AMERICAN ACADEMY OF
OTOLARYNGOLOGY–
HEAD AND NECK SURGERY

September 6, 2017

SUBMITTED VIA ELECTRONIC FILING

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1678-P
P.O. Box 8013
Baltimore, MD 21244-1850

Re: CY 2018 Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs Proposed Rule

Dear Administrator Verma:

On behalf of the American Academy of Otolaryngology—Head and Neck Surgery (AAO-HNS), I am pleased to submit the following comments on the CY 2018 Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs, published in the Federal Register as a proposed rule. Our comments will address the following issues: 1) CY 2018 Comprehensive Ambulatory Payment Classifications (C-APCs); 2) Imaging APCs; and 3) Changes for Computed Tomography (CT) under the Protecting Access to Medicare Act of 2014 (PAMA); and 4) New Bundled Sinus Codes Payment in the Ambulatory Surgical Center (ASC).

1. Additional Comprehensive APCs (C-APCs)

In 2017, CMS finalized a policy changing the APC to which many endoscopic sinus surgery procedure codes map (APC 5155) to a C-APC. This changed the status indicator for these codes from "T" to "J1." By modifying the status indicator, CMS eliminated a multiple procedure reduction for subsequent procedures following the primary service. Although the primary procedure payment increased under this status indicator, overall payment decreased due to $0 reimbursement for subsequent procedures. The Academy expressed concerns about this policy due to the subsequent decreases in payment as a result of the status indicator change (such as for common sinus surgery cases, i.e. multiple procedures in same encounter). Other possible unintended consequences include, potentially affecting patient safety, particularly those with multiple comorbidities, and shifting patient care for the affected procedures from the hospital outpatient site of service to ambulatory surgery centers and office sites-of-service. The Academy remains concerned the proposed CY 2018 C-APC

values do not adequately reimburse clinicians for the work performed and believes CMS should set values that more accurately reflect the cost of the procedures. The Academy recommends CMS reexamine the effects of this change and consider implementing the following pay structure wherein CMS pays the primary procedure at 100 percent, the second procedure at 50 percent, the third procedure at 25 percent, and the remaining procedures at 0 percent. Doing so will allow CMS to develop a payment system that more accurately reflects the resource and clinical heterogeneity of the primary and subsequent procedures, while maintaining the overall homogeneity of the C-APC system. ***The Academy continues to urge CMS to take a cautious approach as it implements the C-APCs system to protect against unintended shifts in site-of-service by phasing in a gradual change of C-APCs over several years.*** A phased in approach will allow institutions to modify practice and business patterns accordingly, rather than responding quickly to rapid implementation and drastic modifications to payment for procedures.

For CY 2018, CMS proposes to apply a frequency and cost criteria threshold, testing claims reporting one unit of a single primary service assigned to status indicator "J1" and any number of units of a single add-on code for the primary J1 service. If the frequency and cost criteria thresholds for a complexity adjustment are met and reassignment to the next higher cost APC in the clinical family is appropriate (based on meeting the criteria outlined above), CMS would make a complexity adjustment for the code combination. As currently defined, many services utilized by Otolaryngology - Head and Neck Surgery are not eligible for the complexity adjustment and therefore have a reduced reimbursement amount***. Should CMS choose not to modify the C-APC system to develop a prospective payment system, it should instead re-examine its complexity adjustment formula to include codes frequently billed together such as the endoscopic sinus codes (31254, 31254, 31267, 31276, 31287, 31288, 31292, 31293, 31294, 31295, 31296, or 31297 (all mapped to APC 5155)) to more accurately reimburse clinicians for work performed.*** Given the new bundled codes are included in the Medicare Physician Fee Schedule proposed rule (31XX2 Nsl/sins ndsc total; 31XX3 Nsl/sins ndsc tot w/sphendt; 31XX4 Nsl/sins ndsc sphn tiss rmvl; 31XX5 Nsl/sins ndsc w/sins dilat), we would like to know how CMS plans to handle. If CMS intends to move forward with this plan, we want to be sure the bundled codes would be eligible for a J1 indicator.

The endoscopic sinus codes present a unique situation where they are frequently billed with multiple CPT codes. For example, of 217 sinus surgery cases performed at Northwestern in 2015, 50 percent included 1-4 CPT codes and 50 percent listed 5+ CPT codes. This is consistent with the overall distribution in national level claims data. Bilateral procedures, which are common to sinus surgery encounters, were counted by Northwestern as 1, not 2 procedures, therefore the actual number of individual procedures is significantly higher, which is again consistent with national level claims data. Once again, the Academy calls on CMS to re-examine C-APC policies to more accurately capture and reimburse the cost of procedures.

2. Radiology and Imaging Procedures and Services

a. Imaging APCs

CMS has the authority to review and revise APC group assignments, relative payment weights, and the wage and other adjustments to consider changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors. After reviewing claims data used for CY 2018 rate setting including resource costs and clinical coherence of the procedures associated with the four levels of imaging without contrast APCs and the three levels of imaging with contrast APCs, CMS proposes to use its authority to split the current Level 4 Imaging without Contrast APC into two APCs. These APCs would be Level 4 Imaging without Contrast APC which would include high frequency low cost services and Level 5 Imaging without Contrast APC which would include low frequency high cost services. ***The Academy***

appreciates CMS' review of these and other APC group assignments annually. In general, the Academy supports the decision to create an additional APC group to more accurately differentiate between different imaging modalities. However, before we're asked to comment, CMS needs to define "high frequency low cost services" and "low frequency high cost services."

3. Payment Changes for Film X-Rays Services and Proposed Payment Changes for X-rays Taken Using Computed Radiography Technology

The Consolidated Appropriations Act of 2016 contains provisions to incentivize the transition from traditional X-ray imaging to digital radiography, including provisions that limit payment for film x-ray imaging services and computed radiography imaging services. Specifically, the Act states for services furnished during 2017 or a subsequent year, the payment under the OPPS for imaging services that are X-rays taken using film (including the X-ray component of a packaged service) shall be reduced by 20 percent. The Act also provides a phased-in reduction of payments for imaging services using computed radiography technology furnished of 7 percent from CY 2018 through 2022 and 10 percent after 2023. While these reductions are mandated by statute, the Academy encourages CMS to consider these substantial reductions in reimbursement when considering additional payment reductions to procedures throughout the Medicare Physician Fee Schedule and Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems. ***We support the transition to digital radiography. However, we urge CMS to exercise caution when looking at other imaging services that do not warrant this reduction (e.g., Ultrasound services).***

4. New Bundled Sinus Codes Payment in the Ambulatory Surgical Center (ASC)

Currently, ASC payment rates are tied to data derived from the OPPS. The Academy is concerned about the difference between OPPS payments relative to ASC payments, particularly, the new endoscopy sinus surgery bundled codes. Based on the data, CMS proposes to pay for the new bundled procedures involving two services, but pays $0 for an additional procedure. This results in a proposed 38 percent reduction, or a reduction of $1,635 for a bilateral procedure (from $4,270 in CY 2017 to $2,562 in CY 2018). We are concerned that the lack of appropriate payment for ASCs may result in moving the more complex cases to the OPPS setting instead of the lower cost ASC setting, thereby adding cost into the health care system.

The Academy does not believe payment of the new bundled codes as the same as the individual sinus codes makes logical sense. This is evident by looking at the total time for the new CY 2018 codes and the individual current CPT codes that make up the new bundled codes.

Table 1. ASC Payment for New Bundled Sinus Codes

New Bundled CPT code	Total Time (mins)	Current CPT code	Total Time (mins)	Current CPT code	Total Time (mins)	Total Time of Current CPT codes combined (mins)	Time Not Accounted For In ASC Payment (mins)
31XX2*	126	31255*	98	31276*	98	196	70
31XX3*	118	31255*	98	31287*	86	184	66
31XX4*	123	31255*	98	31288*	96	194	71
31XX5 *	76	31296*	61	31297*	56	117	41

*31XX2 Nsl/sins ndsc total; 31XX3 Nsl/sins ndsc tot w/sphendt; 31XX4 Nsl/sins ndsc sphn tiss rmvl; 31XX5 Nsl/sins ndsc w/sins dilat; 31255 Removal of ethmoid sinus; 31276 Sinus endoscopy surgical; 31287 Nasal/sinus endoscopy surg; 31288 Nasal/sinus endoscopy surg; 31296 Sinus endo w/balloon dil; 31297 Sinus endo w/balloon dil

For example, the new code 31XX2 Nasal/sinus endoscopy, surgical with total ethmoidectomy plus frontal sinus has a total time of 126 minutes. However, the individual codes making up the new bundled code (31255 and 31276) make up 196 minutes. CMS is not capturing the additional time that an ASC will need to pay for additional anesthesia, non-physician clinical staff, and supply costs involved (eg, additional costs for drugs and IV fluids. (See Table 1 above.) In addition, given these are new codes in CY 2018, it is not clear what data would have been used by CMS to calculate the ASC payment until there are claims data from CY 2018.

Therefore, we recommend that CMS determine some other payment for these new bundled codes that more accurately reflects the costs and resources utilized by ASCs. CMS could allow ASCs to utilize the CY 2017 codes and payments with 100 percent paid for the first service and 50 percent paid for the second service performed. Or CMS could look at the next highest APC payment and calculate a new APC payment based on what the codes have been traditionally paid, looking at payment that is 1.5 times higher. Finally, since CMS does not yet have data with combined code claims yet, we strongly urge CMS to collect the claims under the current system and then re-visit to determine what the claims show. We would be happy to work with CMS to develop the new payment methodology for these set of codes.

5. Conclusion

The American Academy of Otolaryngology—Head and Neck Surgery appreciates the opportunity to provide comment and recommendations regarding these important policies on behalf of our members. If you have any questions or require further information, please contact Jenna Kappel, MPH, MA, Director of Health Policy at jkappel@entnet.org or 703-535-3724. Thank you.

Sincerely,

James C Denneny III

James C. Denneny, III, MD, FACS
Executive Vice President and CEO