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August 18, 2021

Elizabeth Richter
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **CMS-1751-P**
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code CMS-1751-P; CY 2022 Revisions to Payment Policies under the Physician Payment Schedule and Other Changes to Part B Payment Policies;

Dear Administrator Richter:

The North American Neuromodulation Society (NANS) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) Notice of Proposed Rule Making (*Proposed Rule*) on the revisions to Medicare payment policies under the Physician Payment Schedule for calendar year (CY) 2022.

NANS is a multi-specialty association of more than 1,600 physicians dedicated to the development and promotion of the highest standards for the practice of neuromodulation procedures in the diagnosis and treatment of the nervous system, including neurosurgeons, orthopedic spine surgeons, anesthesiologists, physiatrists, psychologists, urologists, and neurologists. We are committed to working with CMS and other stakeholders to promote the highest quality, most efficient, patient care for patients dealing with chronic pain and other conditions that can be with targeted electrical, chemical and biological technologies to the nervous system in order to improve function and quality of life.

This letter includes NANS recommendations and comments regarding the following:

- **CY 2022 Conversion Factor**
- **Payment for Evaluation and Management (E/M) Services**
    - *A. Evaluation and Management (E/M) Office Visit Services*

B. Office Visits Included in Surgical Global Payment

- **Physician Work and Practice Expense Relative Value Unit Recommendations for CPT codes 64633-64636**
- **TeleHealth Issues**
- **Chronic Pain Management Reimbursement**

2022 Medicare Conversion Factor

In the CY 2022 Proposed Rule, CMS announced an update to the Medicare conversion factor of $33.58 for CY 2022. This represents a 4% decrease from the current (2021) conversion factor of $34.89. This adjustment reflects a budget neutrality adjustment for changes in relative values for individual services, with significant increases in relative values for office and outpatient Evaluation and Management (E/M) services (CPT codes 99201-99215) and the fact that CMS opted to maintain budget neutrality which because of the E/M increases necessitates the large conversion factor reduction.

NANS is extremely disappointed and concerned with the drastic reduction in the Medicare Conversion Factor and strongly recommends CMS take action in the CY 2022 Final Rule to eliminate this conversation factor reduction. The most appropriate action would be to not implement the proposed increases in E/M codes. NANS believes the 2021 E/M RVUs to be incorrect and recommends maintaining current RVUs for the E/M codes at their 2020 RVU rates. However, if CMS chooses to move forward with the changes in E/M RVUs, NANS believes it is essential that CMS take action to waive budget neutrality by maintaining the CY 2020 conversation factor for CY 2021. Many practices are struggling to maintain financial viability due to the changes and hardships caused by the Covid-19 pandemic and their closure would significantly impact access to care to CMS covered patients.

If the proposed conversion factor changes are implemented, most pain interventions would see dramatic reductions in total Medicare reimbursement. These procedures are critically important alternatives to opioid based treatment plans which have led to the tragic opioid epidemic that continues to devastate our country. Several efficacious and cost-effective pain treatments which currently are reimbursed at marginal levels that barely cover overhead face drastic reductions if the conversion factor were to be implemented as proposed. These collective reductions would represent a tremendous setback in the efforts by CMS and HHS to effectively address the opioid crisis in the United States and may inadvertently cause a resurgence of opioid prescribing.

CMS has done an admirable job in adjusting rules, regulations, and payment rates in response to the current Public Health Emergency due to the Covid-19 crisis. Yet, despite this recognition and all the efforts by CMS to increase access to care for Medicare patients, CMS is proposing the largest single reduction in payment rates to physicians and providers in many years. This is directly contrary to the efforts and the messaging by CMS and if implemented for CY 2022 would completely undo all the success CMS and physician stakeholders have had in navigating this unprecedented health crisis. If implemented in the final rule, a -4% reduction would cause massive shortage of access as practices reduce staff and hours to absorb the impact. This would result in less access at a time that greater access and greater flexibility is needed in caring for Medicare patients.

The reduced conversion factor also represents a breaking of trust between physicians, CMS, and patients. Our collaboration and cooperation in overcoming these unprecedented times has been one of the few bright spots in the PHE. Reducing payments to physicians is an unfair and unacceptable response to this collaboration and risks future opportunities for cooperation. CMS should maintain their cooperation and collaboration by maintaining conversion factors and waiving budget neutrality in the fee schedule for all physicians and providers under the Medicare Physician Fee Schedule for CY 2022.

Proposed Work and Practice Expense Relative Value Units for CPT codes 64633-64636

In the 2022 Proposed Rule, CMS reviewed RUC recommended adjustments to Work and Practice Expense RVUs for CPT codes 64633, 64634, 64635, and 64636.

64633, Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint, 64634, Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure), 64635, Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint, and 64636, Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure) were flagged by the AMA RUC for review in January 2020 because of misestimates of utilization from the previous review/revaluation of the services in 2011.

These services were surveying by medical specialty societies with recommendations presented to the AMA RUC at the October 2020 RUC meeting. CMS accepted the RUC recommendations for 64634 which maintained the current work RVU of 1.32 and 64636 which maintained the current work RVU of 1.16. The agency proposes slight reductions from the RUC recommended values for 64633 from the RUC recommendation of 3.42 to 3.31 and 64635 from the RUC recommendation of 3.42 to 3.32.

NANS appreciates the agency accepting the RUC recommendations for the add-on codes (64634 and 64636) and accepting the recommended Practice Expense (PE) inputs. However, NANS strongly recommends CMS accept the RUC recommended work RVUs for 64633 and 64635 in the final rule and not adopt the proposed values of 3.31 and 3.32. NANS believes the RUC recommended values at 3.42 for both 64634 and 64636 are the best values to assign based on the 2021 provider surveys that were the basis of the RUC recommendations. The procedures are long established and common procedures, and the survey had a large number of respondents (166). Furthermore, the RUC recommended work RVUs maintain an appropriate difference between 64633/35 and the key reference code for both codes-64625, Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography) which has a work RVU of 3.39 but is a less complex procedure than 64633/35. Survey respondents, who again, commonly perform the services, rated 64633 and 64635 as significantly more complex/intense than 64625 (85% of the survey respondents indicated the codes as more complex than 64625). The work RVU of 3.42 was the median survey work RVU for 64635 and was between the 25th % survey RVU of 3.36 and the median survey work RVU of

3.75 for 64633 and the RUC appropriately interpreted the time and work RVUs from the survey to arrive at work RVU recommendations that maintained similar values for both services with a median survey value matching median times from the surveys.

NANS believes the rationale provided by the agency in the proposed rule is confusing and not based on a reliable and replicable process or methodology. Rather than proposing a direct crosswalk to a similar code, the agency instead referenced the overall relativity within all 010 day global services in the Medicare Physician Fee Schedule. This is particularly confusing given that the most obvious crosswalk and comparison service, which was the survey key reference service, is valued at 3.39. At a minimum, 64633 and 64635 should be valued somewhat higher than 64625 and the RUC recommended work RVUs achieve this relativity.

Furthermore, the CMS proposed values for 64633 and 64635 creates a slight rank order anomaly by have 64635 with a .01 higher RVU. If any difference in value should exist between these services, 64633 is clinically the more complex service, yet under the proposed value would pay very slightly less than 64635. This is not accurate to clinical practice and experience and the RUC recommended values of 3.42 more accurately reflect the physician resources required to perform the services.

NANS strongly recommends that CMS change the recommended work RVU for 64633 from the proposed work RVU of 3.31 to the RUC recommended work RVU of 3.42 and the recommended work RVU for 64635 from the proposed work RVU of 3.32 to the RUC recommended work RVU of 3.42.

Telehealth and Other Services Involving Communication Technologies

During the COVID-19 PHE, pursuant to authority granted in the CARES Act, CMS waived the geographic and site of service originating site restrictions for Medicare telehealth services, allowing Medicare beneficiaries across the country to receive care from their homes. These flexibilities remain in effect through December 31, 2021. In the proposed rule, CMS does not propose to permanently extend these waived restrictions in the PFS stating that it lacks authority to make this adjustment. However, CMS does propose to maintain some telehealth adjustments including expanding the number of services that can be billed as telehealth. NANS fully supports this extension of the PHE status and all related statutory and sub-regulatory changes affected by the PHE emergency authority.

In the proposed rule, CMS is not proposing to continue current coverage and payment for Medicare audio-only visits for all services except mental health services after the conclusion of the COVID-19 PHE. NANS supports the current coverage policies and payment rates for audio-only visits for all services, not just mental health services, and strongly encourages CMS to extend the current coverage and payment rates for a minimum of two years after the end of the PHE or December 31, 2023. We believe this 24-month extension is particularly necessary for Medicare patients as there will be a significant period even after the PHE lapses during which Medicare patients will likely benefit from full access to all non-face-to-face services including audio-only visits. We believe the current payment rates to be appropriate as the provider work for audio-only patient visits is completely equal to in-person or audio-video patient encounters particularly so for Medicare patients who often are only employing audio services, reside in locations with limited internet connectivity, and not using smart technologies with audio-video

programming. We do support the proposal to cover mental health services delivered via audio-only technology and applaud the agency recognizing the importance of allowing of maintaining and possibly expanding access to the services for patients in need of them. We do, however, believe the rationale provided in the proposed rule can and should be expanded to all office e/m services in the final rule.

Category III status for Neurostimulator Programming Services

As part of the transition from the PHE, CMS stated in the proposed rule their intent to remove several services that were included as billable when delivered through telehealth from the list of approved services for telehealth delivery. This includes five CPT codes used to report analysis and programming of neurostimulator devices. The CPT codes are 95970, Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming. 95971, Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple spinal cord or peripheral nerve (e.g., sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional, 95972, Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex spinal cord or peripheral nerve (e.g., sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional 95983, Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, first 15 minutes face-to-face time with physician or other qualified health care professional, and 95984, Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, each additional 15 minutes face-to-face time with physician or other qualified health care professional (List separately in addition to code for primary procedure).

NANS strongly recommends adding these five codes to the category III Telehealth list so as to maintain coverage under Telehealth. These services can be safely and effectively performed through audio/video technology and maintaining them on the list of approved services will reduce Medicare patient's need to make regular in-person office visits for these routine services. This would greatly benefit patients and allow patients to maintain the benefits of

neurostimulation. Patients receiving these services through telehealth will have much better outcomes and fewer complications than if the codes are not allowed to be billed via telehealth.

We recommend that CMS address this in the final rule by adding CPT codes 95970, 95971, 95972, 95983, and 95984 to the category III Telehealth list for CY 2022.

Chronic Pain Management Reimbursement

In the proposed rule, CMS is soliciting comments on whether it should create separate coding and payment for chronic pain management and achieving safe and effective dose reduction of opioid medications when appropriate, or whether these services are already appropriately recognized in the payment system. CMS cites multiple federal reports that urge better support for person-centered pain management, including the 2016 National Pain Strategy and the 2019 HHS Pain Management Best Practices Inter-Agency Task Force Report. It also notes the intersection between the problems with pain care and the worsening epidemic of drug overdose deaths, primarily due to illicitly manufactured fentanyl, other synthetic opioids, and methamphetamine. CMS also notes that untreated and inappropriately treated pain may translate to increased Medicare costs as more patients experience functional decline, incapacitation, and frailty.

NANS is grateful to the agency for their long overdue recognition of the opportunity to address the opioid crisis, which has devastated untold number of American and Medicare beneficiaries, by actively incentivizing alternate chronic pain management treatments. This approach appropriately recognizes the real clinical need for pain management services. It also seeks to rebalance the treatment options way from opioid based prescriptions to repeated and prolonged treatment through mental health and chronic pain relief. NANS members have been at the front lines in responding to the opioid crisis for our patients and believe that it is absolutely appropriate and necessary to provide separate and/or additional reimbursement for these services. CMS has in recent years provided payment through G-codes and modifiers for providers who are treating patients with multiple chronic conditions and patients transitioning from inpatient treatment to outpatient/home based treatment and we recommend the agency create G-codes similar to the chronic care management codes that can be billed by pain management and mental health providers for chronic care for patients with severe pain as a condition.

NANS applauds this move and stands ready to assist the agency in the development of coding and reimbursement options for providers like our members who care for this specific patient population. We look forward to collaborating with the agency and other stakeholders in this process.

Thank you for your time and consideration of NANS 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 Chris Welber, MBA, NANS Executive Director at cwelber@neuromodulation.org.

Sincerely,

Peter Konrad, MD PhD
President
North American Neuromodulation Society (NANS)