



December 15, 2021

Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare & Medicaid Services
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted via email

RE: 2022 Medicare Physician Fee Schedule Final Rule (CMS 1751 FR)

Dear Administrator Brooks-LaSure:

On behalf of the Heart Rhythm Society and the American College of Cardiology, we are providing further input on the 2022 Medicare Physician Fee Schedule Final Rule, and in particular, the final valuation for electrophysiology services which are facing total reductions up to 36% effective January 1. These cuts would be devastating on their own, but CMS has chosen to implement them at a time when they could be exacerbated by looming statutory reductions. While Congress last week delayed the Medicare sequester and other cuts, that relief is temporary and brings the likelihood of additional disruptions in the first two quarters of 2022.

Both HRS and the ACC request that CMS reconsider its decision regarding the work relative value units (wRVUs) for the following codes and implement the April 2021 RUC recommended wRVUs as soon as possible:

- **93653** (*Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording, and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and His bundle recording, when performed; treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry*)
- **93656** (*Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation, including intracardiac electrophysiologic 3-dimensional mapping, intracardiac echocardiography including imaging supervision and interpretation, induction or attempted induction of an arrhythmia including left or right atrial pacing/recording, right ventricular pacing/recording, and His bundle recording, when performed*)

For CY 2022, CMS finalized the CY 2021 wRVUs for these codes without recognizing the work of the newly bundled services that are now described by these codes. Both HRS and ACC urge CMS to replace the CY 2022 finalized wRVUs with the April 2021 RUC recommendations provided to CMS for these codes. In the alternative, if CMS chooses to continue with the wRVUs as finalized in the CY 2022 Medicare Physician Fee Schedule (MPFS) final rule, then we request that CMS exercise the Agency's authority to phase in significant reductions in light of the new data that will be reviewed next year.

We understand that the CY 2022 MPFS rule was finalized without the opportunity to provide additional comment for 2022 rulemaking; however, it is imperative that we share our concerns about the significant reductions our members are facing as of January.

With the decision to maintain the current wRVUs for CPT 93653 and CPT 93656 without regard for the additional work now bundled into their descriptors, along with the Agency's finalized CY 2022 MPFS conversion factor, payment for these services now face a combined reduction of 36% and 30% respectively. As far as we are aware, the reductions hitting electrophysiology providers is one of the largest ever faced because of actions finalized by CMS. More than 700 comment letters on this issue were submitted on behalf of our small specialty, supporting an alternative that would have helped allay such a dramatic reduction.

These drastic cuts do not represent nor fairly compensate the skills, intensity, and, most importantly, the value that these services bring to patients and our overall healthcare system. 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, have a negative impact on future recruitment and training of these highly skilled physicians, result in longer wait times for procedures at sites that may be farther away, and even mean that some patients may not be offered ablation therapies at all.

CMS IGNORED THE BUNDLED SERVICES REFLECTED IN THE REVISED BASE CODES

We believe it is important to recognize that even if CMS implements the January 2021 RUC recommendations for CPT 93653 and CPT 93656, the reductions are still steep. However, rather than accept those values as interim in lieu of new April 2021 recommendations transmitted after the deadline, CMS chose to disregard the RUC by locking in only the current values for the revised Supraventricular Tachycardia Ablation code. By doing so, CMS completely ignores two of the services (3-D mapping/pacing) that will be part of the newly bundled set of services reflected by what, until 2022, had been the base code.

This action significantly undervalues the skill, intensity and risk of these often curative and life-enhancing, or in some cases, life-saving procedures. It also creates a situation that will have significant unintended consequences for research, training future electrophysiologists and patient access. By not exercising its authority to phase in this type of significant reduction, CMS is compounding this situation. CMS has flexibility in its authority to phase in significant reductions and we implore CMS to reconsider and provided a two-year phase-in for these services.

CMS APPLIED INCONSISTENT METHODOLOGIES ACROSS THE CODE FAMILY

Rather than maintain consistencies across this family of services and retain the current work values for all, CMS instead considered and then discounted the values for the two add-on procedures using January 2021 RUC recommendations:

- CPT 93655 (*Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia (List separately in addition to code for primary procedure)*); and
- CPT 93657 (*Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation (List separately in addition to code for primary procedure)*).

Considering that new data and recommendations were submitted for those services, the same logic for maintaining the current values should have been applied. By not doing so, CMS again creates significant reductions of 30% for codes that also now include the bundled services of CPT 93613 (*Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)*) and CPT 93621 (*Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left atrial pacing and recording from coronary sinus or left atrium (List separately in addition to code for primary procedure)*).

The work of performing subsequent ablations is significant due to the patient having complex arrhythmias that requires identifying additional foci to alleviate arrhythmias. The finalized values do not reflect the intensity of that work. The intensity increases when additional lesions are given. There is a fatigue factor, ongoing anesthesia (and hence more risk), and increasing edema from the original ablation that make access to additional target sites more problematic. Mapping can become much more problematic, in addition to the fact that the left atrial catheter may have to be repositioned multiple times during the process. The same additional elements that were bundled into the base codes because they are now inherent to the ablation procedures—3D mapping, left atrial pacing, intracardiac echocardiography—are also performed during the respective add-on procedures.

VALUE/PHYSICIAN WORK OF NEWLY BUNDLED SERVICES DISREGARDED

Due to changes in technology since first valued in 2011, increased utilization and codes frequently being billed together, the RUC recommended that CPT 93653 be referred to the CPT Editorial Panel for revision and bundling. At the October 2020 meeting, the CPT Panel also bundled the same services in to 93656 due to their commonly being billed together.

In December 2020, after receiving the survey data, neither HRS nor ACC were confident in the data and asked the CPT Panel to rescind the code changes for one year so that the codes could be re-numbered. The societies were concerned that the RUC survey respondents may have been confused about the coding changes, ignoring the bundling in the revised descriptors. In February 2021, the CPT Editorial Panel Executive Committee did not rescind CPT's changes, which would be effective for CPT 2022. Due to the Panel's decision, the societies presented the

survey data at the January 2021 RUC meeting yet asked that the recommendations be considered interim and that the codes be re-surveyed for the April 2021 RUC meeting. When the codes were re-surveyed, the RUC permitted the societies to use placeholder codes as one step to ensure that those surveyed might pay more attention to the new code descriptors. The RUC submitted a final recommendation for revised codes 93653-93657 for CY 2022 in May 2021.

Both HRS and ACC as well as the AMA RUC urged CMS to implement the April 2021 RUC recommendations for physician work and practice expense for CY 2022. As CMS indicated it had not yet reviewed the April 2021 RUC recommendations for CY 2022, the Agency proposed and finalized the current physician **times and current wRVUs for CPT codes 93653-93657, 93613, 93621 and 93662 for CY 2022. These ablations services have been extensively revised to include newly bundled work that was previously separately reported, and it is not appropriate to maintain the current times and values for CPT codes that beginning January 1, 2022 will represent a different configuration of services than represented by the current CPT codes.**

Intracardiac echocardiography (93613) is used to provide high-resolution real-time visualization of cardiac structures as well as continuous monitoring of a catheter location within the heart. It commonly guides trans-septal puncture where the operator creates a hole in the septum of the heart to gain access to the other cardiac chambers on the other side of the heart and is useful for early recognition of procedural complications, such as pericardial effusion or thrombus formation. ICE remains highly technical in nature and requires the patient to be anesthetized. ICE is most used with atrial fibrillation ablations, a highly technical and challenging service, this reinforces the intensity of ICE. This is now an integral part of the new bundled service 93653. Another newly bundled portion of 93653 is the pacing described by 93621. The electro-physiologist must place a sheath either in the internal jugular vein or subclavian vein using standard percutaneous techniques. The physician then introduces a catheter into the sheath and advance into the right atrium where the ostium of the coronary sinus is engaged before advancing the catheter into the coronary sinus. The multielectrode catheter is used to record electrical activity from the left atrium and, at times, pace the left atrium to attempt arrhythmia induction. Reposition the catheter as necessary throughout the course of the procedure to optimize recordings and pacing thresholds. At the conclusion of the procedure, the catheter is removed and hemostasis is obtained.

By finalizing the current values, at least until the April 2021 RUC recommendations can be reviewed in 2022, the times and wRVUs of the previous values of the ICE (CPT 93613 (5.23 wRVUs)) and the pacing 93621 (1.75), are ignored. It is not logical that the wRVUs for these services are exactly the same for a CPT code that now represents two additional separately reportable add-on codes.

PHASING-IN STEEP REDUCTIONS OVERLOOKED

HRS and ACC both requested in our proposed rule comments that should the proposed reductions be finalized, CMS should make an exception to its policy that phase-in of reductions of greater than 20% is limited only to codes that have undergone no changes in descriptor and instead phase in such a reduction over two years. **We reiterate and strongly urge CMS to phase-in this reduction.** This recommendation applies whether CMS were to finalize its proposed values, the April RUC-recommended values, or something else that produces bundled

reductions of greater than 20%. **Phasing in the resulting reductions when bundling of multiple services into a single code that produces reductions of greater than 20% aligns with the spirit of that policy.**

For practices and physicians managing practices in the current clinical and financial environment, the CMS logistics around how these services came to experience a significant payment reduction are irrelevant. The physicians providing these services will simply and suddenly see a reduction from 21.73 work RVUs to 14.75 work RVUs for CPT 93653 and from 26.79 to 19.77 work RVUs for CPT 93656. Each of these reductions exceeds 20% without the further reductions that result from not recognizing the services that are now bundled into this procedure.

Phasing in the reduction would mitigate the negative impacts to practices of significant drops in work RVUs and give them additional time to prepare for workflows and logistics to best meet patient care needs in the face of declining revenue.

SKILL/INTENSITY SEVERELY UNDERVALUED

The actual ablation portion of these procedures are more intense relative to when this procedure was last valued in 2010. The cardiac electrophysiologist is now receiving much greater feedback from the catheter that is touching the heart and now knows exactly how many grams of force are being applied. When the base procedure was last reviewed, the physician would not have been certain that the tissue was contacted well enough to be delivering energy, which resulted in the physician delivering repeated ablation on the same spots many times, to produce an effect. The physician now knows exactly how well the catheter is contacting the tissue and is also examining the different impedance and various electrical measurements during the ablation delivery.

Due to these recent improvements in technology, the induction of lesions is now more efficient and effective, but, also because of that, the risk of causing collateral injury during the ablation delivery is higher with each lesion delivery. For instance, the ablation treatment is much more intense in terms of risk of cardiac perforation, heart block and esophageal injury. Furthermore, while the physician is obtaining many more data points to create the 3-dimensional map, the physician still needs to make sure every one of those points are accurate as review of points is not automated.

By maintaining the current wRVU for 2022, CMS is dismissing entirely the additional work entailed in these newly bundled services. CPT 93653 is typically the most intense service to perform among the three base codes in this family (93653, 93654 and 93656). CPT code 93653 is typically performed on a younger patient who does not have other conditions and the ablation site occurs very close to the patient's innate conduction system. Even under the best situation, there is a risk of causing heart block requiring a permanent pacemaker. The time when the physician is applying radiofrequency energy is extraordinarily intense as opposed to the other two ablation services, 93654 and 93656, which are longer procedures on generally sicker patients and the intensity is more spread out over time. The values approved by the RUC from the April 2021 meeting took into account the intensity, complexity and risk of these services. By maintaining the 2020 values for 93653 there was no recognition for the additional physician work nor the intensity/severity and risk involved. **In maintaining the current value, the overall service will be undervalued for 2022.**

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HRS and ACC appreciate the opportunity to provide CMS with feedback on the decisions around cardiac ablation services and forward our request to mitigate the significant reductions being faced in January. In lieu of the revised RUC recommendations forwarded to CMS from the April 2021 meeting. Please contact Anne Marie Smith, Vice President of Practice Improvement at AMSmith@hrsonline.org or James Vavricek at jvavricek@acc.org if you have any questions or need any additional information.

Respectfully,



Fred Kusumoto, MD, FRHS
President, HRS



Dipti Itchhaporia, MD, FACC
President, ACC

cc: Gift Tee, Director Provider Payment

HRS is the international leader in science, education and advocacy for cardiac arrhythmia professionals and patients, and the primary information resource on heart rhythm disorders. Its mission is to improve the care of patients by promoting research, education, and optimal health care policies and standards. HRS represents more than 7,100 specialists in cardiac pacing and electrophysiology, consisting of physicians, scientists, and allied professionals. Electrophysiology is a distinct specialty of cardiology, with eligibility for board certification in both clinical cardiology and clinical cardiac electrophysiology through the American Board of Internal Medicine.

ACC envisions a world where innovation and knowledge optimize cardiovascular care and outcomes. As the professional home for the entire cardiovascular care team, the mission of the College and its more than 54,000 members is to transform cardiovascular care and to improve heart health. The ACC bestows credentials upon cardiovascular professionals who meet stringent qualifications and leads in the formation of health policy, standards and guidelines. The College also provides professional medical education, disseminates cardiovascular research through its world renowned JACC Journals, operates national registries to measure and improve care, and offers cardiovascular accreditation to hospitals and institutions. For more, visit acc.org.
