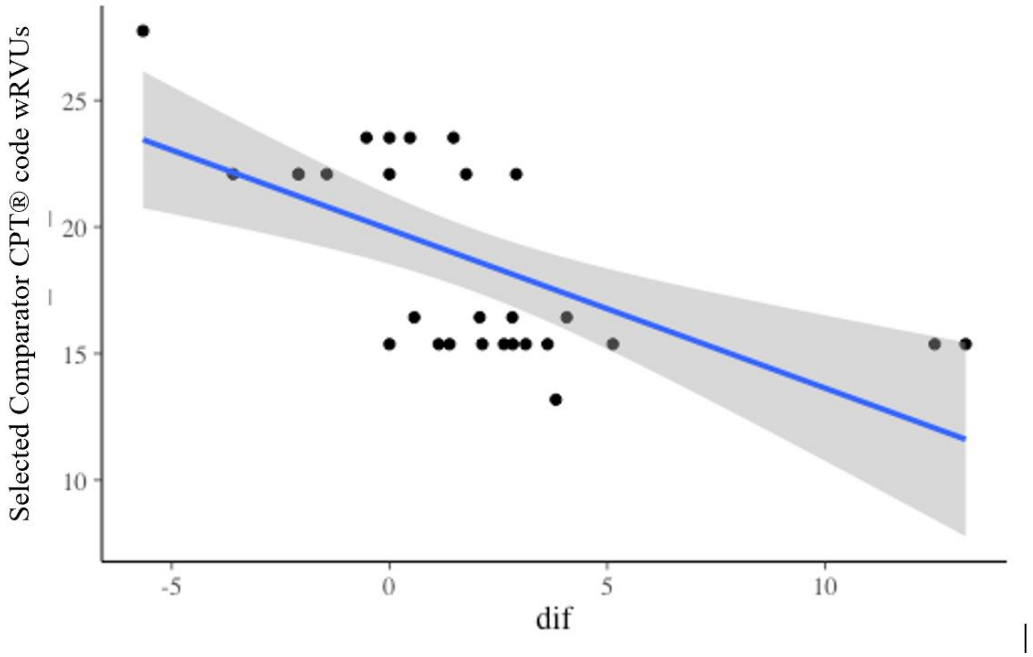

Figure 1. Results of regression analysis of estimated wRVUs of CPT® 22867.

ISASS understands that CMS may need to provide a rationale for increasing the work RVUs for CPT 22867 in the final rule. The following approaches may be considered:

- CMS can explain the procedure described by CPT 22867 includes the work of an open laminectomy, which is coded as 63047.
- CPT 63047 has a work RVU of 15.37.
- If CMS finalizes, as proposed, work RVUs of 15.00, CPT 22867 would be clearly undervalued.

In support of this added value, there is evidence from large samples of intra-service time that the intra-service work time for 22867, which the RUC surveyed at 90 minutes, is in fact greater, with a median time of approximately 110 minutes. This additional 20 minutes further supports and warrants higher work RVUS than the 15.00 proposed by CMS and the RUC.

Additional **new data** from an analysis published in *Spine*[3] suggests far more consumption of physician work RVU by 22867 procedurally than by laminectomy 63047 alone, as indications have grown within a more complex patient population as evidenced by the excerpted study results below:

Eighty-three (83) patients from 2007-2019, which included 37 cases of single-level laminectomy as compared to 46 single level lumbar interlaminar stabilization following decompression (ILS+D). The ILS+D cohort (69 yo) was older than the Laminectomy cohort (64 yo, p=0.042) and had higher ASA grades; the ILS+D cohort, additionally, had a higher American Society of Anesthesiologists (ASA) grade of 2.59 versus the Laminectomy cohort grade of 2.17, p=0.020. The ILS+D cohort patients had (1) greater estimated blood loss (EBL) of 97.50 ml versus 52.84 ml, p=0.004, (2) longer operative time of 141.91 min versus 106.81 min, p=0.001, and (3) longer length of stay (LOS) of 2.0 days versus 1.1 days, p=0.001. ILS+D cohort had higher total perioperative complications (21.7% versus 5.4%, p=0.035) and higher ILS instrumentation complications (10.9% versus 0.0%, p=0.039) than did the Laminectomy cohort. Obviously, both Time and Intensity for ILS=D (or CPT 22867) have been erroneously misvalued, as has the malpractice RVU for this combined open procedure. Currently, Surgalign Spine Technologies, Inc (Deerfield, Illinois) is the only source for the ILS implant component (coflex™) used procedurally.

Moreover, 22867 has demonstrated **organic growth** procedurally by the emergence of lumbar interspinous stabilization following decompression (ISS+D) which is undergoing IDE trial and being coded as 22867 and reimbursed likewise. Procedural time data from the LimiFlex™ (Empirical Spine, Inc, San Carlos, CA) IDE trial (presented in part by Lavelle et al, ISASS21, Miami, FL) is summarized below in Table 1. One hundred-forty (140) procedures completed to date. Mean skin-to-skin time was 112 minutes, with mean 23-minute device implantation time. This illustrates that the bulk of the procedure is dedicated to the decompression laminectomy, and consistent with literature reports of the surgery and anesthesia time required for decompression consistent with CPT 63047. The 23-minute average device insertion time also corresponds to the additional time to insert an interbody fusion device corresponding to CPT 22853. Thus, the work RVU associated with CPT 22867 should reflect the total work of CPT 63047 and an add-on code such as 22853, as described above.

[3] Zhong J et al. Patient Outcomes After Single-level coflex Interspinous [Interlaminar] Implants Versus Single-level Laminectomy. *Spine*. 2021 Jul 1;46(13):893-900. doi:10.1097/BRS.0000000000003924. PMID:33395022.

Table 1: Procedure time details from the LimiFlex™ IDE Study (minutes)

	Mean ± SD	Min.	25th %	Med.	75th %	Max
Skin-to-skin time	112 ± 32	59	88	105	125.25	216
LimiFlex™ implant time	23 ± 15	7	14	18	27.25	84
Total anesthesia/OR time	168 ± 39	97	139	164	191	305

Please also note that **open** ILS/ISS+D (CPT 22867) performed by surgeons is NOT to be confused or conflated with **percutaneous** ILS/ISS (CPT 22869) performed by non-surgeons (Medicare Utilization data from 2019 shows 97% of claims for CPT 22869 to be performed by pain physicians). A parity model for reimbursing the combined procedure has been previously presented to CMS/OMB to rectify the gross mis-valuation of 22867 and additionally supports the increase in work RVU. Finally, ISASS points out that when a surgeon is required to halt implantation of either ILS or ISS due to intraoperative technical considerations that the decompression performed is appropriately coded alone as 63047, which is also consistent with the building block approach.

Moreover, **Health Access Equity** should be taken to heart IF CMS is to correct the gross mis-valuation of CPT 22867 in order to facilitate equitable access to healthcare while addressing health disparities as an objective for society.[4] Degenerative spondylolisthesis is well known to disproportionately impact women, the elderly, African-Americans, and certain Native American populations.[5,6] ISASS believes that bringing the voice of spine surgeon experts, who are in-the-trenches, into the visible-domain of public discourse is good for democracy.

ISASS strongly recommends that CMS adopt a work RVU of 19.62 with the use of a building block methodology in the 2022 Medicare Physician Fee Schedule if they choose not to implement the RUC recommended work RVU of 15.00.

Arthrodesis Decompression (CPT codes 22630, 22632, 22633, 22634, 63052, and 63053)

In January 2021, the RUC submitted interim recommendations for new CPT add-on codes 63052 and 63053. The RUC was concerned that the four base codes had not been surveyed along with the two new add-on codes. The RUC did not deem revisions to the existing code family editorial and recommended that the entire family be resurveyed for April 2021. Thus, CPT codes 63052 and 63053 were surveyed again for review at the April 2021 RUC meeting with their base codes 22630, 22632, 22633 and 22634.

[4] CMS. Equity Initiatives. 2022; https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/framework-for-health-equityAccessed September 4, 2022.
[5] Kalichman L et al. Spondylolysis and spondylolisthesis: prevalence and association with low back pain in the adult community-based population. *Spine* (Phila Pa 1976). 2009;34(2):199-205. doi: 10.1097/BRS.0b013e31818edcfd. PMID: 19139672; PMCID: PMC3793342.
[6] Vogt, MT et al. Lumbar spine listhesis in older African American women. *The Spine J.* 2003; 3(4):255-261. https://doi.org/10.1016/S1529-9430(03)00024-X

22630

CMS is proposing a work RVU of 20.42 for CPT code 22630, rather than the ISASS and RUC recommended work RVU of 22.09, based on reverse building block methodology to account for the surveyed reductions in physician time. CMS states that it would be inappropriate to maintain the current work RVU given the significant decrease in intra-service time, absent an obvious or explicitly stated rationale for why the relative intensity has increased. The RUC thoroughly considered the substantial decrease in intra-service time of 30 minutes for 22630 and even considered crosswalk code alternatives; however, none of the crosswalk code options were clinically comparable or sufficiently matched to the difficulty of the procedure. The change in time for 22630, since it was valued in 1995, was attributed to changes in technology that reduced operator time but increased the intensity of the service provided within that time. Routine use of fluoroscopy to obtain intraoperative films may decrease the amount of time required for the procedure, but the surgeon is using that data in real time to determine the positioning and safety of hardware placement. The use of electric high-speed drills eliminates the routine need to change out air pressure tanks required for pneumatic drills, but the differences in torque and handling change the "feel" of a procedure that involves using a high-speed drill in close proximity to the spinal nerves. Pneumatic drills were routinely used in 1995, electric drills were not available at the time of the original valuation of 22630.

The decrease in intraoperative time is a decrease in time devoted to low risk and less intense portions of the procedure (waiting on a radiology technician to obtain an intraoperative cross table lateral film, waiting on X-ray films to be developed after a flat plate film was shot to localize in surgery, waiting on air tanks to be changed out for a pneumatic drill, etc.). The decrease in intra-service time, however, is matched by a related increase in the intensity of the procedure itself. The lower intensity aspects of the procedure have been eliminated, leaving the high-risk aspects of the procedure unchanged. As the RUC noted, while the procedure may be more efficient, it is not safer or less difficult. The risks of the procedure, the possibility of neurological injury, and technical demands of the procedure are now provided in less time. Therefore, ISASS continues to recommend to CMS that the current value should be maintained.

By proposing to base the work RVU of CPT code 22630 on the reverse building block methodology, CMS disregards the input of 111 neurosurgeons and orthopedic spine surgeons, as well as the entire RUC process. The ISASS does not agree with any suggested approach that uses "reverse building block methodology" to systematically reduce work RVUs for services. ISASS strongly believes that reverse building block methodology, or any other purely formulaic approach, should not be used as the primary methodology to value services. It is inappropriate as magnitude estimation has been used to establish work RVUs for services since the publication of the first Medicare Physician Payment Schedule in 1992. This includes 010 and 090-day global codes which include post-operative office visits.

ISASS reiterates that reductions in intraoperative time from the current values to the survey values can be attributed to improvements in the intraoperative workflow and the surgical technique regarding low-risk aspects of the procedure. These low-risk aspects of the procedure

do not entail work around neural elements and the spinal cord and do not change the inherent high intensity and complexity of the procedure. The intensity of the procedure has not decreased. The RUC also noted that the total recommended time of 479 minutes is nearly identical to the current total time from the original review in 1995. Postoperative visits have decreased by one, but the level of the visits has changed, practically resulting in a net change of zero in overall physician time despite the decrease of one visit.

Finally, to justify the current work RVU of 22.09, the RUC compared the survey code to the top key reference service codes 22533 *Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar* (work RVU = 24.79, 180 minutes intra-service time and 549 minutes total time) and 22612 *Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)* (work RVU = 23.53, 150 minutes intra-service time and 482 minutes total time) and noted that the majority of respondents indicated that the overall intensity/complexity of code 22630 is somewhat or much more relative to the key reference codes.

ISASS disagrees with CMS utilizing reverse building block methodology for valuing services and strongly recommends that CMS maintain the work RVU of 22.09 which falls below the survey 25th percentile. **ISASS urges CMS to accept a work RVU of 22.09 for CPT code 22630.**

22633

For CPT code 22633, CMS disagrees with the approved RUC recommended work RVU of 26.80 and proposes a work RVU of 24.83, based on the reverse building block methodology. CMS believes its proposed work RVU is more accurate than the RUC recommended work RVU because there was no explicitly stated rationale in the RUC's recommendations for the change in intensity of intra-service time, and there was a 20-minute decrease in intra-service time for CPT code 22633.

Similar to the discussion regarding 22630, reductions in intraoperative time from the current values to the survey values are due to improvements in intraoperative work-flow and techniques regarding low-risk aspects of the procedure that do not involve work around neural elements and the spinal cord and do not change the inherent high risk of this procedure. The complexity and intensity of the procedure have not changed; instead, it is now "packed into" a shorter intra-service time.

For CPT code 22633, the RUC determined that survey respondents overvalued the physician work involved in performing this service. The RUC determined that changes in intra-service and total time for the procedure warranted a direct work RVU crosswalk to MPC code 55866 *Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed* (work RVU= 26.80, 180 minutes intra-service and 442 minutes total time) which fell below the survey 25th percentile and has identical intra-service time that appropriately accounts for the total physician work involved in this service. The RUC used a crosswalk due to the changes in visits that caused a decrease in total time, primarily due

to a change in inpatient care. Previously, there were two level-3 hospital visits and one level-2 hospital visit, this has been decreased to two level-2 and one level-1 inpatient visit along with a discharge day visit causing a substantial decrease in total time for the procedure, greater than the decrease in intra-service time; thus, a crosswalk was selected rather than recommending maintaining current value.

The RUC values services using magnitude estimation, not reverse building block methodology, and justified the crosswalk value of 26.80 work RVUs by comparing the survey code to the top key reference service code 22612 *Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)* (work RVU = 23.53, 150 minutes intra-service time and 482 minutes total time) and 2nd key reference code 22857 *Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar* (work RVU = 27.13, 180 minutes intra-service time and 550 minutes total time).

While acknowledging changes in intra-service and total time for the procedure, ISASS disagrees with the use of reverse building block methodology and concurs that CPT code 22633 should be valued based on a direct work RVU crosswalk to CPT code 55866 which falls below the survey 25th percentile. **ISASS urges CMS to accept a work RVU of 26.80 for CPT code 22633.**

22634

For CPT code 22634, CMS proposes a work RVU of 7.30, rather than the RUC recommended work RVU of 7.96, based on a comparison to its base code, CPT code 22633. The proposal is derived by dividing the proposed parent code's work RVU by its current work RVU and multiplying it by the current work RVU for add-on code 22634. The RUC noted that the current value for 22634 is also based on a calculation in 2011 that estimated the new add-on code was 70% of the survey 25th percentile work RVU. CMS proposes a new and flawed approach to determine the RVU and claims that it accounts for the decrease in intra-service time. Meanwhile, using a well-established and consistent process involving many stakeholders, the RUC recommends a decrease in the work RVU for this code to account for the five-minute decrease in median intra-service time and recommends 65 minutes of intra-service time as supported by the survey.

By proposing to establish the work RVU for CPT code 22634 using an arbitrary equation based on its base code, CMS disregards the input of from 111 neurosurgeons and orthopedic spine surgeons and the RUC in its entirety. ISASS strongly believes that any purely formulaic approach should not be used as the primary methodology to value services. This differs from the RUC methodology to utilize survey data to determine the RVU and then compare it with key reference codes based on similar intra-service time and total time. This approach utilizes clinical expertise to support the final recommendation from physicians who are experts in their given field.

The RUC noted that the survey code is well bracketed by comparator codes 34820 *Open iliac*

artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure) (work RVU = 7.00, 60 minutes intra-service and total time) and 33746 *Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catheterization for congenital cardiac anomalies, and target zone angioplasty, when performed (e.g., atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); each additional intracardiac shunt location (List separately in addition to code for primary procedure)* (work RVU = 8.00, 60 minutes intra-service and total time). CMS notes that its proposed value is bracketed by similar comparison codes (CPT codes 34820 and 34833), calling to question the use of a formula rather than the robust survey data.

Using magnitude estimation, the RUC concluded that CPT code 22634 should be valued at the 25th percentile work RVU, less than the current value, and supported by the survey. **ISASS urges CMS to accept their methodology and recommendations and finalize a work RVU of 7.96 for CPT code 22634.**

63052

CMS disagrees with the RUC's work RVU recommendation of 5.70 for CPT code 63052 which accounts for an increase in intra-service time from the most recent survey. Rather, CMS proposes to maintain a work RVU of 4.25 as finalized in the CY 2022 MFS Final Rule. CMS based its value on a crosswalk to CPT code 22853 *Insertion of interbody biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure)* (work RVU = 4.25 and 45 minutes intra-service time) and proposes to maintain this value because the intra-service times now match.

CPT code 22853 is not a valid crosswalk code because it does not entail the work of decompressing neural elements and removing compression around the spinal cord. Further, 22853 should not be used as a crosswalk due to multiple process issues regarding its valuation. The RUC recommended value for 22853 of 4.88 work RVUs was less that the 5.25 work RVUs recommended by the physician survey. A crosswalk was used to define the value of 22853, comparing the code to 57267 *Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (List separately in addition to code for primary procedure)* (work RVU = 4.88, 45 minutes total time). CMS ignored the extensive RUC rationale and instead imposed a value for 22853 at 4.25 work RVUs. By using 22853 to value 63052, a code surveyed twice recently with consistent values, CMS is using an invalid method to propose a work value for 63052.

The RUC noted that the intra-service time increased by five minutes to a total of 45 minutes and that the time included in this add-on service is essentially all high-risk. The lower intensity surgical exposure activities have already been completed with the base code, so the physician

work of 63052 involves only the high intensity, dangerous aspects of neural element and spinal

cord decompression. This is distinct from other add-on codes, such as CPT code 63035 which involve lower intensity but time-consuming work. Therefore, we believe that the intra-service time for CPT code 63035 is not comparable to the work done in the intra-service time for CPT code 63052 and 63053 which is all highly intense and complex.

CMS states that commenters on the CY 2022 MFS Proposed Rule supported the brackets for CPT code 63052. The Agency reiterates the RUC's comments which compared CPT code 63052 to the key reference service code 22552 *Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for primary procedure)* (work RVU = 6.50 and 45 minutes intra-service time) and noted that the reference code has slightly higher intensity as anticipated for a surgical procedure and in comparison, with a lumbar procedure. CMS also restates the RUC comparison of CPT code 63052 to MPC code 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)* (work RVU = 4.13 and 40 minutes intra-service time) which notes that the MPC code involves open femoral artery exposure by groin incision and closure of the wound, typically for separately reported delivery of an endovascular prosthesis for an asymptomatic infrarenal abdominal aortic aneurysm. In comparison, exposure and closure for the survey code are performed as part of the primary arthrodesis code and the intra-service time includes higher intensity bony and soft tissue resection (typically pathologic and not normal in nature) and decompression of neural elements in immediate high-risk proximity of the pathologic anatomy. Therefore, although both codes require the same time, the physician work and intensity of 63052 is greater than 34812. ISASS submits that these bracket codes are still supported and appropriate to justify a work RVU of 5.70.

CMS states that "it is best for entire code families to be surveyed at the same time." However, the CMS proposal to maintain the value CMS set for CPT code 63052 in the 2022 Final Rule disregards the recent survey of the entire code family from April 2021. Survey results from 111 neurosurgeons and orthopedic spine surgeons and the RUC determined that the survey 25th percentile work RVU of 5.70 appropriately accounts for the physician work involved in this add-on service. Suggesting a crosswalk value to a code valued by crosswalk is an unreliable method of valuation that completely ignores a survey of 111 practicing spine surgeons and the efforts of the RUC to establish appropriate relativity.

ISASS and other relevant spine surgery societies met with CMS on 08-25-22 in order to urge CMS to reconsider the RUC-recommended value for 63052. One CMS reviewer in particular queried the intensity of the work involved in 63052; an extended discussion thus followed. The spine surgeons in the meeting described in detail the step-by-step work involved in the extensive decompression to create the space necessary to alleviate stenosis-compromised neural elements encountered with a TLIF indication, which is both physically and mentally demanding, requiring precise work. There is no opening or closing work, or any work done

outside/extrinsic to the actual vertebral elements as all the work, which is both high risk and high intensity, is intrinsic to resecting bony elements and to facilitating tedious neural decompression. From a coding perspective, the ZZZ global period ("add on") for Arthrodesis Decompression (63052/63053) is performed AFTER the work of the base codes 22630/33 is completed. Therefore, 63052 should be valued to reflect this higher sustained level of intensity in comparison to other, albeit less intense spine surgery add-on codes; CPT code 63035 and 63048 are clearly NOT comparable work efforts by the surgeon. The work for both 63052 and 63053, as indicated by survey respondents, is much more intense and the values assigned by the RUC capture this correctly.

ISASS urges CMS to accept a work RVU of 5.70 for CPT code 63052.

63053

In the CY 2022 MFS Final Rule, CMS finalized a value of 3.19 for CPT code 63053 based on an intra-service time ratio and now proposes to modify the work RVU to 3.78 based on a revised intra-service time ratio between CPT codes 63052 and 63053 (40 minutes/45 minutes) * 4.25 = 3.78). ISASS strongly disagrees with CMS calculating intra-service time ratios to account for changes in time. This approach ignores magnitude estimation and is inconsistent with RBRVS principles. CMS is not using a valid method to propose a work RVU for CPT code 630XX by offering a value based on an intraoperative time ratio. The second survey of 63053 included more respondents who routinely perform this procedure. The RUC acknowledged the survey times for 63053 accurately reflected the work.

CMS disregards the input of 111 neurosurgeons and orthopaedic spine surgeons and the RUC by proposing to base the work RVU of code 63053 on an intra-service time ratio. ISASS strongly recommends a work RVU of 5.00 for CPT code 63053 that supports the survey 25th percentile. The new survey from April 2021, which included all six codes in the family, elicited an intra-service time of 40 minutes, which is only five minutes less than the work related to 63052 and is believed to be a more accurate reflection of the difference in work between laminectomy/ facetectomy/foraminotomy with decompression of the first segment and of an additional segment.

To justify a work RVU of 5.00, the RUC compared CPT code 63053 to several comparator codes with the same intra-service time. The RUC compared the survey code to top key reference service code 22614 *Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)* (work RVU = 6.43, 40 minutes intra-service and total time) and noted that while the codes have identical intra-service time, the reference code is more intense and is appropriately valued higher than the survey code using magnitude estimation. The RUC compared the survey code to MPC code 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)* (work RVU = 4.13, 40 minutes intra-service and total time) and noted that the MPC code involves open femoral artery exposure by groin incision and closure of the wound, typically for separately reported delivery of an endovascular prosthesis for an asymptomatic infrarenal

abdominal aortic aneurysm (AAA). In comparison, exposure and closure for the survey code are performed as part of the primary arthrodesis code and the intra-service time for 63053 includes bony and soft tissue resection (typically pathologic and not normal in nature) and decompression of neural elements in immediate high-risk proximity of the pathologic anatomy. Therefore, the physician work and intensity of 63053 is appropriately greater than 34812.

Similar to CPT code 63052 the work done for 63053 is only the complex work done in the interspace with no exposure work or removal work and is therefore distinct from other add-on codes, such as CPT code 63035 which involve lower intensity but time-consuming work. Therefore, we believe that the intra-service time for CPT code 63035 is not comparable to the work done in the intra-service time for CPT code 63052 and 63053 which is all highly intense and complex.

ISASS and other relevant spine surgery societies met with CMS on 08-25-22 in order to urge CMS to reconsider the RUC-recommended value for 63053. One CMS reviewer in particular queried the intensity of the work involved in 63053; an extended discussion thus followed. The spine surgeons in the meeting described in detail the step-by-step work involved in the extensive decompression to create the space necessary to alleviate stenosis-compromised neural elements encountered with a TLIF indication, which is both physically and mentally demanding, requiring precise work. There is no opening or closing work, or any work done outside/extrinsic to the actual vertebral elements as all the work, which is both high risk and high intensity, is intrinsic to resecting bony elements and to facilitating tedious neural decompression. From a coding perspective, the ZZZ global period ("add on") for Arthrodesis Decompression (63052/63053) is performed AFTER the work of the base codes 22630/33 is completed. Therefore, 63053 should be valued to reflect this higher sustained level of intensity in comparison to other, albeit less intense spine surgery add-on codes; CPT code 63035 and 63048 are clearly NOT comparable work efforts by the surgeon. The work for both 63052 and 63053, as indicated by survey respondents, is much more intense and the values assigned by the RUC capture this correctly.

ISASS recommends that CMS embrace the input from practicing physicians when valid surveys are conducted, rigorous review by the specialty society committees was performed, and review of magnitude estimation and cross-specialty comparison has been conducted by the RUC.

ISASS urges CMS to accept a work RVU of 5.00 for CPT code 63053.

Lumbar Laminotomy with Decompression (CPT codes 63020, 63030, and 63035)

In October 2018, CPT code 63030 was identified by the RUC as having a site of service anomaly when compared to Medicare utilization data. The Medicare data from 2014 through 2017 indicated that CPT code 63030 was performed less than 50 percent of the time in the inpatient setting yet included inpatient hospital evaluation and management (E/M) services within its global period. CPT codes 63020, 63030, and 63035 were surveyed. CMS disagreed

with the RUC recommended work RVUs for all three codes because CMS believes the recommendations do not account for the surveyed changes in time and code 63630 did not apply the CMS 23-hour stay policy appropriately.

63020

CMS disagreed with the RUC work RVU recommendation of 15.95 for CPT code 63020. CMS references a time ratio calculation and proposes a direct crosswalk to CPT code 27057 *Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (e.g., gluteus medius,gluteus minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle) with debridement of nonviable muscle, unilateral* (work RVU = 14.91, 90 minutes intra-service time, and 389 minutes total time). The RUC recommended the survey 25th percentile work RVU using magnitude estimation from a valid survey of physicians who perform this service. The RUC recommended work RVU appropriately accounts for the decrease in intra-service time and therefore, it did not need to be decreased further. In addition, the RUC considered the key reference service 63047 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; lumbar* (work RVU = 15.37, 90 minutes intra-service time, and 362 minutes total time) as strong support for the 25th percentile as both closely match 63020 and have almost identical pre-, intra-, and post-service times and visits.

ISASS urges CMS to use valid survey data to establish work RVUs when possible, instead of a calculated value supported by another code in the payment schedule with no clinical relevancy. CPT code 27057 is a rarely performed procedure (<30) for a significantly different patient population making it an inappropriate comparison that discounts the time, work, and intensity required to perform CPT code 63020.

ISASS disagrees with directly crosswalking the work RVU from CPT code 27057 to code 63020. CPT code 63020 requires removal of bone, along with dissection around nerve roots and the spinal cord, whereas 27057 only requires the soft tissue work of a fasciotomy. The physician work described by 27057 does not entail the same intensity of work required by 63020, does not include significant risk of paralysis, and does not require routine use of fluoroscopy and image guidance to perform the procedure. Positioning for 63020 requires use of the Mayfield headrest and is more complex than a routine prone positioning for 27057. CPT code 27057 includes gluteal muscle debridement, which is tedious and time consuming, but not as complex as work involving the resection of bone and retraction of spinal nerves.

ISASS urges CMS to accept a work RVU of 15.95 for CPT code 63020.

63030

CMS disagreed with the RUC recommended work RVU of 13.18 for CPT code 63030 because they state that the CMS 23-hour stay policy was not calculated correctly. For code 63030, CMS states “the work RVUs for services that are typically performed in the outpatient setting and require a hospital stay of less than 24 hours may in some cases involve multiple overnight stays

while the patient is still considered to be an outpatient for purposes of Medicare payment. Because such services are typically furnished in the outpatient setting, they should not be valued to include inpatient postoperative E/M visits." However, in this same Proposed Rule, CMS has accepted the revised E/M services codes that combined inpatient and observation (outpatient) services because they represent identical physician work. Therefore, it is inconsistent for CMS to state in one part of the Rule that code 99231 cannot be included in the valuation of a global code, and in another part of the same Rule that code 99231 represents physician work for both inpatient and observation (outpatient) (e.g., 99231, *Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded*). When the RUC reviewed CPT code 63030, it was noted that the physician service times stayed the same and the only adjustment was the change in post-operative visits—one less facility visit and a higher level of an office visit. The survey indicated that the physician total work was much higher than the current value based on magnitude estimation compared with similar services, with a survey median work RVU of 15.46 and the 25th percentile work RVU of 15.31. Therefore, the RUC recommended maintaining the work RVU of 13.18 accounting for the change in post-operative facility and office visits and to maintain the correct rank order with the cervical laminotomy service, CPT code 63020 and key reference CPT code 63047. In addition, and more importantly, the RUC determined that the recommended work RVU of 13.18 already takes into consideration the CMS policy reduction of work RVUs related to the post-op visits. The true starting work RVU is the survey median and the proposed RUC work RVU is below the 25th percentile – many work RVUs less than the work RVUs that would be subtracted per the CMS 23-hour policy. Reducing CPT code 63030 to a work RVU of 12.00 without considering the relation to 63020 causes a disproportionate difference between the values of these services.

CMS indicates that their proposed work RVU is higher than using total time ratio math (which is based on changes to time per the 23-hour policy) and higher than using reverse building block (which is contrary to the valuation of the code based on magnitude estimation). CMS also notes their value is bracketed by CPT codes 28725 *Arthrodesis; subtalar* (work RVU = 11.22, 90 minutes intra-service time, and 298 minutes total time) and 58720 *Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)* (work RVU = 12.16, 90 minutes intra-service time, and 309 minutes total time). However, the RUC work RVU recommendation of 13.18 is bracketed by codes 53500 *Urethrolysis, transvaginal, secondary, open, including cystourethroscopy (e.g., postsurgical obstruction due to scarring)* (work RVU 13.00, 90 minutes intra-service time, and 289 minutes total time) and 33203 *Insertion of epicardial electrode(s); endoscopic approach (e.g., thoracoscopy, pericardioscopy)* (work RVU = 13.97, 90 minutes intra-service time, and 326 minutes total time). As with code 63020, CMS proposed to use math and discounted work (i.e., time instead of visit work RVUs and half visits) instead of magnitude estimation.

ISASS urges CMS to accept a work RVU of 13.18 for CPT code 63030.

63035

For CPT code 63035, CMS is proposing a work RVU of 3.86 based on a reverse building block methodology to account for the 11-minute increase in intra-service time. The proposed value is between the surveyed 25th percentile value of 3.50 and the ISASS recommended survey median work RVU of 4.00. CMS references CPT code 50706 *Balloon dilation, ureteral stricture, including imaging guidance (e.g., ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure* (work RVU = 3.80, 60 minutes intra-service and total time total time) and CPT code 63621 *Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional spinal lesion (List separately in addition to code for primary procedure*) (work RVU = 4.00, 60 minutes intra-service and total time) to support the proposed value. However, there are 34 RUC reviewed procedure ZZZ add-on codes with 60 minutes of intra-service time and even the 25th percentile work RVU for this group of procedure codes is 4.44 or more than the RUC recommendation of 4.00. Of the 34 codes, only five codes are less than 4.00 work RVUs and these are office-based or radiology department services. CPT code 63035 represents an additional level of a major surgical procedure that is more intense and more complex than these five codes.

CPT code 63035 was a Harvard valued code with time and work values that were generated from the base code 63030, which has since been resurveyed twice. The Harvard survey did not include all the surgical specialties that now perform this service, with only 17 responses from neurosurgeons. Therefore, the previous intra-service time should not be used to arrive at a calculated value.

ISASS is concerned that CMS did not address the compelling evidence provided and proposed a work RVU using calculations that ignore clinical relativity instead of magnitude estimation, which is the basis for the Medicare Physician Payment Schedule since its implementation. ISASS requests that CMS address this rationale, as CMS has a long-standing history of adopting the same compelling evidence standards since the first Five-Year Review and continues this practice when reviewing potentially misvalued services annually.

ISASS recommends the survey median of 4.00 work RVUs based on the survey time of 60 minutes from the neurosurgeons and orthopedic surgeons who perform this service. The RUC recommended work RVU appropriately accounts for the correct time and uses magnitude estimation when compared with 34 RUC reviewed ZZZ add-on codes with 60 minutes of time.

ISASS urges CMS to accept a work RVU of 4.00 for CPT code 63035.

Evaluation and Management (E/M) Visits

ISASS again recommends that CMS apply the office E/M visit increases to the office visits, hospital visits and discharge day management visits included in the surgical global payment, as it has done historically.

Split (or Shared) Services

ISASS appreciates CMS proposing to delay, until January 1, 2024, the requirement that only the physician or qualified health professional (QHP) who spends more than half of the total time with the patient during a split or shared visit can bill for the visit. We urge CMS to allow physicians or QHPs to bill split or shared visits based on time or medical decision-making. The CPT/RUC Workgroup on E/M will convene to address clarification and definitional requirements for split or shared visits.

ISASS also appreciates CMS proposing to delay, until January 1, 2024, the requirement that only the physician or qualified health professional (QHP) who spends more than half of the total time with the patient during a split or shared visit can bill for the visit. CMS cites the concerns raised by the AMA and 46 national medical specialty societies in our March 29th letter that adopting this policy change would drastically disrupt team-based care and interfere with the way care is delivered in the facility setting. We urge CMS to allow physicians and QHPs to bill split or shared visits based on time or medical decision-making.

We understand that CMS believes time-based billing is auditable; however, CMS has a long history of auditing E/M services based on documentation in the medical record substantiating appropriate billing based on history, exam, and medical decision-making. We see no reason why CMS would be unable to continue to use these same program integrity levers to audit split or shared visits billed on the basis of time or medical decision-making.

We strongly urge CMS not to disrupt team-based care in the facility setting and to revise the split or shared visit policy to allow the physician or QHP who is managing and overseeing the patient's care to bill for the service. We look forward to providing additional input following the CPT/RUC Workgroup on E/M's meeting on split or shared visits.

Office Visits Included in Codes with a Surgical Global Period

As stated in previous communication with the Agency and reviewed above, ISASS strongly believes it is appropriate to apply the increased 2021 valuation of the office E/M visits to the visits incorporated in the surgical global packages and disagrees with the CMS decision to not apply the office E/M visit increases to the visits bundled into global surgery payment. ISASS also believes that the increases in the hospital visits and discharge day management services should be applied to the surgical global period.

CMS has incorrectly maintained that the visits in the global package codes are not directly included in the valuation. Rather, the work RVUs for procedures with a global period are generally valued using magnitude estimation.

We agree that RUC survey methodology uses magnitude estimation to develop work RVU recommendations that are relative to other codes in the physician fee schedule. However, the

basis of the fee schedule—the work done during the Harvard study—is a building block method that used time and intensity that was directly surveyed and/or extrapolated to develop the initial work RVUs in the first fee schedule in 1992. The RUC's method of "magnitude estimation" has consistently identified and used component comparisons of pre, intra, and post times along with number and level of visits to assess relativity. The RUC also uses total time (including total E/M time) to compare relativity between codes with different global periods.

To maintain the relativity which was established in 1992, CMS has twice (1998 and 2007) adjusted the work RVUs and time for global codes to account for adjustments to work and time for office visit E/M codes. The issue that CMS raises in this rule regarding MACRA legislation to review the number and level of visits in global codes is not related to maintaining relativity across the fee schedule based on current data in the CMS work/time file.

By failing to adopt all the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC)-recommended work and time values for the revised office visit E/M codes for CY 2021, including the recommended adjustments to the 10- and 90-day global codes, CMS improperly proposes to implement these values in an arbitrary, piecemeal fashion.

It also violates the basic operating payment methodology in the Medicare Physician Fee Schedule and implies that the same work done by different types of physicians and for different reasons have different value. We do not believe CMS intends this, however, if global payments are not adjusted, CMS opens the door to specialty-based payments for services which could lead to a wholesale revaluation of all services in the MPFS based on the "value" of each specialty type. This would be unsustainable and have profoundly negative impacts on patient care.

It is highly inappropriate for CMS to continue to not apply the RUC-recommended changes to global codes. If CMS finalizes the proposal to adjust the inpatient E/M code values, the agency should also apply these updated values to the global codes along with the updated 2021 outpatient visit codes. It is imperative that CMS take this crucial step.

Request for Information: Medicare Potentially Underutilized Services

In the proposed rule, the Agency announced it is soliciting comments on potentially underutilized Medicare services. The Agency indicates they are considering using their statutory authority to promote review of families that services that are underutilized by Medicare beneficiaries and asking for comments on what some of these services are and how to create additional incentives that might increase utilization and increase access to Medicare beneficiaries.

ISASS commends this initiative and proposal and the thinking behind it. ISASS believes there are many services that are underutilized by Medicare beneficiaries such as CPT code 22867 which currently has an economic barrier to access for this service and has resulted in lower

quality care for a burgeoning Medicare population of patients, thus exhibiting a flat utilization curve. ISASS recommends CMS strongly consider increasing financial incentives to providers who treat Medicare patients suffering with significant back pain and functional decline. ISASS also recommends that CMS use their authority and this initiative to solicit and review data on services that are based on newer technologies and approaches that provide better patient outcomes and higher quality and can be performed in less intense settings. This is especially true for many spine surgeries where innovation has transformed the types of interventions patient can access but unfortunately, because reimbursement is in part based on whether patients have inpatient visits included in their global periods, physicians get underpaid when they perform these newer, safer, higher quality procedures because the RVUs are lower. This is costing Medicare and the entire health care system billions of dollars and those savings alone would more than offset any increases in physician reimbursement.

ISASS appreciates the opportunity to comment on underutilization of vital services and recommends CMS consider increased financial incentives for treatments that when done clinically appropriately and consistently can reduce costs but increase patient quality and satisfaction. This is a unique opportunity to improve physician payment rates while saving the system many billions of dollars.

Rebasing and Revising the Medicare Economic Index (MEI)

The MEI, first implemented in 1975, has long served as a measure of practice cost inflation and a mechanism to determine the proportion of payments attributed to physician earnings and practices costs. The MEI measures changes in the prices of resources used in medical practices including, for example, labor (both physician and non-physician), office space and medical supplies. These resources are grouped into cost categories and each cost category is assigned a weight (indicating the relative importance of that category) and a price proxy (or proxies) that

CMS uses to measure changes in the price of the resources over time. The MEI also includes an adjustment to account for improvements in the productivity of practices over time.

From 1975, when payments reflected the usual, customary and reasonable charge payment methodology, through 1993, the year after implementation of the Resource Based Relative Value Scale (RBRVS), the physician earning component was 60% and the practice expense component, including professional liability insurance (PLI) costs, was 40%. These initial weights were derived from data obtained from the AMA. In the nearly 50 years since the initial establishment of the MEI, data collected by the AMA has served as the consistent source of information about physicians' earnings and their practice costs.

In 1993, the MEI components were updated, using AMA data and then proportioned to 54.2% Physician Work, 41% Practice Expense and 4.8% PLI. Currently, the allocation is 50.9% Physician Work, 44.8% Practice Expense and 4.3% PLI. The CMS proposal is to dramatically shift payment allocation away from physician earnings (work) to practice expense: 47.3% Physician Work, 51.3% Practice Expense and 1.4% PLI using non-AMA data.

MEI History

	1975-1992	1993	Current	Proposed
Physician Work	60%	54.2%	50.9%	47.3%
Practice Expense	40%	41.0%	44.8%	51.3%
Professional Liability Insurance	(incl with PE)	4.8%	4.3%	1.4%

The current MEI weights are based on data obtained from the AMA's Physician Practice Information (PPI) Survey. This survey was last conducted in 2007/2008 and collected 2006 data. As discussed below, the AMA is actively engaged in a process to collect these data again.

CMS proposes to update the MEI weights using 2017 data from the United States Census Bureau's Service Annual Survey (SAS). However, the Agency clarifies that they will not implement these new weights in 2023 as they must first seek additional comments due to significant redistribution. The proposed shift in payment weights from physician work to practice expense principally favors Diagnostic Testing Facility (+13%), Portable X-Ray Supplier (+13%), Independent Laboratory (+10%) and Radiation Therapy Centers (+6%) to the detriment of Cardiothoracic Surgery (-8%), Neurosurgery (-8%), Emergency Medicine (-8%), and Anesthesiology (-5%). Modest increases occur to specialties who provide services in the office with extremely expensive disposable supplies embedded into physician payment. Primary Care would face decreases (Family Medicine (-1%), Geriatrics (-2%), Internal Medicine (-2%) and Pediatrics (-2%). Meanwhile, a recent new study published in the *Journal* of General Internal Medicine found that a primary care physician would need 27 working hours per day in order to provide a 14h/day of guideline-recommended preventive care for example.[7] The same article suggests a team-based care approach might help in this regard but that approach is currently under the planned CMS split or shared visit chopping block. Physicians are at the precipice of the tipping point.

In summary, this proposal redistributes physician payment from physician work to the business side of healthcare. This proposal is particularly unfortunate as physicians face uncertainty about the Medicare conversion factor and continue to suffer from burnout. The Administration should be doing more to emphasize the importance of physicians, rather than directing resources away from their individual contributions.

Thank you for your time and consideration of ISASS comments. We greatly appreciate the opportunity to participate in efforts to more efficiently and accurately capture current spine care delivery. We commend CMS on its continued efforts to improve care quality and access.

[7] Porter J. Revisiting the Time Needed to Provide Adult Primary Care, *J of Gen Int Med*, 01 July 2022, doi: 10.1007/s11606-022-07707-x PMID: 35776372

If you have any questions on our comments, please do not hesitate to contact Morgan Lorio, MD, Chair of the ISASS Coding and Reimbursement Task Force at mloriomd@gmail.com.

Sincerely,

Morgan Lorio, MD
Chair, ISASS Coding and Reimbursement Task Force