

American Society of Interventional Pain Physicians®

"The Voice of Interventional Pain Management"

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September 10, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1753-P
P.O. Box 8010
Baltimore, MD 21244-1850

Re: CMS-1751-P: Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-Payment Medical Review Requirements

Dear Administrator Brooks-LaSure:

On behalf of the Board of Directors of American Society of Interventional Pain Physicians (ASIPP), 49 state societies and the Puerto Rico Society of Interventional Pain Physicians, as well as the entire membership of ASIPP, we would like to thank you for providing the opportunity to comment on CMS-1751-P: Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-Payment Medical Review Requirements.

At the outset, we would like to thank CMS for numerous bold steps taken during the pandemic. We greatly appreciate what you have done in reference to Telehealth and specifically adding telephone only codes during the pandemic. However, while we are grateful that you are extending coverage of services that were added to the Medicare telehealth list on an interim basis in response to the COVID-19 public health emergency (PHE), until the end of 2023, we are also disappointed that CPT codes for telephone evaluation and management services (CPT 99441 to 99443), were excluded and considered only for mental health services.

Other important issues are related to proposed payment cuts, which may be as high as 9.75%, which will be devastating to patients and providers.

BACKGROUND

ASIPP is a not-for-profit professional organization founded in 1998 now comprising over 4,500 interventional pain physicians and other practitioners who are dedicated to ensuring safe, appropriate and equal access to essential pain management services for patients across the country suffering with chronic and acute pain. There are approximately 8,500 appropriately trained and qualified physicians practicing interventional pain management in the United States.

Interventional pain management is defined as the discipline of medicine devoted to the diagnosis and treatment of pain related disorders principally with the application of interventional techniques in managing sub acute, chronic, persistent, and intractable pain, independently or in conjunction with other modalities of treatment (The National Uniform Claims Committee. Specialty Designation for Interventional Pain Management- 09, www.cms.hhs.gov/transmittals/Downloads/r1779b3.pdf).

Interventional pain management techniques are minimally invasive procedures including, percutaneous precision needle placement, with placement of drugs in targeted areas or ablation of targeted nerves; and some surgical techniques such as laser or endoscopic discectomy, intrathecal infusion pumps and spinal cord stimulators, for the diagnosis and management of chronic, persistent or intractable pain (Medicare Payment Advisory Commission. Report to the Congress: Paying for interventional pain services in ambulatory settings. Washington, DC: MedPAC. December. 2001. <http://www.medpac.gov/documents/reports/december-2001-report-to-the-congress-paying-for-interventional-pain-services-in-ambulatory-settings.pdf?sfvrsn=0>)

- ◆ A perfect storm has arisen due to a rare combination of adverse factors, including the coronavirus pandemic, which has catapulted the country into one of the deepest recessions in the United States' history. The decimation of multiple medical services, a convergence of concurrent PHEs due to the COVID-19 epidemic, the exacerbation of the existing opioid epidemic, the addition of a epidemic of economic consequences, and a tsunami of deleterious payer policies leading to a perfect storm.
 - Providers in many sectors, specifically in interventional pain management, continue to see significant reductions in their patient load for any type of interventional procedure, ranging on average from 20% to 25%, with escalating costs in providing care, and with impending cuts for Medicare and other insurers.
 - We have had discussions concerning the opioid epidemic in the past and CMS is well aware of it.

Impending cuts, increases in providing care, and the elimination of telephone only services will lead to extensive disastrous situations for both patients and physicians including an escalation of the opioid epidemic.

- The importance of interventional techniques and curtailing the opioid epidemic has been an important issue for CMS and other agencies along with congress and the administration. In fact, the document from the Department of Health and Human Services (DHHS), Pain Management Best Practices Interagency Task Force Final Report on Pain Management Best Practices: Updates, Gaps, Inconsistencies, and Recommendations, published on May 19, 2019, clearly outlines the role of interventional techniques.

Reduction in interventional pain management services is a great disservice to chronic pain patients who have suffered more than their share during the COVID-19 epidemic and these patients will continue to suffer. Elimination of convenient opportunities for this vulnerable population will be inappropriate and will force patients into more expensive settings such as hospitals since many pain physicians will be shifting to hospital based practices.. With few tangible choices, many other physicians have already relocated their practices to hospitals. Hospitals and corporations control 70% of physician practices. This only increases the expenses rather than reducing them and ultimately renders the Medicare program vulnerable.

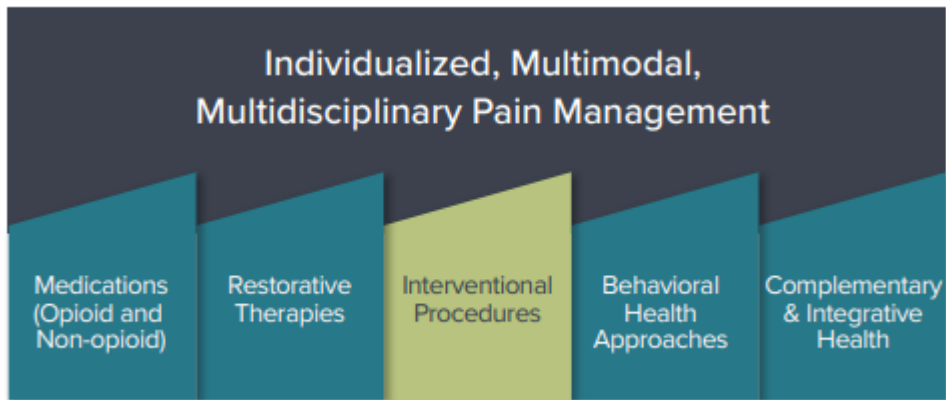


Fig. 1. Chronic pain management consists of five treatment approaches informed by four critical topics.

Source: U.S. Department of Health and Human Services. Pain Management Best Practices Inter-Agency Task Force. Final Report on Pain Management Best Practices: Updates, Gaps, Inconsistencies, and Recommendations. May 9, 2019.

COMMENTS:

Our major concerns are related to two issues – elimination of telephone only services and physician payment cuts as high as 9.75%.

1. Physician payment cuts

At ASIPP, we are deeply concerned about the growing financial instability of physician practices due to the severe reduction in revenues caused by the COVID-19 PHE. For interventional pain physicians, the revenue stream has been significantly reduced by 20 to 25%. The majority of interventional procedures have declined. New patient evaluations have declined. The only service which has not significantly declined is evaluation and management services for follow-up visits. The looming payment cuts facing physician practices at the beginning of the year, including cuts due to budget neutrality, must be addressed to ensure that practices can remain fiscally viable.

In January 2022, physician practices face the following Medicare financial hits:

- Expiration of the congressionally enacted 3.75% temporary increase in the Medicare physician fee schedule conversion factor to avoid payment cuts associated with budget neutrality adjustment tied to PFS policy changes.
- Expiration of the current reprieve from the repeatedly extended 2% sequester stemming from the Budget Control Act of 2011. It appears that while Congress originally scheduled this policy to sunset in 2021, but it will now continue into 2030.
- Imposition of a 4% statutory pay-go sequester resulting from passage of the American Rescue Plan Act, presumably extending for at least another 10 years.
 - Should lawmakers fail to act, it will mark the first time that Congress has failed to waive statutory PAY-GO.

- A statutory freeze in annual Medicare fee-for-service updates under the Medicare Access and CHIP Reauthorization Act (MACRA) that is scheduled to last until 2026, when updates resume at a rate of 0.25% a year indefinitely. This figure well below the rate of medical consumer price index inflation.

Thus, overall, combined physician practices face 9.75% cut on January 1. Additionally, potential penalties under the merit-based incentive payment system, which applied to Medicare fee-for-services, will increase to 9% in 2022. All of this financial uncertainty comes at a time when physician practices are still suffering from the financial impact of COVID-19 PHE, including continued infection control protocols that, while necessary, have increased the costs of providing care. In addition to this, the Delta insurgence has also created numerous new problems with reduced patient load and increased practice costs. There are numerous unpaid mandates by the federal government and state governments. Consequently, CMS, Congress and the Government Administration may be stretching physician practices to their limits clinically, emotionally, and financially as the pandemic persists and continues. It is unknown as to what other variants will be attacking us. The enactment of further Medicare payment cuts will undoubtedly threaten patient access to care, specifically for the vulnerable population suffering with chronic pain. The stark reality is that when adjusted for inflation in practice costs, Medicare physician payment actually declined 22% from 2001 to 2020, or by 1.3% per year on average.

2. Elimination of Telephone Only Services

While we are also requesting Congress to take appropriate action, CMS on their own may be able to avert some of these disastrous cuts and improve the stability of the program by maintaining access to phone only services. We are extremely disappointed at the decision of CMS on the proposed rule to eliminate phone only services, except for mental health services. While we wish to express our sincere support for extending coverage of services that were added to the Medicare telehealth list on an interim basis in response to the COVID PHE until the end of 2023, we strongly recommend these proposals be finalized. We vehemently urge CMS to change their present position to avoid disruption of care for vulnerable patients in rural areas suffering with chronic pain who may not have video capabilities. Altering your position would allow them to continue to receive appropriate care. Refusal from other insurers is already causing a significant impact on patients forcing them make several visits to physician offices. Requiring COVID-19 testing, (which is becoming expensive and difficult) only increases costs and patient inconvenience. CMS in the proposed rule contends that the telephone only services, CPT codes 99441-99443, do not meet the criteria except for mental health services.

We disagree with this assumption. Telephone only services do meet criteria for chronic pain patients. It is essential that these services be preserved for these patients for their convenience and to afford them the ability to maintain basic services. This may be the only opportunity for them to receive certain types of services without foregoing care. Reviewing and refilling patient prescriptions is just one example of this vital care, missing opioid prescriptions or other important drugs will result in patients seeking drugs elsewhere, fueling the opioid epidemic.

The contention that telephone services have been excessively overused may not be accurate. Although the epidemic has increased need, our surveys at ASIPP have repeatedly shown a 5-10% decrease, or 5% increase in the evaluation and management services for established patients which are the only services these codes are used for.

Consequently, we request language revision.

“e. Payment for Medicare Telehealth Services Furnished Using Audio-Only Communication Technology”

To propose permanent modifications to the definition of “interactive telecommunication system” to allow for use of audio-only communications technology despite your interpretation of statutory requirements, as well as concerns, which may not be any more than two-way communication with video that the use of audio-only communication technology for Medicare health services could lead to inappropriate overutilization.

The last part of the sentence is not accurate. The similar service is provided on most occasions. When it is not, patients are called in at any time for an in-person visit. Of the thousands of visits we have looked at, the patients were called in for further assessment less than 1% of the time. Consequently, we believe that it is reasonable to re-assess these concerns especially given the current widespread COVID-19 with delta variant dissemination and the likely transmission of other variants.

Again, it is accurate that EM services using audio-only codes have increased substantially for mental health services. However, the same concern must not be applied to other areas, and other areas must not be punished with unfounded concerns in chronic pain.

Consequently, we request to change the following language:

We are proposing to amend our regulation at § 410.78(a)(3) to specify that an interactive telecommunication system can include interactive, real-time, two-way audio-only technology for telehealth services furnished for the diagnosis, evaluation, or treatment of **chronic pain** ~~a mental health disorder as described under paragraph (b)(4)(D)~~, under the following conditions: The patient is located in their home at the time of service as described at § 410.78 (b)(3)(xiv); the distant site physician or practitioner has the technical capability at the time of the service to use an interactive telecommunication system that includes video; and the patient is not capable of, or does not consent to, the use **of** video technology for the service.

In addition to the above, another issue relates to inclusion of electrical analysis of neurostimulator codes as a *Medicare Telehealth Category 3* to allow additional time for stakeholders to collect, analyze and submit data.

It is our position that the codes (95970, 95971, 95972, 95983 and 95984) should now be transitioned to the Medicare telehealth list on a Category 3 basis to allow time for additional data collection.

We believe allowing telehealth for these patients has been extremely beneficial. It has allowed for real time trouble shooting and reprogramming to improve the patient experience, while avoiding travel and time expenses to the patients. Several neurostimulators are able to be reprogrammed remotely with continuous engagement with the patient through a two way communication interface. At the very minimum it makes reasonable sense to allow time for additional data collection, thus including these codes as category 3 seems quite appropriate. We have come to see that this remote interface has been extremely helpful, therefore we are requesting that the neurostimulator programming & analysis codes (95970-95972 & 95983—95984) be granted a category 3 telehealth

If you have any questions, please feel free to contact us.

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