Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1751-P
P.O. Box 8016
Baltimore, MD 21244-8016

August 31, 2021

Submitted electronically via www.regulations.gov

RE: 2022 Medicare Physician Fee Schedule Proposed Rule (CMS-1751-P)

Dear Administrator Brooks-LaSure:

On behalf of the Heart Rhythm Society, we appreciate the opportunity to provide feedback on the 2022 Medicare Physician Fee Schedule (PFS) proposed rule. 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 clinical cardiac electrophysiology through the American Board of Internal Medicine, as well as certification in cardiology.

Our comments below focus on: work valuations for electrophysiology services; revisions to practice costs; telehealth; MIPS Value Pathways; and subgroup reporting.

Work Valuations for Electrophysiology Services

HRS is concerned that CMS accepted only 77% of the RUC's recommendations and none of the recommendations for the electrophysiology related codes. It appears that CMS, the RUC and the specialty societies need to have a larger discussion about why this discord is happening. For almost thirty years, the three entities had worked well to establish physician work relative values and practice expense costs. CMS' increasing shift away from implementing RUC recommendations shows a significant change in how the Agency regards the process including the physicians who complete surveys. It is discouraging that physician input about the services that they provide holds decreasing value to CMS. For the sake of transparency, we believe CMS should work with the RUC and specialties to identify the Agency's areas of concern so that all can come to agreement on any changes that the process needs.

For all of the following CPT codes, CMS should implement the RUC recommended values.

External Cardiovascular Device Monitoring (CPT codes 93228 and 93229)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
93228	**External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional**	**0.43**	**0.52**
93229	**External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional**	**0.00** **(PE Only)**	**0.00** **(PE Only)**

In October 2019, the RUC's Relativity Assessment Workgroup identified codes 93228 and 93229 as part of its screen for services with rapid Medicare utilization of 10,000 or more and a Medicare volume increase of at least 100% from 2013 through 2018.

For CPT code 93228, CMS disagrees with the RUC recommended work RVU of 0.52 and proposes a work RVU of 0.43, based on an intra-service time ratio between the code's current and RUC-recommended intra-service times (0.43= ((10 minutes/12 minutes) * 0.52). CMS notes that they are proposing "…a work RVU that accounts for decrease in total time to provide this service, given that the increased tracings and daily reports are offset by the efficiencies gained by technological advancements." However, the work RVU proposed by CMS is a reduction of 17 percent, whereas the total time only decreased by 8 percent

The physician work intensity of CMS' proposal is a small fraction of the work intensity for the top two key reference codes. In addition, the assigned intensity by CMS would be dramatically lower than the one assigned to a level 1 established patient office visit (99211), which does not

even require the presence of a physician or other qualified healthcare professional. **HRS urges CMS to accept a work RVU of 0.52 for CPT code 93228.**

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)**

CMS proposes a work RVU of 1.50 while the RUC affirmed the 1.75 Work RVUs at the April 2021 meeting. The RUC chose a crosswalk to CPT code 36483 (*Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure).* CMS is basing its proposal on a crosswalk to CPT code 16036 (*Escharotomy; each additional incision*). CMS states that CPT code 16036 is also an add-on code for a surgical incision that shares both an identical intra-service work time and a total time of 20 minutes with CPT code 93621, believing that the code has a similar intensity to 93621. We disagree with CMS' decision to crosswalk 93621 16036. The crosswalk that the RUC agreed upon was based on discussions among the RUC reviewers. CMS's proposed crosswalk is problematic because the service is completely different from cardiac procedures. Also, 16036 can be billed multiple times. The RUC recommended crosswalk is a cardiac procedure; and carries similar intensity of work. **CMS should accept the RUC recommended value of 1.75 work RVUs.**

Cardiac Ablation Services Bundling (CPT codes 93653, 93654, 93655, 93656, and 93657)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
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**	**14.75**	**15.00** **(Final RUC Recommendation submitted in May 2021)**
93654	**Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted**	**19.75**	**18.10**

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
	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; with treatment of ventricular tachycardia or focus of ventricular ectopy including left ventricular pacing and recording, when performed		(Final RUC Recommendation submitted in May 2021)
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)	5.50	7.00 (Final RUC Recommendation submitted in May 2021)
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	19.77	17.00 (Final RUC Recommendation submitted in May 2021)
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)	5.50	7.00 (Final RUC Recommendation submitted in May 2021)
93613	Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)	5.23	5.23 (Affirmed at the April 2021 RUC meeting)

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
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)**	**1.50**	**1.75** **(Affirmed at the April 2021 RUC meeting)**
93662	**Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)**	**1.44**	**2.53** **(Affirmed at the April 2021 RUC meeting)**

HRS strongly recommends that CMS implement the April 2021 RUC recommendations for these codes or utilize the January 2021 RUC recommendations as interim values for 2022. If the Agency opts to maintain the existing values as it has proposed, then the RVUs for all of the services that are being bundled into 93653 and 93656 should be included. In its rationale, CMS said that it questioned the validity of the survey data because of the drops in the recommended times and values that came out of the survey process. HRS and the American College of Cardiology made the same statement at the January RUC meeting and the RUC agreed to set the values as interim so that the two societies could re-survey the codes for April meeting. CMS did not include any rationale as to why it would maintain the current value for the base codes for SVT (93653) and AF ablations (93656) while the additional services still will be bundled into those codes. CMS is proposing approximately 30% cuts in payment for those two services even after stating that the reduction in times in the January RUC recommendations were lower than anticipated. Dropping the payments so significantly without providing an explanation for the decision is not supportable.

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 Panel also bundled services in to 93656 due to their commonly being billed together.

In December 2020, after receiving the survey data, neither HRS nor the American College of Cardiology 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 that was happening. 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 CY2022 in May 2021.

As CMS had not yet reviewed the April 2021 RUC recommendations, the Agency is proposing to maintain the current physician times and current work RVUs for codes 93653-93657 for CY2022. With this letter, we are including a comparison of the current work relative values (Attachment 1), CMS' proposal to maintain the existing values which ignores the newly bundled services, and the RUC's April 2021 recommendations. The data nearly matches the outcomes of the first survey showing that the times for cardiac catheter ablation services have decreased. With that, as technology has advanced, providing added safety to the patient, the eligible patient population has expanded to include those with more co-morbidities and increased risks adding to the procedures' intensities. The RUC accepted those intensities. CMS should implement the April 2021 RUC recommendations for 93653 and 93656.

In addition to accepting the RUC's recommendations, which will include 20-22% cuts in value, CMS should phase-in these reductions. The data shows that overall payment for the bundled services will result in an overall payment decrease of over 20%. Given that the codes have been billed together for a number of years, thus requiring the bundling, these decreases will have strong impacts on physician payments and hospitals' financial planning.

We disagree with CMS' plan to reduce the RUC recommended values for **93655 and 93657.** The work of performing subsequent ablations is due the patient's having more complex arrhythmia requiring identifying additional foci to alleviate arrhythmia. The proposed values do not reflect the intensity that goes along with the add on codes. 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 base codes reflecting placement of the catheters is unchanged, however, bundling the mapping and left atrial recordings into the additional procedures makes the intensity that much greater.

In the January 2021, the survey data showed that the value should be 6.5 RVUs. In the survey reviewed in April 2021, the survey data resulted in a 25thpercentile of 7.00 work RVUs for 93655 and 93657. As stated above, the intensity of the work has remained if not increased due to the broader population of eligible patients. Patients who receive the add-on services typically are in a more complex disease state thus adding to the services' intensities. Decreasing the values to 5.5 discounts the supported data of two surveys. The crosswalks they have recommended for the add on procedures are not cardiac. **CMS should implement the RUC recommended values of 7.0 RVUs for CPT codes 93655 and 93657.**

Changes to Direct PE Inputs for Specific Services

In the proposed rule, CMS highlights that clinical labor rates were last updated for CY 2002 using Bureau of Labor Statistics (BLS) data. CMS stated that it has received input from stakeholders that CMS should update the clinical labor rates with newer data to create more accurately valued practice expense relative value units (PE RVUs). In response, for CY 2022, CMS proposes to update clinical labor pricing using the methodology the Agency used in CY 2002 rulemaking. This relies primarily from BLS wage data to calculate updated clinical labor pricing. However, because the 2019 BLS survey data does not cover all the staff types contained in the direct PE database, CMS also proposes to crosswalk wages for several staff types using supplementary data sources for verification where that data exists as well as to use the national salary data from Salary Expert where there are no other data sources.

HRS recommends that CMS adopt its alternative proposal to phase-in the shifts in PE based on the updated clinical labor inputs over 4 years. While we believe clinical labor pricing inputs should be based on up-to-date data to help ensure the accuracy of the MPFS, we also believe that the integrity of the MPFS is anchored in stability. Particularly in the current environment of the Public Health Emergency, CMS should avoid drastic fluctuations in RVUs for services. While specialties can overall see little fluctuation in total reimbursements, some codes experience drastic increases with others experience drastic decreases. To ensure that practices are not subjected to drastic fluctuations, we believe CMS should phase in implementation to help ensure that practices are not do not feel any unnecessary increased pressures in the current environment.

The total direct practice expense pool increases by 30 percent under this proposal, resulting in a significant budget neutrality adjustment., Increasing payment for clinical labor shifts funds that were previously directed to supplies and equipment. This approach essentially devalues existing supplies. Due mostly to this proposed update, the practice expense direct scaling adjustment would decrease by 24.4% for CY 2022 (from 0.5916 in CY2021 to 0.4468 in CY 2022) — in other words, if a supply that is not being repriced had an adjusted direct cost of $100 for CY2021, that same supply would have an adjusted direct cost of $76.60 for CY 2022. By increasing the clinical labor pricing, physician services with high-cost supplies and equipment are disproportionately impacted by budget.

As an example of these impacts, the practice expense relative values for CPT 33285 (insertion of subcutaneous cardiac rhythm monitor) will decrease by 25% in the non-facility setting, dropping to 118.83 from 153.37non-faciity PE RVUs. The facility PE RVUS will remain almost unchanged, moving to .71 from .72 PE RVUs. The dramatic decrease in the practice expense supply costs in the non-facility setting will lead to these services reverting to being a facility-based service. That shift in site-of-service because the practice expense values for physician practices will be less than the cost of the subcutaneous device will increase the overall Medicare costs for implanting the device due to additional facility fees.

Telehealth and Other Services Involving Communications Technology

Through a series of previously issued waivers, the U.S. Department of Health and Human Services (HHS) and CMS have made great strides in providing flexibility for furnishing and billing Medicare Telehealth Services during the public health emergency (PHE). ***HRS appreciates the steps that you have taken to remove the geographic, originating site, and established patient Telehealth requirements, greatly expanding accessibility of Medicare Telehealth Services, particularly to patients who are home-bound or have transportation challenges***.

Approved Medicare Telehealth Services

CMS also discusses list of “Category 3” approved Medicare Telehealth Services, which it created for adding services to the Medicare telehealth services list on a temporary basis following the end of the public health emergency (PHE) for the COVID-19 pandemic. This category describes services that were added during the PHE for which there is likely to be clinical benefit when furnished via telehealth, but there is not yet sufficient evidence available to consider the services for permanent addition. Here, CMS proposes to retain all Category 3 services until the end of CY 2023 (rather than just the year in which the PHE ends). ***HRS strongly supports this policy.*** We believe that providing stability and certainty in this environment, even after the conclusion of the PHE is in the best interest of patients and our health care system, and we strongly encourage CMS to consider applying these stabilizing

policies in as many applications as possible given the current stresses on our health care system.

Audio Only
Medicare requires that Medicare Telehealth Services must be provided via "interactive telecommunications technology," which CMS goes on to define as "*interactive multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner*" (emphasis added). However, during the PHE, CMS waived the requirement for use of video communications technology, allowing certain telehealth services to be paid when furnished using audio-only communications technology. This waiver will not be available after the PHE ends. ***For office and outpatient E/M visits furnished via telehealth, HRS urges CMS to waive the requirement that interactive telecommunications technology must include a video component through at least the full year in which the PHE ends***. We seek to ensure that patient access to services could be inappropriately restricted and as we eventually come out of the PHE, we believe that this change could help bring stability and continuity of care to patients who have been receiving certain health care services via telehealth. Many Medicare beneficiaries do not have access to or familiarity with video-based telecommunications technology (even Skype or FaceTime). If a video component is necessary and available to provide the E/M, we believe many physicians will use it. However, there will be many instances in which audio-only technology (i.e. phone-based communications) will be the only technology available.

Virtual Check-ins
Finally, separate from the Medicare Telehealth Services policies, CMS has made changes to recognize and expand access to other non-face-to-face services that are not under the umbrella of Medicare Telehealth Services (as recognized by Social Security Act §1834(m)), including PHE policies directed at Virtual Check-ins (as recognized by G2012) and telephone assessment and management codes (CPT 98966-98968; CPT 99441-99443). ***We appreciate those changes for when those services are provided. However, we do not believe that these codes describe all phone-only interactions***. We note that the telephone codes were largely intended for monitoring basic information with the patient. They do not describe the resources or value of service provided when full E/M services are being delivered, sometimes via phone only. In addition, in the CY 2021 PFS final rule, CMS finalized the establishment of HCPCS code G2252 *(Brief communication technology-based service, e.g., virtual check-in service, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11–20 minutes of medical discussion)* on an interim basis for CY 2021. Here, CMS proposes to permanently adopt coding and payment for HCPCS code G2252. ***HRS supports the CMS proposal to permanently adopt G2252, and we agree with comments CMS has received that payment for longer virtual check-in can be important for determining the need for an in-person visit than is otherwise recognized in the existing permanently accepted virtual check-in codes***.

MIPS Value Pathways Framework
In this rule, CMS proposes to continue its effort to implement the MIPS Value Pathways (MVP) Framework, including a delayed start date of 2023 to account for the strains of COVID-19 on medical practice. The MVP Framework aims to move away from the siloed nature of the four MIPS performance categories by offering more focused sets of measures and activities that are

more meaningful to a clinician's practice, specialty, or public health priority and that require less reporting burden. Under this proposal, CMS would offer an initial set of 7 MVPs that clinicians, groups, and APM entities could voluntary report for the 2023-2027 performance years. CMS also expresses interest in phasing out the traditional MIPS pathway and making MVPs mandatory beginning with the 2028 performance year.

HRS supports the goal of the MVP framework, which is to move towards more cohesive sets of measures and activities that focus on specific specialties, conditions, or patient populations and result in a program that is less burdensome and more meaningful to both patients and physicians. Nevertheless, we continue to hold the following concerns, which we do not believe have been adequately addressed in this rule:

- ***To truly streamline the program, CMS must take more concrete steps to break down the silos that currently result in four disjointed MIPS performance categories that each have a distinct set of measures, reporting requirements and scoring rules***. Clinical actions captured by measures and activities should translate into credit across multiple performance categories to unify the program and minimize administrative burden.

- ***Encourage meaningful participation among specialists.*** In previous comments, we have expressed concern about MIPS scoring policies that disincentivize the uptake of more specialized measures, including the 3 point scoring cap on measures that lack a benchmark and policies that CMS has adopted to remove measures from the program if they continually lack a benchmark. These policies unfortunately feed into each other. The scoring cap makes these measures unattractive to physicians. When they are not used by physicians, this results in a chronic lack of data to create benchmarks and the measures are eventually removed from the program (as one of the measures in the Electrophysiology Cardiac Specialist measure set was last year). The two measures that currently remain in our specialty measure set (#392 and #393) are extremely meaningful to our members, but continue to go unreported because they lack a benchmark.

  We appreciate CMS attempting to address some of these concerns by proposing a 5-point floor for "new" measures during their first 2 years in the program, beginning with the CY 2022 performance period/2024 MIPS payment year. However, this proposal does nothing to address the numerous measures that have been in the program for many years now and continue to lack a benchmark. In fact, CMS is proposing to remove the special scoring policies that apply to these measures (i.e., a 3-point floor) and instead award 0 points to clinicians who report on such measures. As CMS implements the MVP framework and particularly as it considers the adoption of a sub-group reporting mechanism, as discussed below, it is critical that it maintain and incentivize the ongoing development and use of a diverse inventory of specialty- and sub-specialty specific measures that are meaningful to both physicians and their patients. Instead of allocating 0 points, CMS should give credit to clinicians who take the time to report these measures and contribute to the building of performance benchmarks. It is important that CMS recognize that low measure reporting rates are not necessarily an indication of a low value measure, particularly for highly specialized procedures or patient populations. Rather, these trends may instead be a result of program policies that disincentivize the uptake of these measures.

- ***Adopt non-mandatory participation options.*** CMS contemplates assigning clinicians and groups to MVPs in the future. It is essential that clinicians maintain the ability to

choose the most appropriate MIPS participation pathway—whether that is through an MVP or traditional MIPS. If an MVP is the preferred pathway, the clinician or group should have the ability to select which MVP is most appropriate based on CMS guidance.

- ***Recognize more innovative and cross-cutting ways of measuring clinicians under the Promoting Interoperability (PI) category***. In the CY 2021 PFS final rule, as a part of the MVP development criteria, CMS finalized that MVPs must include the full set of Promoting Interoperability measures. As we have stated in the past, clinicians should have the flexibility to demonstrate meaningful use of EHRs in more innovative ways that account for differences in practice makeup, infrastructure, and experience with health information technology. It is critical that CMS move beyond what is still largely a one-size-fits-all approach that focuses more on EHR functionality than true improvements in patient care. To realize the full potential of EHRs, requirements under this category need to be less prescriptive to allow clinicians to creatively incorporate technology into their unique clinical workflows and to respond to their patient's needs. For example, clinicians should be recognized for making use of data from wearables and new platforms through which clinicians can assign digital health programs to patients and monitor the patient's data via their health system's EHR.

  To realize the full potential of EHRs, requirements under this category need to be less prescriptive to allow clinicians to creatively incorporate technology into their unique clinical workflows and to respond to their patient's needs. Ideally, clinicians should be able to attest that they are using CEHRT or health IT that interacts with CEHRT, rather than reporting on individual Promoting Interoperability measures. If CMS insists on using specific measures to capture clinician performance in this category then at the very least, it should offer a larger inventory of measures that focus less on the functionalities of CEHRT (since this is something vendors must already ensure their products comply with) and more on innovative ways of capturing, applying and sharing electronic data (e.g., implementation of practice improvements based on patient-generated electronic health data; the use of clinical registries that incorporate EHR data; the use of electronic platforms, including apps, that allow clinicians to better communicate with patients, etc.).

  For electrophysiologists, the primary, ongoing challenge with health information technology (HIT) is the lack of interoperability. Interoperability is the cornerstone to developing a robust health information technology network that could be used to improve quality and efficiency. In addition, the lack of interoperability standards is a key barrier to improving patient safety in HIT. The HRS looks forward to continuing to work with federal agencies, including CMS and ONC, as well as private industry on solutions to current interoperability challenges and metrics that fairly account for any ongoing limitations to data exchange.

Subgroup Reporting

As part of this proposal, CMS also proposes to establish voluntary subgroup reporting to help provide patients and clinicians information that is clinically meaningful at a more granular level. The intent of the subgroup reporting proposal is to move away from large multispecialty groups reporting on the same set of measures, which may not be relevant or meaningful to all specialists that participate within a multispecialty group. CMS is concerned that some current group submissions do not accurately reflect the performance of all clinicians within the group, do

not provide all clinicians with results that lead to data-driven improvements in quality, and do not provide patients and caregivers the granularity of data needed to make informed decisions. CMS also believes that transitioning multispecialty groups to subgroup reporting will address some inherent gaming risks, where clinicians in a group may rely on the performance of other clinicians (of a different specialty) within the group to meet quality reporting requirements. Overall, CMS believes that subgroup reporting will provide more direct attribution of quality measure data and results to clinicians, which would lead to more valuable, meaningful, and actionable results that contribute to patient care and improvement. Ultimately, CMS envisions an end state where technology will allow for the submission of discrete data elements. CMS will be able to calculate measure performance for clinicians, subgroups, and groups, rather than having measure performance aggregated and calculated at a group or subgroup level prior to reporting.

Under this proposal, multispecialty groups may report as groups or choose to form subgroups to report MVPs for the CY 2023 and CY 2024 performance period/2025 and 2026 MIPS payment year. Beginning with the CY 2025 MIPS performance period/2027 MIPS payment year, CMS proposes that if a multispecialty group would like to report MVPs, they could only do so if they form subgroups. CMS believes this 2-year span of time would give multispecialty groups time to familiarize themselves and prepare for subgroup reporting. CMS does not anticipate the need to require single specialty groups to form subgroups in order to report an MVP.

CMS notes there may be instances where some clinicians in a multispecialty group may have a relevant MVP available for reporting, while other clinicians within that same multispecialty group may not. In this scenario, the clinicians within the multispecialty group that have an MVP available may form a subgroup to report the MVP, while the group continues to report traditional MIPS.

HRS has urged CMS numerous times in the past to adopt a subgroup reporting mechanism, noting that specialists in larger multi-specialty groups, such as electrophysiologists, have limited control over the selection of measures and reporting mechanisms that are best for their unique patient population. We anticipate that the extra reporting burden will only be an issue over the short term as industry transitions to electronic quality measures and greater interoperability of data. CMS has a goal of automating the submission of quality data in the near future, including transitioning to all digital quality measures by 2025. Until CMS has gotten closer to automating these submissions, subgroup mandatory reporting for multi-specialty practices is premature.

Again, we appreciate the opportunity to provide CMS with feedback on these topics. Please contact Kimberley Moore, Senior Director of Health Policy and Reimbursement at KMoore@hrsonline.org if you have any questions or need any additional information.

Sincerely,

Fred Kusumoto, MD, FHRS
President

ATTACHMENT 1

2021 Work Values for Separately Billable Codes

Code	Description	Work Value
93653	Ep & ablate supravent arrhyt	14.75
93613	3D mapping	5.23
93621	LA pacing and recording	2.1
Total RVUS for bundled services		**22.08**
93654	Ep & ablate ventric tachy	19.75
93655	Ablate arrhythmia add on	7.5
93656	Tx atrial fib pulm vein isol	19.77
93613	3D mapping	5.23
93662	Intracardiac Echo	1.44
Total RVUS for bundled services		**26.44**
93657	Tx l/r atrial fib addl	7.5

April 2021 RUC Recommended Work Values

93653	Ep & ablate supravent arrhyt	15.00
93654	Ep & ablate ventric tachy	18.10
93655	Ablate arrhythmia add on	7
93656	Tx atrial fib pulm vein isol	17
93657	Tx l/r atrial fib addl	7

2022 CMS Proposed Work Values

93653	Ep & ablate supravent arrhyt	14.75	(excludes the values for 93613 and 93621)
93654	Ep & ablate ventric tachy	19.75	
93655	Ablate arrhythmia add on	5.50	
93656	Tx atrial fib pulm vein isol	19.77	(excludes the values for 93613 and 93662)
93657	Tx l/r atrial fib addl	5.50	