



September 6, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
US Department of Health & Human Services
200 Independence Avenue SW
Washington, DC 20543

Re: Medicare and Medicaid Programs; CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medicaid Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts

Dear Administrator Brooks-LaSure,

On behalf of the American Society of Echocardiography (ASE), we thank you for the opportunity to comment on the CY 2023 Medicare Physician Fee Schedule (PFS) proposed rule (CMS-1770-P). The ASE is the Society for Cardiovascular Ultrasound Professionals™. ASE is the largest global organization for cardiovascular ultrasound imaging serving physicians, sonographers, nurses, veterinarians, and scientists and as such is the leader and advocate, setting practice standards and guidelines for the field. Since 1975, the Society has been committed to advancing cardiovascular ultrasound to improve lives. In this capacity as the voice for the cardiovascular ultrasound professionals and patients, we recommend herein that CMS revise its proposed rules on:

- MPFS Payment Reductions
- Split (shared E/M) Visits
- Practice expense (PE) data collection and methodology
- Medicare Economic Index (MEI) and Practice Expense Data Collection Update Strategies
- Services to be Removed from the Medicare Telehealth Services List After 151 Days Following the End of the PHE
- Determination of Professional Liability Insurance Relative Value Units (PLI RVUs)

We provide further detail on these specific issues below.

MPFS Payment Reductions

CMS proposes a steep, 4.5% reduction in Medicare payments to physicians for 2023 due to statutory requirements and regulatory changes discussed in the rule. This conversion factor accounts for the statutorily required update to

the conversion factor for CY 2023 of 0%, the expiration of the 3% increase in PFS payments for CY 2022 as required by the Protecting Medicare and American Farmers from Sequester Cuts Act, and the statutorily required budget neutrality adjustment to account for changes in Relative Value Units. CPT code level changes are estimated to require an additional reduction of about 1.5% to the 2023 Medicare conversion factor due to statutory budget neutrality requirements.

In contrast, most other Medicare providers, will receive increases in their 2023 payments (e.g., inpatient hospitals – 4.3%; inpatient rehabilitation facilities – 3.9%; hospices – 3.8%; hospital outpatient departments – 2.7%; and MA plans – 8.5%). This continues to be a disproportional gap between health care facilities, MA plans and physicians/qualified healthcare professions — those who diagnose, treat and manage Medicare beneficiaries’ care.

We urge CMS to promote predictability and stability in physician payments and to mitigate the financial impacts of significant fluctuations in relative weights that might accompany updates. **The ASE is disheartened with the proposed reduction of the proposed physician CF. For physicians to be able to provide high quality care and equitable patient access, we urge CMS to work with Congress to offset or avert these cuts.** Specifically, we request CMS to extend the 3% payment increase through CY 2023 to provide continued relief to struggling providers, implement specific strategies to minimize the additional 1.5% increase in cuts.)

Split (shared E/M) Visits

In the CY 2022 PFS final rule, CMS finalized its proposal regarding who should bill for split or shared visits when elements of the visit are performed by both a physician and a qualified healthcare professional in the same group practice in the facility setting where “incident to” billing is not available. In the CY 2022 PFS final rule, it was determined that whoever performs more than 50% of the total visit time should bill the split or shared visit. CMS agreed to revise the rule after providing another opportunity for public comment on this policy.

CMS is proposing to delay the split (or shared) visits policy finalized in the CY 2022 PFS for the definition of substantive portion, as more than half of the total time, for one year with a few exceptions. For CY 2023, as in CY 2022, the substantive portion of a visit may be met by any of the following elements:

- History
- Performing a physical exam
- Making a medical decision.
- Spending time (more than half of total time spent by the practitioner who bills visit)

Team-based patient care provides patients with high quality treatment and care. Significant variability in mental difficulty exists between different elements of the visit. Time alone is not a proper indication of who contributed the most in a visit. Billing solely based on time could disincentivize the collaboration between physicians and QHPs. For example, medical decision making, which impacts the management of patients care and outcome of the visit, typically requires less time than other less rigorous elements of the visit such as paperwork and visit documentation. Additionally, there is significant variability in how much time it takes to perform elements of the visit based on the level of training and expertise of the physician and QHP.

We thank CMS for proposing this delay and urge CMS to allow physicians or QHPs to bill split or shared visits based on time or medical decision making. We support the inclusion of all four elements: History, performing a physical exam, making a medical decision, and spending time, when determining who should bill for the visit to best capture accurate contributions. We urge CMS to revise the split or shared visit policy to allow the physician or QHP who is managing and overseeing the patient’s care and course of treatment to bill for the service.

Soliciting Public Comment on Strategies for Updates to Practice Expense Data Collection and Methodology

We thank CMS for an opportunity to comment on updates to the practice expense methodology used for the PFS. We believe that the methodology used for the calculation of practice expense needs to be reviewed and revised to account for the ongoing changes in the delivery of medical care, especially the advances in medical technology. We appreciate that CMS has recently updated the data for supplies, equipment and clinical labor and contracted with RAND to develop and assess potential improvements in the current PE methodology, but instead of iterative steps CMS needs to develop a comprehensive plan that allows for public comment.

As a first step, we note that CMS needs a methodology that will allow the Agency to provide frequent updates of practice expense data similar to other updates to the PFS (e.g., the 5-year updates to malpractice). We urge CMS use a methodology that will allow more frequent updates of practice expenses to avoid last year's significant shifts for certain physician specialties because clinical labor costs had not been updated for 20 years.

To promote predictability and stability in physician payments and to mitigate the financial impacts of significant fluctuations in relative weights that might accompany updates, we also recommend that CMS consider a threshold for limiting the level of reductions in payments that would occur in a single year because of the updates and transition over a timeline consistent with the threshold. At the present time, ASE is not advocating for a specific threshold of reduction protection because of updates, only for consideration of the concept to protect physician practices against some of the negative financial consequences accompanying the update.

Medicare Economic Index (MEI) and Practice Expense Data Collection Update Strategies

The ASE supports CMS's proposal to rebase and revise the MEI. The Proposed Rule lays out the case for needing to do so: the current MEI is based on 2006-based costs and the cost weights should reflect current market conditions. The 2017 weights for the proposed rebased and revised MEI are significantly different than the 2006-based current weights reflecting changes in the cost of providing physician services. The practice expense share of overall physician costs, for example, increased by 6.5 percentage points from 44.8 percent to 51.3 percent, while the share of physician work and malpractice declined. These data indicate that specialties and services with higher PE costs have been undervalued relative to other services in the PFS and that an update to the MEI weights is long overdue. This update is also necessary to bring fairness and equity to payments for physician services to, and stability to these payments given the significant revisions the PFS during the last several years.

The American Medical Association (AMA) has shared with you that it is engaged in an extensive effort to collect practice cost data from physician practices, many of which are specialty practices that Alliance members represent. Given the important role that the MEI currently plays (and may potentially play in the future), like the AMA, we urge CMS to pause consideration of other sources of cost data for use in the MEI until the AMA effort is complete.

The ASE supports CMS' approach to delay implementation of these adjustments to the PE calculation until the public has commented on the data sources and methodology of the rebased and revised MEI. We believe a multi-year transition is appropriate given the large specialty specific impacts of implementing the proposed rebased and revised MEI fully in one-year. Such a transition would also be consistent with other significant payment changes in the PFS including how CMS updated prices of supply and equipment inputs and its current transition of clinical labor updates for use in its PE methodology.

Services to be Removed from the Medicare Telehealth Services List After 151 Days Following the End of the PHE

We are disappointed CMS has proposed to remove telephone E/M codes 99441-99443 from the telehealth list 151 days following the expiration of the public health emergency (PHE). There is a growing body of evidence supporting the addition of telephone E/M (99441-99443) to the Medicare telehealth services list on a permanent basis. The only difference between telehealth office visits and telephone E/M is the absence of real-time video. Moreover, studies have demonstrated that seniors, non-English speakers and Black patients are more reliance on telephone than video for care.^{1,2,3,4,5} Elimination of coverage for telephone E/M will only exacerbate disparities and structural biases.

The physician time, intensity and level of medical decision making for telephone E/M and office visits are identical. The interactions among the beneficiary and physician (or other practitioner) that take place during a telephone E/M visit are like telehealth office visits. In both cases, the physician can assess the patient's condition, make a medical decision, and communicate that decision to the patient equally well via telephone only or a real-time audio/visual telehealth platform. The absence of video does not change or diminish the time, intensity, or level of medical decision making. Therefore, we urge CMS to reconsider its proposal to remove 99441-99443 from the Medicare Telehealth Services List after 151 days following the end of the public health emergency (PHE).

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

The ASE notes that 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 (ARC) to update the PLI premium data, as CMS had also done for CY 2020, and has provided the *CY 2023 Medicare PFS Proposed Update to the GPCIs and PLI RVUs Interim Report* as part of its supporting documentation to the *Proposed Rule*. The *Interim Report* describes proposed methodologic changes related to the approach for the imputation of missing malpractice premiums. CMS is also proposing to change from using risk factor score, which benchmarked each specialty to the physician specialty with the lowest premiums, to a risk index score which benchmarks each specialty's premiums to the volume-weighted average of all specialties.

Imaging and diagnostic services are generally comprised of two components: a professional component (PC); and a technical component (TC). The PC and TC may be furnished independently or by different providers, or they may be furnished together as a global service. When services have separately billable PC and TC components, the payment for the global service PLI RVU equals the sum of the payment for the TC component (reported separately using the -TC modifier) and PC (reported separately using -26 modifier).

For CY 2022 (and every year prior), virtually every global service with a PLI RVU greater than 0.02 (e.g. any PLI RVU that was large enough to split more than just 0.01 and 0.01), had a large majority of the PLI RVUs allocated to the PC component (reported using -26 modifier), and only a relatively small amount allocated to -TC only reporting. This long-standing precedent aligns with the updated risk premiums for specialties, as for example, the CMS' 2023 normalized risk premium rate for cardiology is \$16,826 whereas the updated risk premium rate for an independent diagnostic testing facilities (IDTFs) is only \$379.

¹ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8496485/>

² <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7674139/>

³ <https://www.ajmc.com/view/differences-in-the-use-of-telephone-and-video-telemedicine-visits-during-the-covid-19-pandemic>

⁴ https://journals.lww.com/painrpts/fulltext/2022/06000/disparities_in_telehealth_utilization_in_patients.6.aspx

⁵ <https://aspe.hhs.gov/sites/default/files/documents/4e1853c0b4885112b2994680a58af9ed/telehealth-hps-ib.pdf>

Due to a technical error, this relationship has inverted as most -26 modifier PLI RVUs, which typically represent a vast majority of the claims, have decreased by -75% or more, whereas most - TC only PLI RVUs have greatly increased. TC only reporting only represents a small subset of claims for CPT code 93306 – see table below:

CPT Code	Mod	DESCRIPTION	CY2022 PLI RVU	CY2023 NPRM PLI RVU	% Change in PLI RVUs	2021 Medicare Utilization	Change in Aggregate PLI RVUs Payment (using CY2022 CF)
93306		Tte w/doppler complete	0.07	0.08	14%	2,293,275	\$ 839,481
93306	26	Tte w/doppler complete	0.05	0.01	-80%	4,308,256	\$ (6,308,355)
93306	TC	Tte w/doppler complete	0.02	0.07	250%	137,071	\$ 250,882

The ASE is deeply concerned that this error has particularly impacted two specialties, radiology, and nuclear medicine. CMS impact table (NPRM table 148) projects PLI RVU changes alone to reduce cardiology’s overall allowed charges by 2% and when fully implemented it will decrease facility-based services by 7%. The 80% decrease in PLI RUV changes for 93306-26 is clearly an error. **This technical error has collectively reduced the aggregate allowed charges for PLI RVUs for all specialties by more than \$110 million for CY 2023. The ASE urges CMS to identify the root cause of this technical error and to correct prior to implementation for CY 2023. If CMS is unable to identify and resolve the error, we recommend that CMS delay implementation and apply the previous methodology for PC/TC codes until the technical error is corrected.**

Conclusion

Thank you for the opportunity to comment on the CY 2023 PFS proposed rule and issues concerning echocardiography. We appreciate the ongoing dialogue concerning these important issues, as well as CMS’ significant effort in the proposed rule. If you have any questions about our request or if we may provide any additional information, please contact Irene Butler, ASE’s Vice President of Health Policy and Member Services, at 919-297-7162 or ibutler@asecho.org.

Sincerely,



Stephen Little, MD, FASE
 President, American Society of Echocardiography