American Society of Anesthesiologists®

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September 6, 2016

Acting Administrator Andrew Slavitt
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1654-P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: CMS-1654-P, Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Low Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model

Dear Acting Administrator Slavitt:

On behalf of over 52,000 members, the American Society of Anesthesiologists® (ASA) appreciates the opportunity to comment on provisions in the proposed rule for the CY 2017 Physician Fee Schedule. As the medical specialty representing the recognized leaders in patient safety and quality, ASA welcomes the opportunity to work with the Centers for Medicare & Medicaid Services (CMS) to ensure high quality and high value care for Medicare patients.

In this letter, ASA specifically addresses:

1. Medicare Telehealth Services
2. Potentially Misvalued Services
3. Collecting Data on Resources Used in Furnishing Global Services
4. Valuation of Specific Services
    a. Paravertebral Block Injection
    b. Anesthesia Services Furnished in Conjunction with Lower Gastrointestinal (GI) Procedures
    c. Endotracheal Intubation
    d. Epidural Injections
    e. Implantation of Neuroelectrodes
    f. Fluoroscopic Guidance
5. Accountable Care Organization (ACO) Participants Who Report Physician Quality Reporting System (PQRS) Quality Measures Separately

Medicare Telehealth Services

CMS is considering a request to add critical care to its list of procedures that may be done via telehealth. A previous request to add these services as Category 1 services was denied because critical care is not similar to any services currently on the telehealth list due to patient acuity. A previous request to add them as Category 2 services was denied because the literature that accompanied the request did not convince the agency that there was sufficient evidence of clinical benefit. A subsequent request, under consideration in this proposed rule, has caused the agency to

recognize that critical care consultations done remotely may have potential clinical benefit. The agency proposes to create new G-codes to describe these consultations and to include those new G-codes on the telehealth list. CMS requests comments as to whether these new G-codes would capture the distinction between critical care services described by CPT® code 99291 – 99292 and seeks comments to include examples of different scenarios when each code could be appropriate.

While critical care medicine requires face-to-face care by critical care physicians, there are some clinical situations in which a patient may benefit from a telemedicine consultation with a critical care physician and we provide two examples as follows. We support establishment of G-codes to describe these specific consultation services and adding those codes to the telehealth list.

Scenario 1

Critical care physicians include specialists who have received critical care training after completing residency training in surgery, anesthesia, medical subspecialties, neurology and other programs. In addition, the patient populations within critical care units vary depending on the underlying condition and clinical needs of each patient. Some hospitals have separate medical and surgical ICUs, respiratory ICU, neurologic ICU, burn ICU or other specific patient populations. Although the primary focus of care for each patient depends on the underlying clinical condition for which the patient requires intensive care, each patient may also require subspecialty ICU care. For example, a critically ill surgical patient who suffers a stroke during the ICU course may benefit from the expertise of a neurocritical care provider. In some cases, teleconsultation with the subspecialty critical care provider may be the most appropriate and timely way to address an acute issue. Teleconsultations with other colleagues can be a valuable way to ensure that each ICU patient benefits from input from a diverse group of critical care providers who can work collaboratively through bedside interactions when clinically necessary, but also utilizing teleconsultations with diagnostic peripherals to support the assessment of each patient.

Scenario 2

Critical care physicians are often asked to assess patients in other hospitals to guide clinical management, determine whether transfer to another ICU is appropriate, and, when transfer is planned, to determine what is needed to stabilize and safely transport the patient. With the expansion of health systems, the support of physicians across the system can also be most effectively provided through teleconsultation and care planning. In some cases, the teleconsultation can provide recommendations and support for physicians caring for a patient in the local community, preventing the need for costly and potentially challenging transfer. In other cases, the teleconsultation can clarify options and more effectively determine next steps in management. For example, a physician caring for a patient with severe respiratory failure who continues to deteriorate despite maximal ventilatory support may request consultation with another critical care provider regarding possible transfer, potential value of extracorporeal membrane oxygenation (ECMO) or other modalities not available in the community hospital. Initial teleconsultation can define the clinical options, guide initial management, and if necessary, arrange for implementation of ECMO or other therapies prior to transfer.

Potentially Misvalued Services under the Physician Fee Schedule

CMS continues its efforts to establish filters to identify potentially misvalued services. In the notice of proposed rulemaking (NPRM), CMS proposed to review codes that have a 0-day global and that are typically billed (more than 50% of the time) with an E/M service with modifier 25. CMS plans to give priority status to codes that fit that criteria, have not been reviewed in the past five years and have more than 20,000 allowed services. Table 7 of the NPRM includes a list of services that CMS proposes as potentially misvalued under these criteria. We have reviewed the codes that are

relevant to the services our members perform and recommend that the following codes be removed from the CMS list of potentially misvalued services under this new filter:

Code	Descriptor	ASA Comment
20552	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)	Code has been reviewed within the past five years.
20553	Injection(s); single or multiple trigger point(s), 3 or more muscles	Code has been reviewed within the past five years.
20600	Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); without ultrasound guidance	This code was reviewed within the past five years and performance of an E/M on the same day was taken into consideration as the code was valued.
20604	Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); with ultrasound guidance, with permanent recording and reporting	This code was reviewed within the past five years and performance of an E/M on the same day was taken into consideration as the code was valued.
20605	Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance	This code was reviewed within the past five years and performance of an E/M on the same day was taken into consideration as the code was valued.
20606	Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting	This code was reviewed within the past five years and performance of an E/M on the same day was taken into consideration as the code was valued.
20610	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance	This code was reviewed within the past five years and performance of an E/M on the same day was taken into consideration as the code was valued.
20611	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting	This code was reviewed within the past five years and performance of an E/M on the same day was taken into consideration as the code was valued.

Code	Descriptor	ASA Comment
31500	Intubation, endotracheal, emergency procedure	This code has been reviewed within the past five years. The code is modifier 51 exempt. The fact that it is typically performed with another procedure has been considered when the code was valued.
64418	Injection, anesthetic agent; suprascapular nerve	This code was reviewed within the past five years and performance of an E/M on the same day was taken into consideration as the code was valued.

Collecting Data on Resources Used in Furnishing Global Services

In its Final Rule for the CY 2015 fee schedule, CMS announced it would eliminate the surgical global period. Codes with a 10-day global were to be transitioned to 0-day globals by 2017 and codes with a 90-day global were to be similarly transitioned by 2018. MACRA overruled that decision but did impose some data collection requirements that are to begin by 2017. Results of those efforts are to be used to improve the accuracy of the fee schedule by 2019. MACRA allows CMS to impose a 5% penalty to physicians and other practitioners who do not comply with data collection requirements which we are pleased that CMS is not proposing to implement that at this time.

We agree that having accurate base line data for all services is becoming increasingly more important and essential – under both current and new payment methods. However, we are very concerned about CMS's proposal to require *all* physicians and practitioners to report *all* follow-up services within the global period with newly created G-codes for *all* services they provide that have either a 10 or 90-day global period. The need for data must be balanced with all the other administrative demands physicians are facing in terms of time, costs and other resources that are necessary to comply with MACRA, the expiration of ICD-10-CM flexibilities and other increasing administrative requirements.

We note that MACRA states that, "the Secretary shall through rulemaking develop and implement a process to gather, from a representative sample of physicians, beginning not later than January 1, 2017, information needed to value surgical services. Such information shall include the number and level of medical visits furnished during the global period and other items and services related to the surgery and furnished during the global period as appropriate. Such information shall be reported on claims at the end of the global period or in another manner as specified by the Secretary."[1] We believe that CMS may be exceeding the intention of the legislation which specifically states that this claims-based data collection effort needs to include a *representative sample*; it does not state that the effort must be applied across-the-board in the manner CMS proposes.

The claims based data collection process as proposed will be complex, burdensome and a distraction from patient care. If CMS finalizes its proposal, physicians will have to develop and implement new and complex processes to comply. This will result in increased costs and diversion of resources away from important patient-focused priorities.

[1] Medicare Access and CHIP Reauthorization Act of 2015, Section 523

We urge the agency to play close heed to the concerns and comments it receives from ASA and other specialty societies and stakeholders. We also urge CMS to revise the proposal to be consistent with congressional intent, to avoid the creation of more administrative burdens on physicians and their practices and to keep the patient at the center of care.

Valuation of Specific Services

Paravertebral Block Injection (CPT Codes 64461, 64462 and 64463)

CMS proposed to finalize the interim values it assigned to these services in the CY 2016 Final Rule. In that rule, CMS did not accept the RUC recommended value for code 64463 - *Paravertebral block (PVB) (paraspinous block), thoracic; continuous infusion by catheter (includes imaging guidance, when performed)*. The RUC recommendation was a work RVU of 1.90 and CMS implemented a work RVU of 1.81.

ASA's response was to point out that CMS based its decision on an inappropriate comparison of code 64463 with codes that describe continuous peripheral nerve blocks that do not include imaging guidance. CMS used these codes for comparison due to similarities in the intraservice time data. Time is just one component that must be considered when valuing work. We continue to believe that the imaging component included in code 64463 is justification for at least the 0.09 difference between the RUC recommendation and the CMS proposed value. Further, we believe that CMS should consider an appropriate and consistent differential between the single shot *technique (64461 - Paravertebral block (PVB) (paraspinous block), thoracic; single injection site (includes imaging guidance, when performed)* (work RVU 1.75)) and the continuous technique as described with code 64463. We also point out that CMS could compare 64463 with code 47000 - *Biopsy of liver, needle; percutaneous*. This code has a work RVU of 1.90 and the same intraservice time as 64463. These arguments – taken together – support a work RVU of 1.90 for code 64463.

We request that CMS implement a work RVU of 1.90 for code 64463.

Anesthesia Services Furnished in Conjunction with Lower Gastrointestinal (GI) Procedures (CPT Codes 00740 and 00810)

During the CY 2016 fee schedule rulemaking cycle, CMS identified both code 00810 - *Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum* and code 00740 - *Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum* as potentially misvalued due to the "significant change in the relative frequency with which anesthesia codes are reported with colonoscopy services." ASA continues to believe that this frequency of use is not due to any potential mis-valuation but rather to specific and valid changes to CMS coverage and payment policies intended to encourage Medicare beneficiaries and other patients to undergo screening colonoscopies. Such screening promotes earlier detection of cancer, resulting not only in saved dollars but more importantly, saved lives.

Codes 00740 and 00810 were the subject of a RUC survey. When reviewing the survey results, the RUC had questions about the typical patient who would undergo the underlying GI procedure with anesthesia care, rather than under moderate sedation administered by the endoscopist. The RUC recommended that the current value for these anesthesia services be maintained for one year while a number of issues are addressed via the CPT and RUC processes. We are pleased that CMS agrees by noting that, "…it is premature to propose any changes to the valuation of CPT codes 00740 and 00810, but continue to believe that these services are potentially misvalued and look forward to receiving input from interested parties and specialty societies for consideration during future notice and comment rulemaking." This is consistent with a point CMS made in the CY 2016 Final Rule about another use of High expenditure/High volume" as criteria for potential misvaluation. The fact that a code may be identified as potentially misvalued does not mean that it is misvalued.

> Comment: Various commenters objected to the presence of individual codes that met the high expenditure screen criteria based on absence of clinical evidence that the individual services are misvalued.
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> Response: We reviewed each of these comments, and believe that these kinds of assessments are best addressed through the misvalued code review process. As we describe in this section, the criteria for many misvalued code screens, including this one, are designed to prioritize codes that may be misvalued not to identify codes that are misvalued. Therefore, we believe that supporting evidence for the accuracy of current values for particular codes is best considered as part of the review of individual codes through the misvalued code process.[2]

In Table 23 - Proposed CY 2017 Work RVUs for New, Revised and Potentially Misvalued Codes, codes 00740 and 00810 are listed with a current work RVU of 0.00. We note that the values for these anesthesia services are expressed in base unit values rather than RVUs. We believe the listing of these codes in Table 23 with a work RVU of 0.00 does not reflect CMS's statement that it is "premature to propose any changes to the valuation of CPT codes 00740 and 00810."

We appreciate the agency's fair-minded proposal to maintain current value for codes 00740 and 00810 and will continue to work with CPT, the RUC and CMS to address concerns about the valuation of these anesthesia services.

Endotracheal Intubation (CPT Code 31500)
CPT Code 31500 underwent RUC survey subsequent to being identified as potentially misvalued. Survey results indicated that the code was undervalued and the RUC agreed recommending that the work RVU be increased to 3.00 from its current value of 2.33. CMS agrees that an increase is warranted and is proposing a new work RVU of 2.66 based on a comparison to code 65855 - *Trabeculoplasty by laser surgery*. We do not agree that code 65855 is an accurate comparison code because it describes a non-emergent clinical scenario. It has a 10-day global period; its work RVU of 2.66 includes a follow-up visit. If the work of that follow-up is removed, the remaining intra-service work is not comparable to that of code 31500. The RUC recommendation of 3.00 is based on a very solid survey with 150 responses and more appropriate comparison codes.

We request CMS adopt the RUC recommended work RVU of 3.00 for code 31500. We request Refinement Panel review of code 31500.

Epidural Injections (CPT Codes 623X5, 623X6, 623X7, 623X8, 623X9, 62X10, 62X11, and 62X12)
We are pleased that CMS proposes to accept the RUC recommended work RVUs for these new codes and did not recommend further cuts in payment for these procedures. At the same time, we want to take this opportunity to address a question that CMS poses about the practice expense inputs associated with these services.

CMS is proposing to remove the 10-12 ml syringes (SC051) and the RK epidural needle (SC038) from all eight of these codes. CMS states that these are duplicative of items already included in the epidural tray (SA064). ASA disagrees with removing the requested syringe and the needle; they are not duplicative of the items within the tray. These two supplies are necessary to perform these procedures. We particularly note that the tray does not include an epidural needle. While the specified RK needle may not be used, there must be an epidural needle. Performance of these services requires all the elements in the tray and the extra syringe and an epidural needle. ASA is

[2] Federal Register, Vol, 80, No 220, November 16, 2015, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016; Final Rule, p 70913

willing to work with CMS and/or the RUC to review and update the components included in the epidural tray package.

ASA requests the CMS accept the RUC recommended practice expense supplied for codes 623x5 – 62X12.

Implantation of Neuroelectrodes (CPT Codes 64533 and 64555)
We are pleased that CMS is taking a fair-minded approach to the concerns it has about these codes and is proposing to maintain current value, as these issues are addressed via the CPT and RUC processes.

We will continue to work via the CPT, RUC and CMS processes to insure that identified concerns about practice expense and work associated with temporary vs permanent placement are fully addressed and resolved.

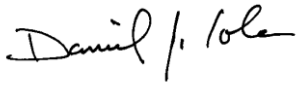
Fluoroscopic Guidance (CPT Codes 77001, 77002, and 77003)
Codes 77002 and 77003 have been the subject of several recent RUC surveys and each survey has supported their current work RVUs. For CY 2017, codes 77002 and 77003 are to be converted from stand-alone codes to add-on codes to be reported in conjunction with applicable procedures when the procedure does not already include imaging guidance. Code 77001 is already an add-on code. CMS is proposing to assign a work RVU of 0.38 to codes 77002 and 77003 (a decrease from their current values as stand-alone codes of 0.54 and 0.60 respectively). This would make all three codes carry the work RVU already assigned to code 77001. We acknowledge CMS's statement that these three codes describe similar services, but note that they do not describe *identical* services. This is especially important for code 77003 as that code pertains to spinal procedure and as such, carries more risk than either 77001 or 77002.

ASA believes that CMS should acknowledge the increased risk and complexity associated with codes 77002 and 77003 as compared with code 77001 and assign a work RVU of 0.54 to code 77002 and 0.60 to code 77003. We request Refinement Panel review of codes 77002 and 77003.

Accountable Care Organization (ACO) Participants Who Report Physician Quality Reporting System (PQRS) Quality Measures Separately
CMS has proposed to allow an eligible professional's practice to report Physician Quality Reporting System (PQRS) measures separately for 2017 and 2018 payment adjustment when the Accountable Care Organization (ACO) failed to report on behalf of its eligible professionals. ASA supports the intent of CMS in allowing ample opportunities for physicians to have greater control over their quality reporting. The proposal eases the reporting burden for a number of eligible professionals and group practices. ASA supports this approach to quality reporting.

Thank you for your time and consideration of our comments. If you have any questions, please contact ASA's Director of Payment and Practice Management, Sharon Merrick, M.S., CCS-P (s.merrick@asahq.org) or ASA's Director of Quality and Regulatory Affairs, Matthew Popovich, Ph.D. (m.popovich@asahq.org) at (202) 289-2222.

Sincerely,



Daniel Cole, M.D.
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