



September 8, 2017

Seema Verma, MPH, Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-5517-P, PO Box 8016  
Baltimore, MD 21244-8016

VIA ELECTRONIC FILING

**Re: [CMS-1676-P] RIN 0938-AT02  
Medicare Program; Revisions to Payment Policies under the Physician Fee  
Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings  
Program Requirements; and Medicare Diabetes Prevention Program**

Dear Administrator Verma:

The Spine Intervention Society (SIS), a multi-specialty association of more than 2,600 physicians dedicated to the development and promotion of the highest standards for the practice of interventional procedures in the diagnosis and treatment of spine pain, would like to take this opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) Proposed Rule on the Medicare Program's Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018 published in the Federal Register on July 11, 2017.

SIS appreciates the opportunity to provide input and comments to CMS and to work closely with the agency in the development of the physician fee schedule rules and regulations. SIS is committed to collaborating with CMS and other healthcare stakeholders working to improve patient care and provide appropriate incentives for physicians providing quality care to Medicare patients.

SIS commends the Administration's efforts to provide regulatory relief to providers by offering greater flexibility and efficiencies. SIS has previously commented to CMS regarding the continual expansion of reporting and tracking requirements for physicians and their office staff, and the resulting escalating costs in terms of effort and resources. SIS recommends that the agency rigorously review the multiple requirements under the Physician Fee Schedule and consider methods that would simplify, reduce, and streamline these requirements for physicians and their staff. This will free physicians to spend more time in patient care, improving the care process for patients and providers alike. SIS welcomes the opportunity to directly engage with CMS on these issues and looks forward to future meetings and discussions with CMS on reducing administration inefficiency and streamlining the process for physician and physician offices.

### Low Volume Service Codes

In the proposed rule, CMS proposed to override claims data for low volume services with an expected specialty for both the practice expense and professional liability insurance valuation process. This proposal is consistent with a long-standing AMA RUC recommendation to use the expected specialty for services performed less than 100 times per year. Even a few claims made in error by one physician could result in substantial year-to-year payment swings to these codes. This has been particularly problematic when the low-volume services in Medicare are performed in significantly higher volumes in non-Medicare populations.

Subsequent to the publication of the proposed rule, the AMA RUC requested a review of all codes in the Medicare Physician Fee Schedule with fewer than 100 claims and asked participating societies to submit recommendations for codes they use commonly. SIS has reviewed the list, provided input to the AMA RUC, and recommends that CMS utilize this list for rate-setting for the CY 2018 Medicare Physician Payment Schedule. We understand that the list will require maintenance on an annual basis and SIS will collaborate with the RUC on future maintenance of the low volume list. SIS also recommends that CMS use the RUC specialty assignments recommendations for fee schedule codes that have no volume.

### Preservice Clinical Labor for 0-Day and 10-Day Global Services

CMS indicates that for the 1142 total 0-day global codes, 741 (65%) of the codes had preservice clinical labor of some kind. CMS also noted a general correlation between preservice clinical labor time and the year in which the code was reviewed. CMS is seeking comment specifically on whether the standard preservice clinical labor time of zero minutes should be consistently applied for all 0-day and 10-day global codes in future rulemaking.

The RUC PE Subcommittee assumes that 0- and 10-day global codes have no preservice clinical staff time unless the specialty representing that code can provide evidence to the PE Subcommittee that some preservice time is appropriate. The RUC agreed that, with evidence, some subset of codes in the facility setting may require *minimal* use of clinical staff; for these codes, the RUC has allocated 15 minutes when appropriate. The RUC also agreed that with evidence, some subsets of codes may require *extensive* use of clinical staff and, for those codes, has allocated 18 minutes for the non-facility and 30 minutes for the facility when appropriate. On a case-by-case basis, the RUC PE Subcommittee reviews evidence submitted by specialties to determine if the evidence justifies preservice time.

For example, many recently reviewed interventional codes are actually major procedures, but had been assigned a 0-day global status. Clinical staff preservice work is consistent with 90-day global codes; however, because these codes are 0-day, the preservice clinical staff work has been discounted. Another example is endoscopy

services where clinical staff will, among other activities, coordinate clearance for anesthesia and confirm diet and bowel prep. This necessary preservice clinical staff work cannot be performed on the day of the procedure after the patient has arrived. This is different than "minor" procedures (for example, laceration repair) where minimal or no preservice clinical staff work is required.

SIS respectfully disagrees that all 0-day and 10-day global codes should have zero preservice clinical staff time and urges CMS to allow the RUC PE Subcommittee to continue to review compelling evidence on a code-by-code basis to determine the need for preservice clinical staff time.

#### Physician Work and Practice Expense Recommendations

SIS wishes to comment on the proposed rule's physician work and practice expense RVU recommendations for services commonly performed by interventional spine specialists.

##### *Suprascapular Nerve Injection*

CMS reviewed CPT code 64418, Injection, anesthetic agent; suprascapular nerve and proposed a wRVU of 1.10. This is the work RVU recommended at the RUC and accepted by the RUC. We support the proposed value.

##### *Percutaneous Implantation of Neurostimulator Electrode Array*

CMS reviewed CPT code 64453, Percutaneous implantation of neurostimulator electrode array; cranial nerve, and 64455, Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve) for revaluation for 2017. CMS proposed work RVUs of 6.13 for 64453 and 5.76 for 64455. We believe the values recommended by CMS are appropriate for these services and commend CMS for accepting these new values, showing a recognition that the services described by the CPT descriptors are greater than at the time of prior valuation and that the work RVUs of 6.13 and 5.76 more accurately reflect the physician work involved in providing these services. We urge CMS to finalize the values of 6.13 for 64453 and 5.76 for 64455.

#### Evaluation and Management (E/M) Guidelines

In the proposed rule, CMS asked for a multi-year effort to revise the CMS Evaluation and Management (E/M) Guidelines, which were last updated in 1997. The agency indicates a desire to use this effort to reduce administrative burden on physicians and streamline E/M guidelines. CMS suggests a focus on eliminating guidelines related to history and physical examination, with greater importance placed on medical decision-making and time spent performing the service.

SIS agrees that streamlined guidelines and requirements for E/M codes would be beneficial to physicians and practices. We also believe that, if constructed correctly, streamlined E/M guidelines could improve patient experiences and overall quality. We believe that it is essential that the agency adhere to the multi-year timeline described in the proposed rule with the goal of creating the most current and appropriate set of E/M guidelines; we also encourage CMS to work closely with medical specialty societies to ensure that the guidelines reflect and accommodate the significant variation in E/M requirements across medical specialties. It is critical that all providers be involved throughout the process and SIS looks forward to working with CMS and other stakeholders on this important effort.

#### Appropriate Use Criteria (AUC)

The Protecting Access to Medicare Act (PAMA) required CMS to create a program that, effective January 1, 2017, would have denied payment for advanced imaging services unless the physician ordering the service had consulted appropriate use criteria (AUC). In previous rulemaking, CMS delayed implementation of the advanced imaging AUCs until 2018, and, in the 2018 proposed rule, the agency is proposing to further delay the requirement until January 1, 2019. This first year of reporting would be regarded as an opportunity for testing of the components of the AUCs, along with provider education, and would not affect payment to the physician providing the imaging. Furthermore, the agency is also proposing that physicians who wish to begin testing earlier could participate in a voluntary reporting period expected to begin in July 2018.

SIS believes this delay is appropriate and timely and supports the recommended actions. We also encourage CMS to provide data from testing as quickly as possible to allow the agency and stakeholders to review the testing and access potential future revisions to the AUC standards, based on actual and actionable data. We also strongly support the increased education in this area, as outlined in the proposed rule.

#### Physician Quality Reporting System (PQRS)

For CY 2018 under PQRS 2016, physicians were required to report 9 measures across 3 National Quality Strategy Domains, with one cross-cutting measure included. In this rule, CMS proposes to revise what was finalized for CY 2016 PQRS quality reporting requirements to only require physicians to report 6 measures with no domain or cross-cutting measure requirements. This proposal aligns the PQRS quality reporting requirements with the new quality reporting requirements for physicians under the Quality Payment Program (QPP).

In addition, CMS previously finalized in CY 2016 that groups of 100 or more eligible clinicians who participated in 2016 PQRS under the group reporting option (GPRO) were required to administer the CAHPS for PQRS survey. To align with the QPP

requirements, CMS proposes to make the CAHPS for PQRS survey optional under GPRO for practices of 100 or more eligible clinicians in 2016.

SIS strongly supports this proposal and the effort to align the current quality programs with the QPP standards which will take effect for CY 2019.

Value-based Modifier

In addition to the PQRs changes, CMS also proposes revisions to the value-based modifier (VM) that is designed to incentivize physicians to provide high quality care with lower costs. The agency proposes to hold harmless from any negative VM payment adjustments in 2018 all groups and solo practitioners who met 2016 PQRs reporting requirements and halve penalties for those who did not meet PQRs requirements to -2 percent for groups with 10 or more eligible professionals and to -1 percent for smaller groups and solo practitioners.

SIS strongly supports the changes to the value-based modifier as outlined in the proposed rule. We appreciate the agency acting to better align the legacy quality programs with QPP and easing penalties under the VM, which clearly has not been sufficiently developed; relying on the VM for a significant incentive was unfair to physicians who might have been inaccurately punished under the VM standards.

\*\*\*\*\*

SIS appreciates both the opportunity to provide comments and CMS' attention to these issues. We look forward to continuing to work with CMS to update and improve physician payment policies in the future.

If we may answer any questions or provide any assistance, please feel free to contact Belinda Duszynski, Senior Director of Policy and Practice, at [bduszynski@SpineIntervention.org](mailto:bduszynski@SpineIntervention.org).

Sincerely,



Timothy P. Maus, MD  
President  
Spine Intervention Society