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September 5, 2013

Marilyn B. Tavenner

Administrator

Centers for Medicare & Medicaid Services

200 Independence Avenue, SW

Hubert H. Humphrey Building

Washington, DC 20201

RE: CMS Proposed Rule (CMS-1600-P) – Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Medicare Part B for CY 2014

Dear Ms: Tavenner:

On behalf of the International Society for the Advancement of Spine Surgery (ISASS), I am writing to submit comments on the proposed Medicare Physician Fee Schedule (MPFS) for CY 2014. ISASS is an international, scientific and educational society organized to discuss and assess existing strategies and innovative ideas in the clinical and basic sciences related to spine surgery to enhance patient care.

Overall, we are very concerned with the proposal to cap payment rates for over 200 physician services at outpatient prospective payment system (OPPS) or ambulatory surgical center (ACS) rates. Such a proposal will reduce payment for some services by more than 50 percent, which will reduce or eliminate their utilization in physician offices, and will thus require patient to obtain such service in a more costly and less convenient setting.

For example, the AMA estimates that for 82 percent of the codes with proposed reductions, the direct expenses alone exceed the proposed payment rate. Additionally, the AMA analysis shows that 78 of the 211 services for which CMS proposed to reduce payments to the ASC level are already paid less under the MPFS than the OPPS rate; thus, Medicare and patients will actually pay *more*, not less, if these services are driven out of physician offices and into outpatient settings.

We are also concerned with proposals specific to proposed reductions to non-facility practice expense (PE) relative value units (RVUs) for more than 200 codes where Medicare pays more for services furnished in a physician's office than in an outpatient hospital department or ASC. CMS does not provide detailed evidence that the hospital Outpatient Prospective Payment System (OPPS) rates are more accurate for each of these codes. Instead, CMS claims that "inaccurate resource input costs may distort the non-facility PE RVUs used to calculate physician fee schedule payment rates," while "OPPS payment rates are based on auditable hospital data and are updated annually."

We believe that CMS should use a deliberate, data-driven process to set PE RVUs, rather than establish an absolute ceiling on physician rates based on reported hospital costs. CMS itself has acknowledged in recent years that OPPS rates have been skewed by charge compression – or the hospital practice of applying a lower charge markup to higher cost services, and a higher charge markup to lower cost services, which has the result of undervaluing high-cost items and overvaluing low-cost items.

CMS has taken a series of steps to create additional hospital cost centers to mitigate charge compression and improve the accuracy of OPPS rates, but these initiatives are still being implemented. We therefore are concerned about CMS automatically assuming OPPS rates are more accurate than established MPFS rates. If CMS is convinced that OPPS rates are automatically more accurate than MPFS values, CMS should also consider OPPS data when it would increase MPFS rates, not only when it serves to cut those rates.

With regard to examples specific to spine care, ISASS is concerned about the negative impact the arbitrary OPPS/ASC cap would have on physician reimbursement for kyphoplasty and vertebroplasty procedures. Based on our preliminary review of CMS data, it appears that the following CPT codes would all be subject to the OPPS/ASC cap, and the procedures would experience non-facility PE RVU cuts ranging from 27 percent to 54 percent, as illustrated in the following chart:

CPT Code	Descriptor	2013 Non-Facility PE RVUs (final)	2014 Non-Facility PE RVUs (proposed)	Percent Change 2013-2014
22520	percut vertebroplasty thor	58.41	42.64	-27 percent
22521	percut vertebroplasty lumb	59.10	42.59	-28 percent
22523	percut kyphoplasty thor	224.14	102.51	-54 percent
22524	percut kyphoplasty lumb	223.31	102.28	-54 percent
22525	percut kyphoplasty add-on	139.24	98.82	-29 percent

If adopted, reductions of this magnitude would significantly compromise patient access to these important spine procedures in the physician office setting.

While we agree that CMS could flag for further review those MPFS values that exceed OPPS rates, CMS should use its established procedures to individually review and, if appropriate, revise such potentially misvalued codes based on code-specific data, rather than automatically cap MPFS rates at OPPS levels.

Thank you for your consideration of our comments.

Sincerely,

Luis Pimenta, MD, PhD
President

Morgan P. Lorio, MD
Chair, Coding & Reimbursement Task Force