AdvaMed
Advanced Medical Technology Association

March 2, 2022

Carol Blackford
Director, Hospital and Ambulatory Policy Group
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Comments in Advance of Calendar Year (CY) 2023 Physician Fee Schedule (PFS) Notice of Proposed Rulemaking (NPRM)

Dear Ms. Blackford,

On behalf of the Advanced Medical Technology Association (AdvaMed), we are writing to urge the Centers for Medicare and Medicaid Services (CMS) to consider several important issues as the Agency begins to develop its CY 2023 Physician Fee Schedule (PFS) proposed rule.

AdvaMed member companies produce the medical devices, diagnostic products, and health information systems that are transforming health care through earlier disease detection, less invasive procedures, and more effective treatments. AdvaMed members range from the largest to the smallest medical technology innovators and companies. We are committed to ensuring patient access to lifesaving and life-enhancing devices and other advanced medical technologies in the most appropriate settings.

In advance of the proposed rule, AdvaMed is submitting comments on the following:

- ***Transitioning Public Health Emergency Medicare Waivers Following the End of the PHE***
- ***Payment Stability***
- ***Continuation of Telehealth Waivers***
- ***Make Virtual Presence and Telehealth Substitutions for Face-to-Face Encounters Permanent***
- ***External Extended ECG Monitoring (CPT Codes (93241-93248)***
- ***Remote Therapeutic Monitoring (CPT Codes 989X1-989X5)***
- ***Prescription Digital Therapeutics and Software as a Medical Device (SaMD)***
- ***Remote Patient Monitoring (RPM) Services***
- ***Remote Diagnostic Testing***
- ***National Pricing of Category III (CPT Code 0583T)***
- ***Cardiac Ablation Services Bundling (CPT Codes 93653-93657)***

Transitioning Public Health Emergency (PHE) Medicare Waivers Following the End of the PHE

From the very onset of the COVID-19 public health emergency (PHE), CMS has demonstrated decisive leadership and creativity to use new waiver authority provided by Congress to expand access to vitally needed health care services for Medicare beneficiaries at a time when their usual sources of care were not available because of the pandemic. With boldness of vision, the Agency has expanded access to care by waiving requirements in statute, regulations, guidelines, national and local coverage decisions—across the spectrum of health care services, service settings, and health care providers. In many cases, expansion of telehealth and other communication technology-based services have been at the heart of increased access, and during the past two years patients and their physicians and other providers have learned a great deal about the health benefits and efficiencies that come with expanded coverage and payment of a wide variety of digitally based health care services. In many ways, the flexibilities CMS has introduced for increasing access to care have transformed our understanding and assumptions about the nature of health care services delivery and expanded our perspectives on the appropriateness of serving patients in the community and their homes. For instance, we have learned that requirements in law or coverage policies for in-person visits can be met as effectively through telehealth visits. We were able to extend the reach of diagnostic testing, which is foundational to the provision of informed clinical care, decision-making, treatment monitoring, and screening. To return to the constraints of the statute and underlying CMS implementing polices without waivers would be a negation of the many benefits patients and providers have seen during the PHE.

At the present time, some are anticipating an end of the PHE, even though the omicron infection and hospital admission rates are still very high in many parts of the nation. During this period of perhaps transition out of the PHE, we urge CMS to exercise the same leadership it showed during the earliest months of the pandemic and take actions to evaluate as soon as possible the specific flexibilities it introduced during the PHE to determine which of these should lead to legislation and/or specific policy changes that would ensure continuation of the benefits both patients and providers have seen from the flexibilities introduced by CMS. The end of the PHE should not mean the immediate end of changes to the delivery of health care that patients and providers have become accustomed to. Patients and providers alike need a glide path to transition out of the PHE, especially when hospitals and other providers are experiencing staffing shortages and the health system has not fully recovered from the pandemic. If CMS requires more time to evaluate the benefits of its flexibilities, it should support a glide path to continue the flexibilities through the end of 2023, corresponding to the end of the extension CMS has provided for Category 3 telehealth services, rather than reverting to pre-PHE statutory and implementing requirements on the day the PHE ends. We look forward to working with CMS on this important transition.

Payment Stability

In the past few years, CMS has made significant revisions to the PFS resulting in redistributing work and practice expenses for all services paid under the fee schedule. The 2020 E/M updates resulted in a budget neutrality adjustment of -10.2 % to the PFS conversion factor when implemented in 2021; the impact has been partially offset and delayed by legislation on a year-

to-year basis. The update of clinical wages also resulted in significant decreases to practice expense values, particularly for those codes with high supply or equipment costs; over 325 codes had declines of practice expense relative value units of 18 percent or more. Because of the magnitude of these changes, CMS finalized a four-year phase-in with 2023 being the second year of this transition, but even with the phase-in, many office-based procedures are suffering significant cuts in 2022 and will see further reductions over the remaining three years. These policy changes have occurred over a span where the PFS conversion factor has not kept pace with overall changes in price inflation, which has significantly reduced the purchasing power of providers. Comparing the conversion factor to inflation is complex since the conversion factor includes budget neutrality adjustments for increases and decreases in relative value units (RVUs). Relative to the Medicare Economic Index—a measure of inflation specific to physician practices—the annual physician fee schedule update has consistently been less than inflation for every year going back to 2012.

The COVID PHE has also impacted the health care system as physicians and other providers have needed to respond to various demands, including needing additional safety equipment and precautions to minimize risks from COVID exposure. In addition, the difficulties associated with staffing shortages, difficulties obtaining necessary supplies due to supply chain shortages, and inflation have resulted in additional challenges for providers.

The health care delivery system needs time to recover from the COVID PHE and transition into a new "normal" that can both accommodate taking care of acute and chronic illnesses and resume providing important routine preventive health care services. We think it is important that CMS consider the impact of proposed policy changes on reimbursement because it is critical that providers have payment stability and the ability to provide innovative technologies during the next few years to recover from the PHE and focus on improving access to care to all Medicare beneficiaries.

Continuation of Telehealth Waivers

CMS has demonstrated in recent proposed and final rules a commitment to consider the need for changes to existing telehealth polices to enhance beneficiary access to care not only during a pandemic but beyond it as well.

We recognize that CMS rulemaking cannot address provisions of Medicare statute that limit the availability of telehealth services to beneficiaries living in rural areas and do not allow the home as a site of care. We believe that the waiving of these two requirements during the PHE has demonstrated the effectiveness of telehealth as an important source of care for beneficiaries, and especially for the growing number of patients aged 85+ and those with multiple chronic conditions, regardless of whether a pandemic limits access to office-based or facility-based care.

The immediate uptake in telehealth by providers and patients alike has also demonstrated the agility of the health care system to scale up to provide telehealth--in the process transforming the delivery system through innovative technologies that can improve health outcomes and reduce

the rate of growth in health care spending. After this experience, to return to the status quo following the end of the PHE will have the effect of turning back the clock on this innovation, which has positively transformed the delivery of health care services. We strongly urge that CMS support efforts in the Congress to address the statute's limitations that severely impede beneficiary access to telehealth. AdvaMed continues to be on record as supporting these changes and we urge CMS to work with Congress to expand access to telehealth and to implement any expansion quickly. Further, short of a permanent change to Medicare statute to eliminate limitations in access to telehealth services, we urge CMS to support a continuation of existing waivers through the end of 2023, corresponding to the end of the extension CMS has provided for Category 3 telehealth services, to demonstrate the need for changes to statute to avoid an abrupt end to the benefits expanded telehealth has provided to Medicare beneficiaries.

Make Virtual Presence and Telehealth Substitutions for Face-to-Face Encounters Permanent
CMS changed the definition of "direct supervision" during the PHE for supervision of diagnostic tests, physicians' services, therapy services, and some hospital outpatient services, enabling a supervising professional/therapist to be immediately available through "virtual presence" using real-time audio/video technology instead of being physically present. In the 2021 Physician Fee Schedule, CMS finalized the continuation of this policy through the end of the CY in which the PHE ends. CMS should consider making permanent "virtual presence" for provider services including remote therapeutic monitoring treatment management services (CPT codes 98980 and 98981), which are non-face-to-face services and do not require hands-on involvement by clinical staff/auxiliary personnel. This policy change would provide greater access to care for beneficiaries by allowing supervising providers to virtually supervise work performed by clinical staff. This is particularly relevant to CPT codes 98980 and 98981, which are currently general medicine codes requiring direct supervision of staff.

CMS should also continue to explore how best to allow the substitution of a telehealth visit for a face-to-face or in-person encounter for evaluations, assessments, and certifications for DMEPOS and as a condition of coverage required by NCDs and LCDs and thus not subject to requirements for face-to-face visits.

External Extended ECG Monitoring LT-ECG Monitoring and Appropriately Valuing AI/Algorithms/Software (CPT Codes (93241-93248)
In our comment letter on the CY 2022 PFS Proposed Rule, AdvaMed commended the Agency for recognizing that as more services have begun to include innovative technologies, such as AI and software algorithms, that its current practice expense (PE) methodology does not adequately account for application of these technologies in specific physician services.

We note that the variety of different AI and software algorithmic technologies used in health care delivery today and expanding significantly in the future, with their different designs and intended uses, makes it very difficult to generalize about the impact these technologies will have on values of individual components of the RVU for a service. This may require that CMS evaluate each individual physician service with AI and algorithmic components on a case-by-case basis to determine how their values should be changed. We urge CMS to carefully evaluate and define

differences between types of innovative technologies, and whether they are used after acquisition by the physician or through subscription model, before making decisions on how best to value them in rate setting. This evaluation should include consideration of how costs will vary based on the individual service, physician specialty, patient cohort, and the operational model for incorporating the technology into clinical practice.

AdvaMed also strongly urges CMS to reevaluate the assumptions underlying its PE methodology for rapidly evolving technologies used in health care. The reality is that many software-powered services are not simply part of equipment hardware and instead can be attributed to a specific service and should be considered direct costs themselves. It is critical that CMS correct its assumptions about software-supported services so that beneficiaries have access to the benefits that accompany physicians' use of these services and also recognize in its assumptions the need to reflect the costs of innovation and updating of AI and other software.

Further, we argue that CMS has authority to obtain information on PE from any source—physicians, trade groups, industry--and can implement changes to PE RVUs using this information as long as CMS is transparent in how it obtains and uses the information. AdvaMed recommends that CMS consider hiring a contractor with expertise in AI to review different types of AI (algorithmic, self-learning, augmented intelligence, e.g.) to review how each type of AI functions, and what clinical utility it provides and how it interacts with the clinician and extracts more information from data. AI should not be viewed as "operating in the background" and simultaneously for hundreds of patients. Some types of AI should be paid separately because of the added value it provides for a specific patient's condition, while other AI may not need to be paid separately.

In the CY 2022 PFS Final Rule, CMS took important steps forward in addressing the challenges of appropriately recognizing the contribution of AI in physician service reimbursement when it established national payment rates for two AI-based technologies. We are encouraged by this progress and also commend the Agency for establishing for those technologies stable pricing at the national level rather than through region-by-region decision-making.

We ask that CMS reevaluate its decisions about the PE used to furnish LT-ECG services based on the cost analysis AdvaMed and KPMG has shared with the Agency and each of the MACs. This analysis was undertaken by AdvaMed to respond to CMS's request for additional information about the resource costs LT-ECG companies incur for providing these services. The data for the cost analysis was collected by KPMG on an individual and confidential basis from each company. We believe that with this information CMS should now be able to establish a fair and stable price for these services.

Remote Therapeutic Monitoring

In our comment letter on the CY 2022 PFS Proposed Rule, AdvaMed noted that that CMS's proposal—and later finalization—to recognize and pay for new remote therapeutic monitoring (RTM) codes was an important step in making available to Medicare beneficiaries groundbreaking advances in health care delivery made possible through digitally-powered

solutions. We also recognized that with these codes CMS is making possible more home-based care, critically important to an aging Medicare population with multiple chronic conditions, and at the same time reducing transmission risks during this PHE and future PHEs as well.

However, we were disappointed that CMS did not address in the final rule many of the concerns we raised in its request for comments on how the Agency might remedy issues related to the RTM code construction and permit physicians and qualified healthcare professionals to bill for RTM codes by providing general supervision to clinical staff /auxiliary personnel, who are the most appropriate staff for providing these services.

AdvaMed notes that CMS has correctly analogized these new codes to remote physiologic (RPM) codes, which are Evaluation and Management (E/M) codes. As such, the new remote therapeutic monitoring code family should be billed by physicians and qualified health professionals who can bill E/M services. It is our understanding that the RUC intended that the primary billers of RTM codes would be therapists because the codes are intended as "general medicine" codes and not E/M codes, making the incident-to policy irrelevant. By doing so, however, the RUC inadvertently created a significant hindrance for physician providers and those non-physician practitioners who can bill E/M codes. The work involved in these codes are non-face-to-face in nature, requiring remote services typically performed by clinical staff, respiratory assistants (RAs), physical therapy assistants (PTAs). Under general medicine, both RAs and PTAs may only perform services under direct supervision—an impractical limitation given the remote nature of these services. AdvaMed continues to support RUC goals of expanding the provider types who can bill the new RTM codes and allowing physicians and qualified health providers to use clinical staff under general supervision. To accomplish both goals, AdvaMed recommends that CMS consider the following to address these problems:

- Create two (2) new temporary parallel HCPCS G-Codes (modeled after 98980 and 98981) to serve as E/M codes under Care Management Services to facilitate Remote Therapeutic Monitoring Treatment Management Services for physicians, PAs, NPs, CNSs, and CNMs and allow the use of clinical staff or auxiliary personnel to perform some RTM/TMS work as "incident to" under the general supervision of the billing provider; and
- Consider creating two (2) additional temporary companion HCPCS G-Codes (similar to CPT codes 99457 and 99458) to serve as general medicine codes to facilitate Remote Therapeutic Monitoring Treatment Assessment Services by non-physician providers such as physical therapists, and other practitioners for whom these services fall within their scope and benefit category, allowing them to bill and receive separate payment for these services under Medicare.

Further, we urge CMS to clarify that these new RTM codes are excluded from surgical global periods following patient discharge from facility settings for cardiology, orthopedic, and radiation oncology procedures, for instance, since these are additional services apart from those provided by the surgeon. We believe it is critical that physical therapists are allowed to bill for

RTM services, consistent with PT billing practices that exist today and consistent with the intent of the new RTM CPT codes.

The rule also noted that RTM and RPM codes differ by the nature of the data they would collect and how they would collect data. CMS points out that RTM codes, as detailed in their code descriptors, monitor health conditions, including musculoskeletal system status, respiratory system status, therapy (medication) adherence, and therapy (medication response), and as such allow non-physiologic data to be collected. The CY 2022 PFS Proposed Rule also stated that reported data can be "self-reported" as well as digitally uploaded. CMS asked stakeholders to comment on the typical type of RTM device(s) and associated costs of the device(s) that might be used to collect the various kinds of data included in the code descriptors.
As we stated in our comment letter on the CY 2022 Proposed Rule, we have been unable to find in the code descriptors, or the preliminary prefatory references released by the AMA/Specialty Society RVS Update use of the term "self-reported" or limitations on remote therapeutic monitoring to "medication" adherence or "medication" response. In fact, the 2022 CPT prefatory language for RTM services states, "These data may represent objective device-generated and integrated data or subjective inputs reported by a patient." We believe that RTM should not focus on whether the information is "self-reported data" or if "subjective inputs reported by a patient" (as described in the AMA/Specialty Society RVS Update Process) are one and the same. Rather we believe that RTM, like RPM, should focus on three criteria:

1) Whether the data is digitally generated by a medical device as defined by FDA;
2) Whether the medical device "digitally (that is, automatically)" uploads the patient's data; and
3) Whether the data being collected by the device is therapeutic and centered on adherence, response, or both.

RTM should be allowed for a variety of uses, medical specialties, and clinical examples. Unlike Remote Physiologic Monitoring, the RTM CPT codes 98976 and 98977 specify "respiratory" and "musculoskeletal" thereby causing provider and payer confusion as to which medical specialties may report the RTM/TMS codes. Provider work as described by CPT codes 98980 and 98981 should include all medical specialties involved in remote therapeutic monitoring, pain management, substance use, gastrointestinal, etc.). AdvaMed urges CMS to make that clarification.

We also note that in October 2021 the AMA added code 989X6 to the RTM code family to account for a monitoring device supply used to monitor cognitive behavioral therapy (CBT). The AMA has also deleted codes 0X47T and 0X81T because these were—in our view, incorrectly--seen as duplicative. These changes are effective January 1, 2023, and we anticipate CMS will implement these codes in the upcoming PFS and OPPS rulemaking cycles.

While the new RTM CBT supply code may be helpful for certain technologies, the new code, which rightly focuses on *monitoring,* falls short of describing the *therapeutic* devices that many companies have developed to furnish a digital form of CBT. These products are smart, scalable and heavily-vetted alternatives to a service that has been traditionally furnished in-person or

virtually but where access problems have been far too common. The pandemic has severely exacerbated these access challenges. AdvaMed urges CMS to develop separate payment amounts under the PFS and OPPS for each digital CBT program that is cleared or approved by the FDA and have the ability to deliver a full course of CBT.

Prescription Digital Therapeutics and Software as a Medical Device (SaMD)

A growing area of digital health is the rapid proliferation of SaMD, such as prescription Digital Therapeutics (DTx) which deliver medical interventions directly to patients using evidence-based, clinically evaluated software to treat, manage, and prevent a broad spectrum of diseases and disorders. Under the current Practice Expense (PE) methodology, PE is comprised of two separate resources for any service: direct and indirect costs. Categorizing SaMD such as prescription DTx as indirect PE, "computer software" is simply inaccurate. CMS has repeatedly noted this hindrance, most recently in the CY 2022 Physician Fee Schedule Final Rule, by stating that the only input to the respiratory RTM supply CPT code 98976 was a monthly fee of $25, which would not be paid as a direct cost under the Physician Fee Schedule because historically CMS has "considered most computer software and associated licensing fees to be indirect costs." SaMD should be categorized as "medical equipment," a direct PE equivalent to traditional medical device equipment. In fact, by its technological nature most SaMD evolve, improve, update, and continually defend against risks and vulnerabilities. When SaMD is implemented by a provider, there are ongoing costs for maintenance of the SaMD no different than hardware medical devices. SaMD require updates and upgrades to mitigate against cyber threats, other malicious vulnerabilities, security issues, and improvements that are analogous to medical supplies (another PE component). As CMS continues to consider updates to its current PE Methodology, it should consider recategorizing SaMD as direct PE (equipment) and ongoing maintenance of SaMD as direct PE (supplies).

Remote Patient Monitoring (RPM) Services

AdvaMed has commended the Agency's leadership in recognizing the need for coverage and payment for RPM services distinct and separate from telehealth services. We continue to believe that changes are needed to optimize the potential of these services. We recommend the following changes to existing RPM policies for the proposed CY 2023 PFS Proposed Rule:

- *Amending Minimum Monitoring Requirements.* AdvaMed has observed in the past that a diverse range of clinical scenarios exist for which 16 days of monitoring data is not necessary. We continue to support the development of new codes for this purpose and recommend that CMS work with the CPT Editorial Panel to develop these codes to reflect a broader range of scenarios in which RPM can be used.
- *Recognizing Clinical Necessity of Multiple RPM Devices.* As the nation's health care delivery system is transformed to allowing individuals to effectively manage their conditions at home, CMS should establish policies that ensure beneficiaries have all of the devices necessary to generate the data their care team needs to track their conditions. We urge CMS to clarify in the CY 2023 PFS Proposed Rule that the RPM supply codes for RPM may be billed by more than one provider, per patient.

- *Allowing RPM for New and Established Patients.* During the COVID-19 public health emergency, CMS has allowed RPM programs to be initiated by providers for both new and established patients. CMS has subsequently signaled, that once the PHE ends, RPM can be used for established patients only. Mandating an established patient relationship will preclude many patients with acute conditions from benefiting from these services, placing additional strain on the already over-burdened health system.

Diagnostic Testing Issues

Remote Pathology Reads

During the PHE, CMS has exercised enforcement discretion and permitted pathologists to evaluate slides from their homes without a distinct CLIA certificate, based on the exemption for temporary testing sites under the CLIA regulations. As intended, this has increased capacity for health care providers and avoided unnecessary exposure risks for providers, patients, and the communities they serve.

Advances in technology allow pathologists to provide the same high level of patient care through remote reads, and we ask that CMS use its authority to revise the Clinical Laboratory Improvements Amendments (CLIA) regulations to allow remote reads permanently. At a minimum, we ask that CMS extend its enforcement discretion until the end of 2023, corresponding to the extension for Category 3 telehealth services, following the end of the PHE and, in the interim, work with diagnostic testing stakeholders (including the College of American Pathologists and others) to evaluate possible paths forward to update the CLIA regulations to balance provider capacity, patient access, and quality of care with respect to remote pathology services.

Payment for At-Home Specimen Collection

We applaud CMS's efforts to encourage access to COVID-19 testing through its coverage and increased payment for specimen collection using HCPCS codes G2023 and G2024. As part of the CY 2023 rulemaking cycle, we support expanding and making permanent the use of these codes beyond the PHE to promote access to all medically necessary testing among Medicare beneficiaries who have benefited from expanded care settings during the PHE. To effectuate this, we urge CMS to: (1) expand the definition of G2023 and G2034 to permit use of the codes for all clinical diagnostic laboratory tests, recognizing that the additional cost associated with safe specimen handling will not end with the PHE, and (2) codify the applicability of G2023 to all sites of service where specimens are collected, not just homebound or nonhospital inpatients.

Maintain Access to Lab-Based and Point-of-Care Testing Expanded During the PHE

During the PHE, federal coverage and reimbursement was developed to establish and support infrastructure to extend the reach of COVID-19 testing, including in underserved communities. CMS should consider the extension of these policies beyond the PHE to bolster access to testing for all diseases and conditions with a strong emphasis on the principle that all modalities of testing – laboratory-based and point-of-care (POC), including at-home testing – should be fully leveraged to improve access to diagnostic testing for all diseases and conditions, as appropriate.

Prothrombin Time/International Normalized Ratio (PT/INR)
The absence of adjustments to proposed rates for home PT/INR monitoring conflict with recent actions taken by CMS regarding telehealth and remote monitoring services. CMS has taken important steps, in the last few years, to modernize Medicare physician payment by recognizing communication technology-based services including different kinds of patient monitoring, interpretations of diagnostic tests when furnished remotely, and services that would otherwise be furnished in person but are instead furnished via real-time, interactive communication technology as telehealth. The year-after-year reductions in the reimbursement rates for home PT/INR monitoring runs counter to the continuing efforts by CMS to broaden reimbursement for non-face-to-face services included as part of ongoing care management. AdvaMed recommends that CMS permanently waive the requirement that the demonstration and training for home PT/INR monitoring (code G0248) be performed face-to-face (in-person).

National Pricing of Category III (CPT Code 0583T)
AdvaMed requests that CMS establish a national physician payment rate for Category III CPT code 0583T, also known as tympanostomy under local anesthesia (Tula).

In the November final rule, CMS stated it would review practice expense costs submitted on this procedure, and we appreciate the agency's consideration of these costs in future rulemaking. Given that all seven Medicare Administrative Contractors (MACs) still have not set local prices for this procedure, the significance of establishing a national rate is all the more paramount.

Bestowing meaningful national RVUs for this FDA-approved breakthrough device procedure is urgently needed to grant access to thousands of vulnerable children, decrease health disparities, and offer a less-expensive solution for Medicaid beneficiaries and underserved communities. The absence of a national physician payment rate results in Medicaid State Agencies setting crosswalks to non-comparable services that have effectively blocked access of this less invasive procedure to thousands of vulnerable communities and pediatric populations covered by Medicaid.

AdvaMed urges CMS to set meaningful Medicare RVUs in the 2023 proposed rule for this procedure. This would support Medicaid-covered children at risk of learning challenges caused by hearing loss to access breakthrough technologies approved by the FDA.

Cardiac Ablation Services Bundling (CPT Codes 93653-93657)
In the 2022 Medicare Physician Fee Schedule Final Rule CMS finalized the proposed work RVU's for cardiac ablation services (CPT codes 93653 and 93657). The codes, which are bundled services, experienced a 30%-36% decrease in reimbursement from the prior year, after CMS did not accept the recommendation to implement corrected work RVU's from the AMA RUC. The relevant physician societies as well as the AMA RUC had urged CMS to implement the April 2021 RUC recommendations for physician work and practice expense RVUs. At the time, CMS indicated it had not yet reviewed the April 2021 RUC recommendations for CY 2022, and later proposed and finalized the existing physician times and work RVUs for CPT codes 93653 and 93656 for CY 2022. These ablation services have been extensively revised to

include newly bundled work that was previously separately reported (93613, 93621, and 93662), and it is not appropriate to maintain the current times and values for CPT codes that beginning January 1, 2022, represent a different configuration of services than the previous CPT codes. These cuts represent significant reductions and do not fairly compensate the skills, intensity and time or the value that these ablation services bring to patients. Ablation has been shown to improve patient's quality of life and decrease hospitalizations and mortality, particularly in patients with heart failure. It also has been shown to improve patient outcomes when performed early. Significant healthcare resources are conserved through avoidance of complications, such as stroke, myocardial infarction, tachycardia, and heart failure. Dramatic reductions in payment could reduce the number of physicians offering ablation services.
AdvaMed believes that these ablation services in the 2022 PFS are undervalued and urges CMS to re-examine, as it has committed to do, the valuation for CPT codes 93653 and 93656 and consider the latest AMA RUC recommendations.

We thank you for the opportunity to submit these comments. If you have any questions, please contact Richard Price in AdvaMed's Payment and Health Care Delivery Department at rprice@AdvaMed.org.

Sincerely yours,

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