INTERNATIONAL SOCIETY for the ADVANCEMENT of SPINE SURGERY

September 27, 2019

Seema Verma, MPH
Administrator,
Centers for Medicare & Medicaid Services
Attention: CMS-1693-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via http://www.regulations.gov.

RE: File Code CMS-1715-P; CY 2020 Revisions to Payment Policies under the Physician Payment Schedule and Other Changes to Part B Payment Policies;

Dear Administrator Verma:

The International Society for Advancement of Spine Surgery (ISASS), 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. ISASS would like to comment on the Centers for Medicare and Medicaid Services' (CMS) "Revisions to Payment Policies Under the Physician Fee Schedule and Other Change to Part B for CY 2020", published in the Federal Register on July 27, 2019.

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 several issues:

- **Valuation of Specific Services for CY 2020**
  - **Minimally Invasive Sacroiliac (SI) Joint Fusion (CPT 27279)**
- **Determination of Professional Liability Insurance Relative Value Units (PLI RVUS)**
- **Payment for Evaluation and Management (E/M) Services**
  - **Work and PE Recommended Values**
  - **Office Visits Included in Global Services Packages**

Proposed Valuation of Specific Codes For CY 2020

Minimally Invasive Sacroiliac (SI) Joint Fusion, CPT code 27279 Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device

Each year, CMS identifies lists of CPT codes proposed as potentially misvalued. CPT code 27279 has been nominated several times by CMS as potentially misvalued. ISASS applauds CMS' continued recognition of this code as potentially misvalued and has consistently recommended that CMS increase the work component of this code. ISASS has commented on several occasions that we believe the code was misvalued by the AMA/Multi-Speciality Relative Value Update Committee (RUC) upon its introduction into the Medicare Physician Fee Schedule in CY 2015. ISASS became an approved member of the AMA House of Delegates at the June 2014 meeting. As such, our members were ineligible to participate in the April 2014 RUC review when CPT code 27279 was presented and discussed for valuation.

For the 2020 Physician Fee Schedule, CMS asked the RUC to review and survey CPT 27279. The RUC reviewed the recommendations from ISASS, the American Association of Neurological Surgeons/Congress of Neurological Surgeons (AANS/CNS), the American Academy of Orthopaedic Surgeons (AAOS), and the North American Spine Surgery (NASS). These relevant Spine Societies collectively recommended an increase from the current value of 9.03; however, the RUC voted that they did not accept the multi-specialty society's compelling evidence of a flawed methodology and recommended the current value of 9.03 remain. The RUC process effectively blocked the relevant spine societies from even presenting a rationale for a change in the value of 27279.

Through their actions, the RUC failed to carry through on the expectation by CMS that they would evaluate the validity of 27279 as misvalued. Not considering arguments for why the current value is inappropriate; the RUC's recommendation cannot be perceived as addressing the issue of potential misevaluation. CMS made clear in both the 2017 and 2018 Medicare Physician Fee Schedule Final Rules that the agency does believe there was and is evidence of 27279 being misvalued. The RUC had an opportunity to provide input into this question but failed to do so, abdicating a proper review of valuation. ISASS believes CMS should consider the overwhelming evidence presented by the relevant Spine societies regarding the inappropriate work RVU of 9.03; CMS should subsequently adjudicate updated work, practice expense and malpractice RVUs.

Had the RUC reviewed the April 2018 survey results and engaged in a meaningful and fair analysis, they would have noted multiple differences in the survey results of the April 2018 compared to the 2014 survey that strongly support a significantly increased work RVU for 27279. Most notably, the 2018 survey respondents had considerably more experience with the procedure, with a median 12-month experience rate of 6 compared to a median 12-month experience rate of 1 in the 2014 survey. We believe the 2018 survey results to be far more reliable and valid as a result of this change. The 2018 survey also included as a reference code,

27280, Arthrodesis, open, sacroiliac joint, including obtaining bone graft, including instrumentation, when performed which was not part of the Reference Service List in 2014 because it was concurrently being reviewed by the RUC and CMS. In the 2018 survey, with 27280 available as a key reference, it was the most commonly chose reference code. Respondents felt the work for 27279 was comparable to the overall work for 27280, indicated by the median work RVU from the 2018 survey being 18.00, close to the 20.00 work RVU for 27280. 81% of survey respondents felt that the intensity of 27279 was more or much more than the intensity of 27280, thus accounting for the similar work RVU estimates between the two procedures. CMS should use the 2018 survey results to determine the correct work RVU setting for 27279 and not adopt the RUC recommended work RVUs, as the RUC failed to even consider any of these critical indicators of overall work value for 27279. Had the RUC been reviewing 27279 as a new code in 2018, we believe the survey data presents a compelling case for a much greater value than the 9.03 work RVU currently assigned.

ISASS believes the misevaluation of CPT 27279 year after year has been a significant impediment for Medicare beneficiaries to access this cost effective, minimally invasive, efficacious, sacroiliac joint pain treatment.

It is also clear that the impact of the incorrect valuation of 27279 has led to artificially low RVUs for similar spinal procedures subsequently reviewed, in particular CPT codes 22867, Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level and 22868, Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure). Both of these codes were reviewed by the RUC and CMS in 2016. As a result of the RUC and CMS review process and use of crosswalks, a single undervaluation such as 27279 has negative impacts across the entire fee schedule. As a result of these impacts, a correct valuation of CPT 27279 will ultimately lead to improved patient outcomes and better patient experiences for Medicare beneficiaries at a lower cost to BOTH the Medicare System and patients than more invasive procedures for back pain, which cost more and most of which lack adequate evidence.

Correct payment for CPT 27279 will improve coding accuracy for both 27279 and CPT 27280. ISASS does not believe that our Medicare System or patients should be responsible for healthcare costs that are associated with miscoding. CPT 27279 currently has a work RVU of 9.03, which, as shown below, grossly underestimates the time/work involved in the procedure. At a 2015 Multi-Specialty Refinement Panel, ISASS recommended CMS provide a new value of at least 13.18 work RVUs for CPT 27279 for the 2020 Medicare Physician Fee Schedule in order to ensure access to this important treatment option for Medicare patients.

In the sections below, we compare CPT 27279 to the following procedures:

- CPT 62287, disc decompression (which was the RUC comparator crosswalk code for initial valuation in 2015)

- CPT 63030, laminotomy with decompression (which is the code identified by ISASS as the correct comparator code)
- CPT 67039, Vitrectomy, mechanical, pars plana approach (which has the same intra and total service time and is performed by surgeons)
- CPT 27280, open sacroiliac joint fusion (which is the code to describe the open approach that we are referencing for parity)

Each comparison establishes that the current work RVU of 9.03 for CPT 27279 minimally invasive sacroiliac joint fusion is currently misvalued.

Comparison to 62287

CPT 62287 describes the following procedure: Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle-based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar.

ISASS believes that CPT 62287 is an extremely poor choice to use for a crosswalk and comparison to CPT 27279. The table below compares the two CPT codes.

Table 1. Comparison of CPT 62287 and CPT 27279 2020 Proposed Medicare Physician Fee Schedule inputs.

Characteristic	**CPT 62287** Decompression procedure, percutaneous, of nucleus pulposus	**CPT 27279** Minimally Invasive Sacroiliac joint fusion
Global service period	**90 days**	**90 days**
Work RVUs	**9.03**	**9.03** **Recommended value ≥ 13.18**
Practice Expense RVUs	**6.58**	**8.46**
Malpractice RVUs	**1.14**	**2.48**
Total RVUs	**16.75**	**19.88**
Who performs procedure	**Interventional physicians: 76%** **Surgeons: 23%**	**Interventional physicians: <1%** **Surgeons: 98%**
Site of Service (Medicare2016)	**Office: 4.4%** **ASC: 57.3%** **Outpatient: 30.2%** **Inpatient: 8.0%**	**Office: 0.63%** **ASC: 3.9%** **Outpatient: 49.6%** **Inpatient: 45.8%**
Procedure approach	**Percutaneous with guided need-based placement**	**Surgical incision in lateral buttocks**
Pre-service time, minutes	**70**	**63**
Intra-service time, minutes	**60**	**60**
Post-op visits	**3 visits (99213@23 min) = 69 min** **Total 69 min**	**1 visit (99212) = 16 min** **2 visits (99213@23 min) = 46 min** **Total 62 min**
Pre + intra + immediate post + post-operative E/M visits in global period	**248**	**244**
Insertion/implantation of devices?	**No**	**Yes**
Insertion of bone graft	**No**	**Sometimes**
Surgical wound closure required	**No**	**Yes**
Patient complexity	**Typically low**	**Often high**

It is critical to note that CPT 27279 is performed by orthopedic and neurosurgeons (98% of the time in the Medicare population) who have a much higher malpractice insurance expense. CPT 62287 is performed primarily (76% of the time) by interventional physicians (radiologists, anesthesiologists and physiatrists) who have a much lower malpractice insurance expense. The malpractice RVU for CPT 27279 should be much greater than currently valued to reflect the specialty of the physicians performing the procedure. As can be seen in Table 1, CPT 27279 is a far more skill-intensive and complex procedure as compared to CPT 62287. This hospital-based procedure requires implantation of implantable devices and a surgical incision to be appropriately closed. For this reason, in addition to the inappropriately low malpractice insurance expense, the CPT 27279 RVUs are undervalued.

Comparison to CPT 67039

CPT 67039 describes the following procedure:
Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation.

This procedure was valued by CMS at 13.20 work RVUs in 2013. CPT 67039 has the same intra-service time as CPT 27279 at 60 minutes and similar total time of 260 minutes. The similarity of these two procedures in terms of intra-service and total service time further supports the recommended work RVU of 13.18 for CPT 27279.

Table 2. Comparison of CPT 63662 (Removal Spinal Neurostimulator), CPT 67039 (Vitrectomy) and CPT 27279 (SI joint fusion); 2020 Proposed Medicare Physician Fee Schedule inputs.

Characteristic	CPT 67039 Vitrectomy	CPT 27279 MIS SIJ Fusion
Global period	**90 days**	**90 days**
Work RVUs	**13.20**	**Currently 9.03** **Recommended value ≥13.18**
Malpractice RVUs	**0.98**	**2.48**
Who performs procedure	**Interventional physicians: 0%** **Surgeons: 100%**	**Interventional physicians: <1%** **Surgeons: 98%**
Site of Service (Medicare 2016)	**Office: 1.21%** **ASC: 49.10%** **Outpatient: 49.25%** **Inpatient: 0.40%**	**Office: 0.63%** **ASC: 3.93%** **Outpatient: 49.61%** **Inpatient: 45.78%**
Pre-service, minutes	**48**	**63**
Intra-service, minutes	**60**	**60**
Total, minutes	**260**	**244**
Follow-up visits	**99238 discharge** **5 post-op visits 99213**	**99238 discharge** **1 post-op visit 99212** **2 post-op visits 99213**

Comparison to 63030

CPT code 63030 describes the following procedure:
Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar is a better comparator for CPT 27279.

By way of history, CPT code 63030 was initially identified as an equivalent procedure by surgeon responders to the initial 2014 RUC survey. CPT 63030 has a work RVU of 13.18.

Substantial scientific data is cited below that support raising the RVUs for CPT 27279 (currently 9.03 and proposed for 2020) to that of CPT 63030 (currently 13.18).

- Lorio et al[1] used Rasch analysis based on two separate surveys to evaluate surgeons' estimations of the relative difficulty for various procedures including CPT 27279 (SI joint fusion), after which the work RVU was estimated by regression analysis. Using Rasch analysis, this study concluded that, for overall physician work, CPT 27279 was best matched to CPT 63030.

- Garber et al[2] concluded that work effort was greater for SI joint fusion (CPT 27279), and an equal RVU to lumbar microdiscectomy (CPT 63030) was recommended. They found surgical time was comparable between these two comparators, and that work effort for 27279 was greater than for 63030.

- Frank et al[3] asked 5 surgeons to rate various aspects of work intensity for patients undergoing sacroiliac joint fusion (CPT 27279) or lumbar microdiscectomy (CPT 63030). The authors found that the mental, physical, and temporal intra-service demands for sacroiliac joint fusion (CPT 27279) were greater than those same parameters for lumbar microdiscectomy (CPT 63030). The authors concluded that the work RVU for sacroiliac joint fusion (CPT 27279) should be adjusted upwards.

All three publications provide compelling evidence to suggest that the work RVUs for CPT 27279 should be equivalent to that of CPT 63030.

[1] Lorio M, Martinson M, Ferrara L. Paired Comparison Survey Analyses Utilizing Rasch Methodology of the Relative Difficulty and Estimated Work Relative Value Units of CPT® Code 27279. International Journal of Spine Surgery; volume 10; article 40; December 2016
[2] Garber T, Ledonio C, Polly DW. How Much Work Effort is Involved in Minimally Invasive Sacroiliac Joint Fusion? International Journal of Spine Surgery; volume 9; article 58; November 2016
[3] Frank C, Kondrashov D, Meyer SC et al. Work intensity in sacroiliac joint fusion and lumbar microdiscectomy. Clinicoecon Outcomes Res Jun 2016.

Parity with 27280

CPT 27280 describes the following procedure:
Arthrodesis, open, sacroiliac joint, including obtaining bone graft, including instrumentation, when performed.

CPT 27280 was surveyed in 2014 and finalized in the 2015 Medicare Physician Fee Schedule. 27280 has a work RVU of 20.00 which, as noted at the time, is an appropriate work RVU for the work involved in the 90-day global period assigned to 27280. We strongly believe 27280 to be accurate and appropriately valued.

However, we also believe that 27280 is being misused by facilities, based on the utilization data cited in the chart below. This misuse of coding has financial implications on the Medicare System and the Medicare beneficiaries.

Chart 1: Open SIJF Utilization, CPT 27280 (2012-2017)[4]

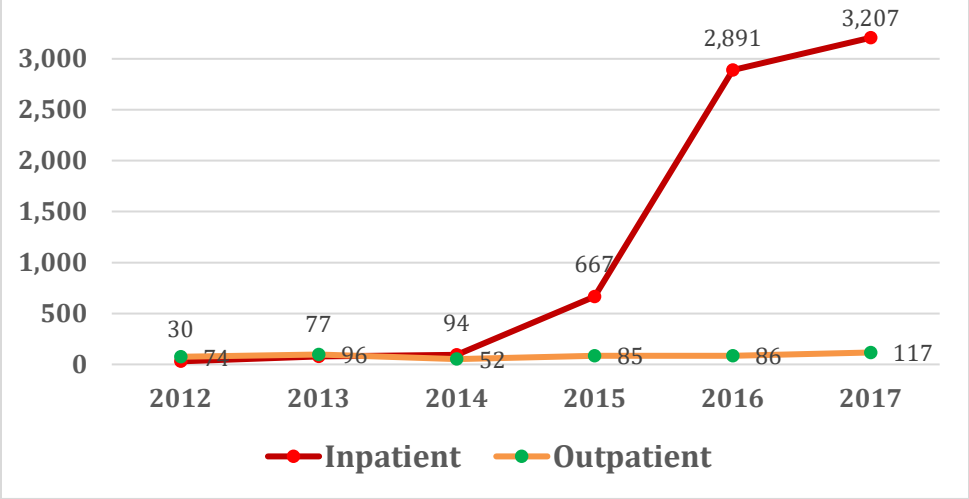

Chart 1 shows that the number of inpatient procedures as reported by CPT code 27280 has exponentially increased in the past few years. This type of increase is not clinically possible as the number of patients would not have grown at such a rate in the past five years. Correct use of 27280 would have linear and low rates of utilization change from year-to-year and not exponential increases as these data show. Clearly, facilities are moving patients into the inpatient setting, and we believe the payment disparity between CPT 27279 and CPT 27280 may be the most likely explanation. It is important to note that CPT 27280 is Status C

[4] Watson Policy Analysis, provided Jan 23, 2019. Based on CY2012-CY2017 SAF data. ICD-10 counts less than 11 were blinded and described a value of "10" where present for purposes of this analysis.
[6] 2019 Medicare IPPS Unadjusted National Payment Rate.

(inpatient only) and is assigned to DRG 460 Spinal Fusion Except Cervical without MCC which has a national average payment of $24,651.[5] CPT 27279 is performed in outpatient settings of care (HOPD and ASC) most commonly.

In the 2020 Medicare Physician Fee Schedule, CMS indicated some stakeholders suggested that 27279 should be valued equal to the open SI Joint Fusion code, 27280, which has a work RVU of 20.00 in order to eliminate potential incentives to choose a typically inpatient procedure (27280) for the same disease/condition when a typically outpatient procedure (27279) could be employed. ISASS agrees that in many situations where the patient could be safely operated on and recover for less than 24 hours in an outpatient facility that the minimally invasive option is better patient care and would lead to lower costs for payers such as Medicare and patients as well.

As additional evidence of the similar overall nature of the two SI Joint procedures, the 2018 survey for CPT 27280 conducted for review by the RUC supports similar values for 27279 and 27280. In the 2018 survey, respondents indicated that 27280 is the most appropriate reference service for 27279. Survey respondents assigned a median work RVU of 18.00, which is nearly equal to 27280, and 81% of survey respondents who chose 27280 as their key reference indicated that they believed 27279 to be more or much more intense the 27280.

If CMS is truly committed to site-of-service parity and incentivizing the most efficient and highest quality care, the value of 20.00, even if done in a pilot or an interim time period, would be recommended.

CMS could also consider an iterative approach to determine the impact of MPFS RVUs on site-of-service by implementing a work of RVU of $\geq$13.18 and an increased malpractice RVU for CPT 27279 for the 2020 Medicare Physician Fee Schedule. If there is a noticeable change in utilization of 27279 and 27280 toward appropriate coding and utilization, CMS could then consider equal value for both procedures. ISASS encourages CMS to strongly consider adopting such an approach.

Table 3. Comparison of CPT 63030 (Lumbar Laminotomy), CPT 27280 (Open SIJ Fusion) and CPT 27279 (MIS SI Joint Fusion); 2020 Proposed Medicare Physician Fee Schedule inputs.

Characteristic	CPT 63030 Lumbar Laminotomy	CPT 27279 MI SI Joint Fusion	CPT 27280 Open SI Joint Fusion
Global period	**90 days**	**90 days**	**90 days**
Work RVUs	**13.18**	**Currently 9.03 (Recommended value: ≥13.18**	**20.00**
Practice Expense RVUs	**10.99**	**8.46 (Recommended value = 63030**	**13.95**
Malpractice RVUs	**3.87**	**2.39 (Recommended value = 63030**	**5.95**
Who performs procedure	**Surgeons: 99%**	**Surgeons: 98%**	**Surgeons: 100%**
Site of Service (Medicare 2017)	**Office: 0.15% ASC: 8.60% Outpatient: 57.54% Inpatient:32.39%**	**Office: 0.13% ASC: 15.34% Outpatient: 55.96% Inpatient:28.47%**	**Office: 0.00% ASC: 1.09% Outpatient: 13.19% Inpatient:85.44%**
Pre-service, minutes	**75**	**63**	**73**
Intra-service, minutes	**90**	**60**	**60**
Total, minutes	**342**	**244**	**383**
Intensity Per Work Unit	**0.548**	**0.065 (recommended to equal at least 0.101)**	**0.101**

The correct Intensity Per Work Unit for CPT 27279 is much higher than 63030 and at least equal to CPT 27280. The intensity of the work of a minimally invasive procedure is significantly greater than open procedures such as 63030 and 27280. This suggests a value at least equal to CPT 63030 to be appropriate. Site-of-service data shows that CPT 63030 and CPT 27279 are similar while CPT 27280 is primarily an inpatient procedure; however, the data from Chart 1 shows an alarming pattern of use in the outpatient setting. If CPT 27279 is correctly valued, CPT 27280 should be closer to 100% inpatient as the patient populations would be more appropriately set.

Summary

We strongly recommend that CMS implement a new work RVU of at least 13.18 for CPT code 27279 for the 2020 Medicare Physician Fee Schedule. We also recommend that CMS update the malpractice RVU to reflect the higher malpractice costs borne by the physicians (orthopedic surgeons and neurosurgeons) performing CPT 27279. The CPT 27279 malpractice RVU should be equal to the malpractice RVU of CPT code 63030 (4.03) which is also performed by surgeons instead of the current malpractice RVU for CPT 27279 (2.05) which is based on the flawed RUC crosswalk to CPT 62287 which is performed primarily by interventional physicians, not spine surgeons.

We believe it is appropriate for CMS to use a surgical spine procedure (versus a procedure performed primarily by non-surgeons) as the appropriate work RVU crosswalk for 27279. These recommendations are consistent with standard surgical opinion and backed up by 4 peer-reviewed publications. Moreover, we believe that the methods used in the 3 publications are more valid and reliable than the arbitrarily chosen crosswalked CPT code 62287. In the spirit of scientific endeavor, CMS should rely on more rigorous methodology used by authors of the above-cited peer-reviewed publications.

We also welcome the opportunity to meet in person with the agency to further discuss this important issue and look forward to the continuation of discussions with CMS and a fair and equitable resolution of the Work and Malpractice RVUs for CPT 27279.

Determination of Professional Liability Insurance Relative Value Units (PLI RVUs)

Proposed Methodological Refinements

CMS is seeking comment on the proposed methodological improvements to the development of the professional liability insurance (PLI) premium data. CMS contracted with the Actuarial Research Corporation and has provided the *CY 2020 Medicare PFS Proposed Update to the GPCIs and PLI RVUs Interim Report* as part of its supporting documentation to the *Proposed Rule*. In the CY 2018 *Final Rule* for the Medicare Physician Payment Schedule (CMS–1676–F), CMS indicated that the Agency would not finalize its proposal to use the most recent data for the CY 2018 professional liability insurance relative value units (PLI RVUs). Significant comments were submitted concerning the accuracy of the premium data collection. The RUC appreciates the Agency's efforts to improve the data collection and methodology surrounding the PLI RVUs. The *Interim Report* describes how the process has been modified to increase the potential for obtaining premiums for historically underrepresented specialties and to reflect current understanding of the marketplace.

For CY 2020, CMS used a broader set of PLI filings, available online from the System for Electronic Rates & Forms Filing (SERFF) Filing Access Interface and largest market share insurers in each state, to obtain a more comprehensive data set. This expansion of filing subtypes beyond those listed as "physician" and "surgeon" represents a welcome methodological change from the prior update, resulting in an expanded amount of premium data available for specialties that previously had insufficient data. There were some states (non-SERFF) that did not have expanded subtypes readily available and the ISASS encourages CMS to request this from the state insurance departments in the future. The Agency was successful in acquiring national premium data for sixteen additional specialties that were formerly mapped entirely to another specialty. There is no longer mention of the arbitrary threshold that triggered the crosswalk methodology used by CMS in developing the PLI RVUs for specialties for which there was not premium data for at least 35 states.

Overall, we commend the CMS on its attempts to improve the premium data collection process. The ISASS also appreciates the opportunity to comment and to work together to make the PLI RVUs as accurate as possible for all specialties and other health care professionals. The RUC offers input below on five key areas of the PLI methodology in the *Proposed Rule*: major vs. minor surgery service risk groups; 3) imputation, partial and total; 4) low volume services; and 5) technical component (TC) only services. The RUC urges CMS to make changes in each of these areas before finalizing the 2020 PLI RVUs.

"Surgery" Service Risk Group – Minor vs. Major Surgery
CMS proposes to combine minor surgery and major surgery premiums to create the surgery service risk group, which it claims will yield a more representative surgical risk factor. In the previous PLI RVU update, only premiums for major surgery were used in developing the surgical risk factor. CMS considers surgical services with physician work values greater than 5.00 as 'major surgeries' for this analysis. The Agency recognizes that inclusion of premiums for 'minor surgery' policies as well as 'major surgery' policies from insurers that charge different premiums based on a physician's case mix has resulted in national premiums and risk factors which are lower for surgical specialties.

There are three methodological flaws in implementing this new policy. 1) The definition of "minor" vs. "major" surgery is arbitrary and has led to undervaluation of certain specialties and codes; 2) certain specialties and services are unfairly penalized as premium rates vary significantly within the specialty; and 3) the physician work RVU shares by service risk type appear to be in error and need further explanation and review.

Policy makers have attempted to define "minor" and "major" surgery for years without success. CMS has selected an arbitrary definition, assigning any CPT code in the 10000-69999 section of CPT with a work RVU below 5.00 is considered minor surgery. While this may appear to be a reasonable approach, there are exceptions that must be made. For example, there are 157 codes with a ZZZ global period and work RVUs lower than 5.00 that clearly are a component of major surgery. The RUC recommends that CMS change the assignment of the attached 157 ZZZ codes to major surgery. *(Attachment 02)*

Within specialties, physicians may subspecialize and perform very different services from other physicians in the same specialty. CMS has recognized this for decades in computing PLI RVUs. The ISASS does not object to improved premium data collection, but the application of these data into computing PLI RVUs is significantly flawed. If CMS intends to collect data at the minor vs. major surgery level, the data must result in different risk factors for those specialties and specifically applied to codes defined as minor vs. major surgery.

The specialty that appears most impacted by this flawed methodology is neurosurgery, in particular, spine surgery procedures. The proposed national PLI premiums and professional liability risk factors by CMS specialty and service risk group (*Interim Report* Table 7.C) demonstrate a 17% reduction in the national premium for neurosurgery from $103,010 to $85,412 which translates to a reduction in the risk factor from current 12.26 to 9.60 for CY

2020. *TABLE 110: CY 2020 PFS Estimated Impact on Total Allowed Charges by Specialty* in the *Proposed Rule* indicates a -1% reduction to neurosurgery allowed charges and a +1% increase in interventional pain medicine. This, along with dramatic decreases in neurosurgery PLI RVUs for major surgery and increases in PLI RVUs for minor surgery interventional pain procedures, illustrate the unfair impact of the application of the minor vs. major surgery premium distinction. If CMS plans to retain this methodology, separate risk factors must be developed for neurosurgery (and other impact surgical specialties) that are then applied to codes to correspond to those physicians who are performing the procedures. A neurosurgeon removing a brain lesion, who has PLI premiums $100,000+, should not be penalized because peers in the same specialty have significantly lower premiums reflecting their performance of mostly minor surgery/procedures, such as spine injections.

Table 8.B Volume-weighted distribution of 2019 Physician Work RVUs by Service Risk Type by CMS Specialty contains errors for at least some of the specialties. The table indicates that both neurology and neurosurgery share of total work RVUs–no surgery is 70%. This figure is NOT accurate for either neurosurgery or neurology. Neurosurgery's share of surgery RVUs (codes in 10000-69999 range) is 80%, leaving 20% as the correct share of total work RVUs – no surgery. Neurology's share of total work RVUs – no surgery is 95%. The table indicates that both cardiology and cardiac surgery share of total non-surgical work RVUs is 80%. This figure is NOT accurate for either cardiac surgery or cardiology. Cardiac Surgery's share of surgical RVUs (codes in 10000-69999 range) is 83%, leaving 17% as the correct share of total non-surgical work RVUS. Cardiology's share of total non-surgical work RVUs is 87%.

There is a fundamental flaw in these computations, and it is not known if this expands beyond these four specialties. The RUC recommends that CMS either abandon the distinction of minor vs. major surgery in premium data collection or create different risk factors for these surgical specialties and apply to codes in the same manner as the current application of surgery vs. non-surgery premium data.

Payment for Evaluation and Management (E/M) Outpatient and Office Visit Codes (99201-99205, 99211-99215

In the 2020 Proposed Rule, CMS accepted RUC recommended adjustments to Work and Practice Expense RVUs for Evaluation and Management services in the Outpatient/Office setting-CPT codes 99201-99215. The set of codes reviewed have had revisions made for CPT 2021 and CMS proposes to adopt the new CPT descriptors and recommended work RVUs for the Medicare Physician Fee Schedule starting in Cy 2021.

ISASS does not agree with the recommended work and PE RVU changes and does not believe that there should be changes to the time or value of the office visit E/M codes until physicians are educated and there is more experience with the new coding system. Only then can we obtain reliable feedback and information regarding the time and work involved.

We note that the impetus to make changes to E/M coding came from CMS as a way to reduce physician burden. We appreciate that CMS has already gone a long way to reduce burden with policy changes. For example, for 2019 CMS reduced the amount of work necessary for documentation by allowing ancillary staff to enter information that is reviewed by the physician and signed rather than entered or re-entered by the physician. For 2021 the proposed new coding system will also rely on medically appropriate H&P documentation or time rather than the current system. This potentially will also reduce physician burden. We believe the survey of the revised codes was premature and urge CMS to delay consideration of the survey time and values that were recommended by the RUC.

Global Surgical Packages

In addition to the RUC-recommendations regarding physician work, time, and practice expense for office E/M visits, the RUC also recommended adjusting the work RVUs for codes with a global period to reflect the changes made to the work RVUs for office E/M visits. Procedures with a 10- and 90-day global period have postoperative visits included in their valuation and each global procedure has at least one-half of an E/M visit included in the CMS time/work file.

CMS mistakenly states in the proposed rule 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. For example, a decrease in inpatient visits is offset by an increase in office visits, such that the value should be maintained. 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 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 is highly inappropriate for CMS to move forward with the proposal to not apply the RUC-recommended changes to global codes. If CMS finalizes the proposal to adjust the office/outpatient E/M code values, the agency must also apply these updated values to the global codes. It is imperative that CMS take this crucial step because to do otherwise will:

- ***Disrupt the relativity in the fee schedule***: Applying the RUC-recommended E/M values to stand-alone E/Ms, but not to the E/Ms that are included in the global surgical package since the inception of the fee schedule, will result in disrupting the relativity between codes across the Medicare physician fee schedule. Changing the values for some E/M services, but not others, disrupts this relativity, which was mandated by Congress and established in 1992 and refined over the past 27 years. Indeed, since the inception of the fee schedule, E/M codes have been revalued four times — in 1993 (through refinement after implementation of extensive E/M coding changes, 1997 (after the first five-year review, 2007 (after the third five-year review) and 2011 (after CMS eliminated consult codes and moved work RVUs into the office visit codes) — and when payments for new and established office visits were increased, CMS also increased the bundled payments for these post-operative visits in the global period.

- ***Create specialty differentials:*** Per the Medicare statute, CMS is prohibited from paying physicians differently for the same work, and the "Secretary may not vary the…number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician."[6] Failing to adjust the global codes is tantamount to paying some doctors less for providing the same E/M services, in violation of the law.

- ***Run afoul of section 523(a) of MACRA***: CMS points to the ongoing global code data collection effort as a reason for not applying the RUC recommended changes to office visit E/M codes to global codes. In addition, the agency states that it is required to update global code values based on objective data on all of the resources used to furnish the services included in the global package. These arguments conflate two separate issues. The issue that CMS raises regarding MACRA legislation is not related to maintaining relativity across the fee schedule based on current data in the CMS work/time file. In fact, section 523(a) specifically authorizes CMS to make adjustments to surgical services, notwithstanding the mandate to concomitantly undertake the MACRA-mandated global code data collection project.

- ***Ignore recommendations endorsed by nearly all medical specialties***: The RUC, which represents the entire medical profession, voted overwhelmingly (27-1) to recommend that the full increase of work and physician time for office visits be incorporated into the global periods for each CPT code with a global of 10-day, 90-day and MMM (maternity). The RUC also recommends that the practice expense inputs should be modified for the office visits within the global periods.

[6] 42 U.S. Code §1395w-4(c)(6).

We believe review and implementation of any changes to the office visit E/M codes is premature given the extensive coding changes and flawed survey process. However, if CMS chooses to move forward with office visit E/M increases, we urge CMS to incorporate the changes into the work, time, and practice expense for global codes to maintain fee schedule relativity.

Thank you for your time and consideration of ISASS's comments. We greatly appreciate the opportunity to participate in efforts to more efficiently and accurately capture current care delivery. We commend CMS on its continued efforts to improve care quality and access. If you have any questions on our comments, please do not hesitate to contact Morgan Lorio, MD, Chair ISASS Coding and Reimbursement Taskforce at mloriomd@gmail.com.

Sincerely,

Morgan Lorio, MD, FACS
Chair, ISASS Coding and Reimbursement Taskforce