AMERICAN SOCIETY OF PLASTIC SURGEONS®
THE PLASTIC SURGERY FOUNDATION™

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September 11, 2017

The Honorable Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1676-P
Mail Stop C4-26-05
7500 Security Blvd,
Baltimore, MD 21244-1850

Via Electronic Submission: http://www.regulations.gov

Re: File Code-CMS-1676-P; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018

Dear Administrator Verma:

The American Society of Plastic Surgeons (ASPS) appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services (CMS) Proposed Rule for the Physician Fee Schedule for CY 2018, published in the July 21, 2017 *Federal Register*.

ASPS is the largest association of plastic surgeons in the world, representing more than 7,000 members and 94 percent of all American Board of Plastic Surgery board-certified plastic surgeons in the United States. Plastic surgeons provide highly skilled surgical services that improve both the functional capacity and quality of life of patients. These services include the treatment of congenital deformities, burn injuries, traumatic injuries, hand conditions, and cancer reconstruction. ASPS promotes the highest quality patient care, professional and ethical standards, and supports education, research, and public service activities of plastic surgeons.

Outlined below are several key areas of concern in relation to the proposed rule.

Medicare Telehealth Services

Under current program rules, Medicare pays for a limited number of Part B services furnished by a physician or practitioner to an eligible beneficiary via a telecommunications system. Beneficiaries are eligible for telehealth services only if they are presented from an originating site located in: 1) a county outside of a Metropolitan Statistical Area (MSA) or 2) A rural Health Professional Shortage Area (HPSA) located in a rural census tract. Currently, the originating sires authorized include hospitals, the office of a clinician, Rural Health Clinics, and Federally Qualified Health Centers.

For eligible telehealth services, the use of a telecommunications system substitutes for an in-person encounter. As a condition of payment, a clinician must use an interactive audio and video telecommunications system that permits real-time communication between them, at the distant site, and the beneficiary, at the originating site. Asynchronous "store and forward" technology is permitted only in Federal telemedicine demonstration programs in Alaska or Hawaii.

Since the inception of this policy, ASPS and other medical societies have repeatedly asked the Agency to re-evaluate how care may be inadvertently restricted by limiting the range of CPT codes that are reimbursed. Additionally, we remain frustrated with the lack of reimbursement for asynchronous telehealth services, where care monitoring includes the exchange of information as schedules permit rather than only in real-time, or synchronous communications.

Because of the restrictions tied to the use of certain telehealth services, ASPS is supportive of CMS efforts to consider broadening the scope of remote patient monitoring services it covers. Technology development combined with physician shortage estimates, including those in plastic surgery, demand that CMS reconsider its approach to ensuring that patients in need of care can be identified and recognize that the method of delivery of high quality care for certain services can be changing

As an illustration of the need for new policy, when Hurricane Harvey made landfall in Texas last month, over 30,000 residents were evacuated to shelters. Many of the displaced have chronic medical conditions or injuries that required medical attention. Because of recent legislation, Texas physicians are able to see patients via telemedicine without an initial in-person visit. Primary care and specialty physicians jumped in to offer their services via telehealth work stations set up at many of the mega-shelters. The use of remote medicine and equipment helped countless residents manage their health and allowed both the medical and nonmedical workers at the site to triage care and resource effectively.

This is an example of how telemedicine can be used in the most extreme situations, when health care is most needed. We'd encourage the Agency to consider telemedicine as a regular part of disaster recovery; reimbursing for both synchronous and asynchronous services when the need for care is urgent and specialists are not on site to provide consultative services.

We also encourage CMS to closely collaborate with the AMA CPT Editorial Panel as telehealth coding proposals and associated policy is established. This is important to ensuring a clear understanding of the rules and requirements in this growing enterprise. By our own count, between CMS and the AMA, multiple proposals for place of service (POS) codes, modifiers, and CPT appendices are all actively being proposed for future claims reporting. Because of this, ASPS supports CMS' proposal to eliminate the use of the GT modifier as it would be duplicative to report along with the newly implemented telehealth POS code. The potential administrative burdens to those providers who will participate in this care delivery model must be reviewed with the least administratively burdensome proposal shared via future rule-making.

Valuation of specific codes under the Physician Fee Schedule

We support the approach CMS used in this proposed rule, accepting a majority of the recommendations provided via the American Medical Association Relative Value Update Committee (RUC), as well as offering suggested alternatives for some CPT codes.

We note, with appreciation, that the Agency agreed with the values derived during prolonged RUC deliberations for seven of the eight codes for nerve repair and myocutaneous flap, most of which are typically reported by plastic surgeons. In response to the request for feedback on an adjusted value for the remaining code, we respectfully suggest no further adjustments are warranted. Decreasing the relative work value for the newly created code "myocutaneous or fasciocutaneous flaps of the head and neck, with named vascular pedicle" would results in inappropriate relativity amongst the other muscle flap codes.

This new code was designed to encompass those flaps requiring facility usage and likely inpatient hospitalization, not to mention moderately more intense physician work. As the Agency is well aware, there was significant discussion about the valuation of this code at the RUC meeting. As such, we believe the RUC-approved value of 15.68 accurately reflects the complexity and intensity of the procedure and urge the Agency to monitor code utilization over the next 24 months, raising any concerns when the code will be re-evaluated to verify site of service, as well as a review of the primary specialty and reporting volumes.

Off-Campus Provider Based Departments

Historically, services provided by physicians in certain off-campus outpatient departments were paid under the Hospital Outpatient Prospective Payment System (HOPPS) fee schedule. The potential for more generous payments led some hospitals to acquire physician practices. As mandated by the Bipartisan Budget Act of 2015, in 2017 CMS began to implement payment reforms designed to address payment differentials across sites of service, with "applicable items and services" furnished by certain off campus provider-based departments of a provider no longer covered under HOPPS, but instead paid under the Medicare Physician Fee Schedule. Under CMS' new policies, the technical component of these items and services are generally reimbursed at 50% of the HOPPS schedule for CY 2017. CMS is now proposing to reduce such payments to 25% of the HOPPS fee schedule for CY 2018. As with CY 2017, "excepted" off-campus provider-based departments would still receive payments under the HOPPS at the HOPPS rates for all billed items and services.

While ASPS concurs that Medicare should not differentially for similar services, we are concerned this proposal will result in an unsustainable payment rate that will further reduce access for people in chronically underserved communities and health care deserts. These areas, including health professional shortage areas (HPSAs) and medically underserved areas (MUAs), have fewer than a generally accepted minimum number of clinicians (physicians, dentists, mental health workers, etc.) per

thousand population. Presently, there are some 3,960 designated HPSAs across the U.S. and its territories and approximately 46 million people reside in these areas

As the Agency is well aware, primary healthcare in underserved areas can be provided by community health centers, but the community relies on hospitals for access to specialists.

Should CMS finalize its proposal to reduce payment for nonexcepted off-campus provider-based department services, patients' access to care will be further compromised. As such, we respectfully ask CMS to retain current payment rates while it studies the effect of these proposed payment reductions on such areas

Evaluation and Management (E&M) Guidelines

In this proposed rule, the Agency has indicated the current E&M guidelines may be outdated, especially as they relate to documentation of the history and physical in the medical record and is seeking input on how to better align E&M coding and documentation with the current practice of medicine.

ASPS agrees that changes are necessary, but we respectfully ask CMS to work closely with both primary care and specialty physicians before implementing any updates to current policy. Over the last twenty years the health of Medicare population has changed. Today, specialists are often called upon to manage multiple, chronic conditions, often serving as the de-facto primary care provider, coordinating care for vulnerable Medicare beneficiaries. Often, a complete review of systems or a patient's past family and or social history identify conditions that will significantly impact care.

Ideally, a multi-year effort will be undertaken to better understand the documentation needs under new payment programs like CMS' Quality Payment Program, and how medical record vendors can ensure information is updated routinely. Any new policy should not, we believe, add additional burden to the current process for written or automated documentation and clinical decision making during a patient's visit.

Appropriate Use Criteria (AUC)

The Protecting Access to Medicare Act of 2014 (PAMA) required CMS to create a program that would have denied payment for the furnishing physician of advanced imaging services, beginning in 2017, if the ordering physician had not provided information about consultation of available appropriate use criteria. Due to the significant feedback the Agency received about such a program in the 2017 Proposed Rule, the Agency delayed implementation of this program. In this 2018 Proposed Rule, and in response to pressure from the AMA and a number of specialties, the Agency is proposing to further delay the requirement until January 1, 2019.

Those who wish to begin testing the AUC program could participate in a voluntary reporting period expected to begin in July 2018. This first year of reporting would be regarded as an opportunity for testing and education and would not affect payment to the physician providing the image.

While ASPS appreciates the opportunity to "test" a new program, we are concerned that the limited time span between July 2018 and January 2019 will not provide sufficient opportunity for CMS to analyze and provide robust feedback on how clinicians have performed prior to full implementation on January 1, 2019.

We are especially concerned about the additional costs a program like this would create for solo practitioners and small practices. We recognize the Agency has and will offer a list of AUC tools available for clinicians ordering advanced imaging but believe additional information is necessary to ensure selection of the most appropriate tool for a practice. As an example, plastic surgeons may occasionally order an MRI of the breast when evaluating a capsular contracture. Because the current CMS website for AUC does not differentiate the contents of the imaging products offered by each vendor, a plastic surgeon could inadvertently purchase access to a platform that does not include the narrow scope of services they might order.

As such, we respectfully request the Agency work with Congress to delay full implementation of this program. We also ask that CMS carefully review the scope and breadth of the Quality Payment Program (QPP) to verify the necessity of duplicate processes of the QPP and the AUC program given that there will be situations in which both programs are seeking to verify cost and quality for the same set of services.

<u>Patient Relationship Categories</u>

To improve resource use measurements, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) directed CMS to create new patient relationship codes that physicians would be required to report on claims starting in 2018 for the purposes of determining which physician would be held accountable for a patient's cost of care. The Agency has proposed five patient relationship categories that would be identified by modifiers. Each modifier designates a different level of responsibility, from continuous to episodic, with broad or focused care.

In anticipation of the "learning curve," CMS proposes to make the reporting of these modifiers voluntary in CY 2018, with education on proper use. Modifier use would not be a condition of payment, affect payment, change the meaning of a reported procedure code(s), or be tied to any reported E/M service(s) intensity.

We recognize the work the Agency has put forth to develop these reporting options but remain concerned that CMS and the AMA CPT Panel seem to be moving in different directions on how best to incorporate this data on a claim form. We note that the Agency has not specified the duration of the voluntary reporting period, and would be remiss to not restate our belief that any voluntary program

should include sufficient time and opportunity for CMS to analyze and provide robust feedback. We believe terms such as continuous and episodic as well as broad and focused will have different meanings to different physicians, with extensive testing and training required prior to full participation.

Additionally, we seek clarification as well on how the relationship codes may be incorporated into future Quality Payment Program measures prior to full-scale implementation by CMS for line-item (CPT-dependent) reporting of this type of data. To decrease administrative burden, we encourage CMS to work with the Workgroup for Electronic Data Interchange (WEDI) to investigate alternative solutions for patient relationship reporting at the claim versus line-item level.

Collecting Data on Resources Used in Furnishing Global Services

While not mentioned in this proposed rule, we would be remiss to not, once again, express our concerns with the Agency's plan to verify accurate valuation of 10- and 90-day global services. Included in the 2017 Final Rule was a plan to collect data on the number of post-operative visits via a claims-based data collection process, effective July 1, 2017 for a sub-set of surgeons, based on a designated subset of surgical CPT codes.

We remain extremely concerned with the validity of the data being captured under this process given the underlying weaknesses of attempting to capture post-op visit information via a claims-reporting mechanism. For this reason, we urge CMS to eliminate the reporting requirement as soon as practicable.

Additionally, mention was made in the 2017 Final Rule of plans to conduct a survey of practitioners to gain information on post-operative activities to supplement the claim-based approach. The Agency had indicated the survey would be in the field by mid-2017; however, ASPS has learned just this week that while a pilot test of the survey will be launched in the coming days, a full launch has yet to begin.

With less than three months remaining in CY 2017, and because neither proposal has produced what we would quantify as high-value data to date, we respectfully request CMS develop a data validation process to ensure the accuracy of the information it is collecting and publicly inform stakeholders that it will not attempt to use the data collected for purposes of code revaluation until the validity and accuracy of the data can be confirmed.

Regulatory Impact

The majority of plastic surgeons work in single or small group practices. We are pleased to see that the Agency recognizes, as we do, that these providers are small businesses and can be significantly impacted by fluctuations in reimbursement for services they have provided. We are cautiously optimistic that the lack of changes in reimbursement the Agency predicts for plastic surgeons in CY18 will in fact be recognized.

Conclusion

ASPS appreciates the opportunity to offer these comments, and we look forward to working with CMS to ensure reimbursement is fair and adequate. Should you have any questions about our comments, please contact Catherine French, ASPS Health Policy Manager, at cfrench@plasticsurgery.org or at (847)981.5401.

Sincerely,

Debra Johnson, MD

President, American Society of Plastic Surgeons

cc: Lynn Jeffers, MD – ASPS Board Vice President of Health Policy & Advocacy
Andrea Pusic, MD – ASPS Board Vice President of Research
Steve Bonawitz, MD – Chair, ASPS Healthcare Delivery Subcommittee
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