AACU
American Association of Clinical Urologists, Inc.

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The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

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

RE: CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies (CMS-1770-P)

Dear Administrator Brooks-LaSure:

On behalf of our physician and medical student members, the American Association of Clinical Urologists (AACU) respectfully submits these comments to the Centers for Medicare & Medicaid Services (CMS) on the Calendar Year (CY) 2023 Medicare Physician Fee Schedule (MPFS) proposed rule (CMS-1770-P) published in the *Federal Register* on July 29, 2022 (87 Fed. Reg. 45860).

Founded in 1968 by urologists concerned by the government's increasing role in the practice of medicine, the AACU is a professional organization representing the interests of more than 3,700+ member urologists, and urologic societies engaged as advocacy affiliates across the United States. We are dedicated to developing and advancing heath policy education as it affects urologic practice in order to preserve and promote the professional autonomy of our members and support the highest quality of care for patients.

We appreciate the opportunity to respectfully provide comments on the following provisions of the proposed rule:

- Conversion Factor Update
- Proposed Valuation of Specific Codes
- Strategies for Improving Global Surgical Package Valuation
- Evaluation and Management Services
- Payment for Medicare Telehealth Services
- Changes to the Medicare Telehealth Services List
- Virtual Direct Supervision
- Reimbursing Health Services at the Facility Rate
- Pausing the Clinical Labor Pricing Update
- Rebasing and Revision the Medicare Economic Index (MEI)

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Conversion Factor Update
CMS has proposed to decrease the conversion factor from $34.6026 to $33.0775. This decrease represents an expiration of the 3 percent increase included in the Protecting Medicare & American Farmers from Sequester Cuts Act at the end of 2022, along with a mandated 0 percent conversion factor increase and required adjustments for budget neutrality.

The AACU understands that CMS' ability to reduce this reduction in the conversion factor is limited due to statutory authority and budget neutrality requirements. We feel it is important to note that this reduction is proposed at a time when physicians face continued challenges as a result of the ongoing pandemic and rising costs due to unprecedented inflation and critical labor shortages, as well as year two of changes to the clinical labor practice expense.

Before the end of the year, the AACU and other organizations are advocating for Congress to:

- Extend the Congressionally enacted 3 percent temporary increase in the MFS;
- Provide relief for an additional 1.5 percent budget neutrality cut that is planned for 2023;
- End the statutory annual freeze and provide an inflation-based update for the coming year; and
- Waive the 4 percent PAYGO sequester necessitated by passage of legislation unrelated to Medicare

We hope that CMS will support these proposed legislative solutions aimed at mitigating reductions and cuts to reimbursement.

Proposed Valuation of Specific Codes

Laparoscopic Simple Prostatectomy (CPT codes 55821, 55831, 55866, and 558XX)
The AACU applauds CMS for accepting Relative Value Scale Update Committee's (RUC) recommended work and PE relative value units (RVUs) for laparoscopic simple prostatectomy procedures as reported by CPT codes 55821, 55831, 55866, and 558XX.

Percutaneous Nephrolithotomy (CPT codes 50080, 50081)
The AACU would like to provide comments on the work RVUs for CPT codes 50080 and 50081, which are used to report services for percutaneous

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nephrolithotomy. The agency has proposed values below the RUC recommended work values. The agency has proposed to compare CPT code 50080 (Percutaneous nephrolithotomy or pyelolithotomy, lithotripsy stone extraction, antegrade ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed, including imaging guidance; simple (e.g., stone[s] up to 2 cm in a single location of kidney or renal pelvis, nonbranching stones) to CPT code 36830 (Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft (eg, biological collagen, thermoplastic graft), and CPT code 36818 (Arteriovenous anastomosis, open; by upper arm cephalic vein transposition). This is not a valid comparison as CMS did not accept the RUC recommended work values for CPT codes 36830 and 36818. The RUC process does not allow codes that have RVU values not accepted by the agency to be used as crosswalks and are flagged as such in the RUC database. We also believe that by simply adding 8.5 work RVUs to work RVUs for CPT code 50080 to then create a value for CPT code 50081 (Percutaneous nephrolithotomy or pyelolithotomy, lithotripsy stone extraction, antegrade ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed, including imaging guidance; complex (e.g., stone[s] > 2 cm, branching stones, stones in multiple locations, ureter stones, complicated anatomy)) is not a standard methodology and does not maintain relativity of procedures, nor does it accurately account for the time, mental effort or skill associated with CPT code 50081.

We suggest that the agency consider the following codes for relative comparison when proposing values for CPT codes 50080 and 50081. The codes listed are more comparable to the time, mental effort and skill associated with CPT codes 50080 and 50081, and therefore would support 13.50 RVU as recommended by the RUC.

CPT Code	Description	Intra-Service Time (min.)	Global	Work RVU
15730	Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)	88	90 days	14.16
55875	Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy	88	90 days	13.50
57260	Combined anteroposterior colporrhaphy, including cystourethroscopy, when performed;	90	90 days	13.46
58542	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;	90	90 days	13.25

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.

The AACU urges CMS to continue to rely on the Relativity Assessment Workgroup process, utilizing objective screens to identify any potential misvaluation of services

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with global periods. The CMS public comment process may also be utilized to identify potential misvaluations, as it has previously been successfully utilized for this purpose.

The AACU 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. The AACU welcomes the opportunity to provide further comment on this issue in the future.

Evaluation and Management Services
Inpatient and Observation Codes
CMS continues revisions to the evaluation and management (E/M) code set. The AACU supports the agency's proposal that the agency make changes to inpatient E/M services, specifically the merger of the inpatient and hospital observation unit E/M services as adopted by the CPT Editorial Panel.

The AACU also supports the revisions to documentation guidelines, providing consistency with the outpatient E/M services. This will allow physicians to bill by time or medical decision making (MDM). These changes will help relieve documentation and administrative requirements that continue to burden practicing physicians.

Split/Shared Services
CMS is proposing to delay the implementation of the CY 2022 MPFS proposed changes to split/shared E/M visit services until 2024. The AACU believes CMS's delay is warranted but the policy can be improved in the interim with input from physicians, providers, and other stakeholders.

Specifically, the reporting requirements for split/shared services are not consistent with other E/M services, as the agency requires reporting by time rather than time or MDM.

Payment for Medicare Telehealth Services
Multiple policies have been proposed by CMS related to how the extension of certain telehealth flexibilities authorized by the Consolidated Appropriations Act, 2022 will be implemented and how telehealth modifiers should be billed after the conclusion of the extension. The members of the AACU have found telehealth services to be crucial in the ability to deliver care during the ongoing pandemic. The AACU remains committed to helping to ensure Medicare beneficiaries can continue to access appropriate telehealth services consistent with CMS's statutory authority.

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Changes to the Medicare Telehealth Services List

The AACU considers telehealth services an important priority and thanks CMS for continuing to propose policies that will expand telehealth service access, including the addition of certain services to the telehealth list both on a permanent Category 1 or 2 basis and a temporary Category 3 basis.

Additionally, the AACU asks CMS to prioritize finalizing the proposal allowing all services added to the telehealth list on a temporary basis during the public health emergency (PHE), to remain available through the 151-day period following the conclusion of the PHE, including those that have not been converted to Category 1, 2 or 3. The AACU looks forward to evaluating the data that results from the PHE and will be pleased to provide further comment on any policy suggestions or changes that result from this data.

After receiving requests to allow the continued delivery of audio-only services by adding telephone E/M codes to the telehealth list on a Category 3 basis, CMS decided not to allow this request. CMS confirms, however, that the telephone visit codes will now be covered on the Medicare Telehealth List for 151 days after the PHE ends. CMS also raises concerns about the statutory authority to extend telehealth coverage for these services, noting that the agency believes the statute requires telehealth services be analogous to in-person care, meaning that telehealth service is a substitute for a face-to-face encounter, but that the audio-only services are not a substitute for face-to-face care.

The AACU disagrees with this interpretation, while recognizing that CMS does not have authority to extend coverage of audio-visits beyond the 151-day extension. The AACU believes that telephone E/M services serve a significant role in expanding access to care for Medicare beneficiaries with poor digital literacy or those in areas without adequate broadband access. In addition, many patients do not have access to hardware/software that provides for real-time audio/video access. The Covid-19 pandemic exposed the risk for the inequitable care delivery for these individuals. Telephone E/M visits have allowed improved access to these beneficiaries. The AACU feels the elimination of coverage for these services could affect access to care and we ask that CMS continue to collect and share data on the utilization of these services and provide other opportunities for public comment on this important issue.

Virtual Direct Supervision

CMS' current policy permits virtual direct supervision through December 31 of the year the COVID-19 PHE concludes. The AACU welcomes the opportunity to provide as requested by the agency on permitting virtual direct supervision on a permanent basis. We will provide feedback from our members as a final policy is

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being developed, but the AACU is concerned about increased documentation requirements that may curtail the use of these services.

Reimbursing Telehealth Services at the Facility Rate
CMS stated that at the conclusion of the PHE, telehealth services will be reimbursed at the facility payment rate, as the agency believes the facility payment amount captures the direct and indirect practice expenses of telehealth services.

The AACU disagrees with this assessment and asks CMS to continue to reimburse telehealth services at the physician office rate. The costs and resources to deliver telehealth services can represent a significant practice expense and are similar to expenses and requirements for face-to-face services. The AACU believes access to care via telehealth service has been an important vehicle in delivering care to high risk and immunocompromised patients during the pandemic. Practices endure considerable expense in providing these telehealth services. These expenses include not only the computer, internet, and appropriate virtual software but also the considerable staff resources required to arrange and prepare for telehealth visits. Telehealth services have also allowed physicians to provide care to Covid-19 patients without risk to the staff or other patients. The AACU is concerned that failure to reimburse virtual visits at the physician office rate will cause additional financial strain to practices already struggling with inflationary pressures. The AACU is concerned that practices may abandon telehealth services, affecting those who greatly benefit from these services.

Pausing Implementation of The Clinical Pricing Update

The AACU strongly urges CMS to pause the implementation of the clinical labor update. In 2022 CMS started a four-year phase in adjustment to clinical labor pricing. Although the AACU praises CMS for trying to update the clinical labor pricing, CMS's method for applying this labor update has significantly affected providers performing technology intensive procedures at the non-facility rate. This has resulted in a financial punishment for these providers during a time of unprecedented inflation. The current method runs counter to CMS's aim to promote site neutrality payments and thus the AACU has recommended that CMS pause the clinical labor update until this can be further studied.

Rebasing and Revising the Medicare Economic Index (MEI)
The AACU recognizes the need for CMS to update the MEI with updated and accurate data.

The AACU appreciates CMS's proposal to delay implementation of the proposed changes to MEI cost weights. However, the AACU would like to stress that any

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new data CMS proposes to use should accurately capture the costs of physician practice.

The American Medical Association (AMA) has begun collecting data on physician costs and is well-equipped to capture data for all types of physician practices, allowing for more accurate findings and, thus, a more accurate MEI. We thus urge CMS pause the MEI update as proposed and work with the AMA on this data collection effort to ensure consistency and reliability in the quality of the data collected, and thus in physician payment.

The AACU is grateful to CMS for the opportunity to provide these comments on the CY 2023 Medicare Physician Fee Schedule proposed rule. We look forward to future opportunities to provide comment and opportunities to work together on related policy issues. Please reach out to Kristin Jimison, AACU Director of Legislative Affairs at kjimison@veritasamc.com with questions.

Sincerely,

Terrence Regan, MD
Health Policy Committee Chair
American Association of Clinical Urologists