September 08, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1784-P
Mail Stop C4-26-05 7500 Security Boulevard
Baltimore, MD 21244-1850
Submitted via: www.regulations.gov

Re: CMS-1784-P—Medicare Program; CY 2024 Payment Policies under the Physician Payment Schedule and Other Changes to Part B Payment Policies; (July 13, 2023)

Dear Administrator Brooks-LaSure:

The Society of Interventional Radiology (SIR) is a professional medical association representing approximately 8,000 members, including most US physicians practicing in the specialty of vascular and interventional radiology. The Society is dedicated to improving public health through pioneering advances in minimally invasive, image-guided therapies. Therefore, SIR appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) CY 2024 Revisions to Payment Policies under the Physician Payment Schedule and Other Changes to Part B Payment Policies proposed rule.

Payment Rates

Practice Expense RVUs - Payment Rates

Proposed: In the CY 2024 proposal, CMS was again limited in some changes and could not override the 2.5 percent decrease to the CY 2023 CF as defined within the Consolidated Appropriations Act (CAA), 2023. After applying the 1.25 percent increase by the same CAA 2023, and budget neutrality, the decreases in the conversion factor (CF) will result in a decrease for physicians and physician offices for 2024. The bulk of the decreases are proposed to impact specialized care such as interventional radiology once again.

<table>
<thead>
<tr>
<th>TABLE 102: Calculation of the CY 2024 PFS Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY 2023 Conversion Factor</td>
</tr>
<tr>
<td>Conversion Factor without the CAA, 2023 (2.5 Percent Increase for CY 2023)</td>
</tr>
<tr>
<td>CY 2024 RVU Budget Neutrality Adjustment</td>
</tr>
<tr>
<td>CY 2024 1.25 Percent Increase Provided by the CAA, 2023</td>
</tr>
<tr>
<td>CY 2024 Conversion Factor</td>
</tr>
</tbody>
</table>

Impact: The proposed combined impact to relative value units (RVUs) (Table 104: CY 2024 MPFS proposed rule) for the specialties of interventional radiology and radiology, along with the added reduction in CF for CY 2024, will again significantly reduce reimbursement. The proposed estimated reductions would result in minus 8 percent for interventional radiology and minus 7 percent for radiology. This is prior to any adjustment for the 2 percent sequestration and brings the potential impact to a minus 10 percent for interventional radiology and minus 9 percent for radiology.
TABLE 104: CY 2024 PFS Estimated Impact on Total Allowed Charges by Specialty

<table>
<thead>
<tr>
<th>(A) Specialty</th>
<th>(B) Allowed Charges (mil)</th>
<th>(C) Impact of Work RVU Changes</th>
<th>(D) Impact of PE RVU Changes</th>
<th>(E) Impact of MP RVU Changes</th>
<th>(F) Combined Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interventional Radiology</td>
<td>$457</td>
<td>-1%</td>
<td>-3%</td>
<td>0%</td>
<td>-4%</td>
</tr>
<tr>
<td>Radiology</td>
<td>$4,517</td>
<td>-1%</td>
<td>-2%</td>
<td>0%</td>
<td>-3%</td>
</tr>
</tbody>
</table>

* Column F may not equal the sum of columns C, D, and E due to rounding.

Reviewing the estimated impact by setting, as provided in Table 105: CY 2024 MPFS proposed rule, the decreases in payment are proposed to be greatest in non-facility settings, but physicians practicing in facility settings are not exempt. The primary reasons for the decreases are explained to be due to year 3 of a phase-in for clinical labor rate changes and the expiring moratorium on the complexity add-on code, HCPCS G2211, which will take any payment increase interventional and diagnostic radiology should expect and direct to other non-specialized care.

At the code level, this results in double-digit cuts for several codes in the non-facility setting. As in previous years, analysis of procedural codes for CY 2024, interventional radiology will see decreases as high as 6.6 percent in reimbursement for procedures treating peripheral arterial disease (PAD), with other similar reductions for end-stage renal disease and cancer. (SIR’s Table A – PAD-Related Impact Analysis and SIR’s Table B – Impact Analysis on Dialysis Circuit Vascular Access IR Procedures).

TABLE 105: CY 2024 PFS Estimated Impact on Total Allowed Charges by Setting

<table>
<thead>
<tr>
<th>(A) Specialty</th>
<th>(B) Total Non-Facility/Facility</th>
<th>(C) Allowed Charges (mil)</th>
<th>(D) Combined Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interventional Radiology</td>
<td>TOTAL</td>
<td>$457</td>
<td>-4%</td>
</tr>
<tr>
<td></td>
<td>Non-facility</td>
<td>$292</td>
<td>-5%</td>
</tr>
<tr>
<td></td>
<td>Facility</td>
<td>$166</td>
<td>-3%</td>
</tr>
<tr>
<td>Radiology</td>
<td>TOTAL</td>
<td>$4,517</td>
<td>-3%</td>
</tr>
<tr>
<td></td>
<td>Non-facility</td>
<td>$1,977</td>
<td>-3%</td>
</tr>
<tr>
<td></td>
<td>Facility</td>
<td>$2,540</td>
<td>-3%</td>
</tr>
</tbody>
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The addendum, CMS-1784-P_Spec Impacts by Practitioner NPRM2024 (2022 claims) to the CY 2024 MPFS proposed rule places interventional and diagnostic radiology, vascular surgery, radiation oncology, and diagnostic testing facilities within the top ten of specialties proposed to see most practitioners’ payments cut by 2-5 percent, based on 2022 weighted claims. Use of unweighted claims had slightly different results, but both diagnostic and interventional radiology are still near the top.

Distribution of Practitioners by % Change in Total RVUs and IMPACT Specialty (weighted by total RVUs)

NPRM2024 (using 2022 CCW claims)

<table>
<thead>
<tr>
<th>Impact Specialty</th>
<th>Practitioner RVUs (millions)</th>
<th>% Change in Total RVUs per practitioner</th>
<th>Share of Total Practitioner RVUs in Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>&lt; -20% to &lt; -10%</td>
<td>-10% to &lt; -5%</td>
</tr>
<tr>
<td>Total</td>
<td>2,575</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interventional Radiology</td>
<td>13</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Radiology</td>
<td>46</td>
<td>0%</td>
<td>0%</td>
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Proposed: CMS updated the values for clinical labor for the first time in 20 years in CY 2022, and CY 2024 is year 3 of the phase-in. Direct practice expenses for a specialty like interventional radiology include a lesser amount attributed to the clinical labor component, but a greater amount related to supplies and equipment experience an increased negative impact. First, any value increased in the office-based setting due to an increase in the value of clinical labor for vascular interventional technologists is not realized for interventional radiology. The increase in value so CMS can remain budget neutral is attributed to non-specialized care. Second, because interventional radiology equipment and supplies are high-value, CMS is proposing to also decrease payments to the technical components of services or any portion attributed to supplies and equipment to pay non-specialized care more to provide evaluation and management (E/M) visits, specifically to pay for a complexity add-on code. Impact: Even though CMS finalized a 4-year phase-in the clinical labor updates, the continued decreases in RVUs and payments to specialized care (i.e., interventional radiology, diagnostic radiology, vascular surgery, and radiation oncology) by CMS, which in turn become increased payments for non-specialized care (i.e., family practice, endocrinology, nurse practitioner, physician assistant, clinical social worker, psychiatry, clinical psychologist, and general practice), would support quality of care is valued only when it the services are routine and expenditures are limited. To care for Medicare beneficiaries, who tend to be sicker and have an increasing number of complicated comorbidities, the expectation of providing quality care and ensuring access to that care is equitable is only true when talking about services provided in facility-based settings.

This approach to continue to burden specialized care with making up the shortfalls the year after-year of non-specialized care undermines the validity of any statement or policy the Agency focuses on health equity because it...
is not. As described earlier and outlined in SIR’s Table A and Table B, services for treating peripheral arterial disease (PAD), end-stage renal disease, and cancer will still see a negative impact because of the proposed changes. Table C: Health Inequity Impacts Due to Clinical Labor Cuts reflects payment cuts since 2022. The inevitable is upon us as practices can no longer stay open, feel the push by CMS to be acquired by hospitals, and disincentivize providers from opening office-based labs in disadvantaged communities. The attempts at site-neutral payments and ensuring beneficiaries have access to equitable care, based on cost, distance, and experience is creating an unbalanced market.

Access to care for beneficiaries is becoming limited for many critical services. The migration of services to facility-based settings impacts beneficiaries with increased co-payments versus those paid for the same services in office or office-based labs (OBL), the need to secure trustworthy and cost-efficient transportation to travel to larger centers, and increased wait times for care. Some of the critical procedures most impacted include:

- Hemorrhagic and ischemic strokes
- Maternal health (antepartum, intrapartum, and postpartum hemorrhaging)
- PAD (limb salvage)
- Dialysis access (creation and revision AVF, AVG, and central lines)
- Radiation oncology and other innovative cancer treatments
- Pain management, such as non-opioid alternatives

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<tbody>
<tr>
<td>Venous Ulcer / Endovenous Radiofrequency Ablation</td>
<td>Black patients present with more advanced venous insufficiency than White patients¹</td>
<td>Key Code (36475) Cut by 23%</td>
<td>Key Code (36475) Cut by 12%</td>
<td>Key Code (36475) Cut by 7%</td>
<td>Key Code (36475) Cut by 5%</td>
<td>Key Code (36475) Cut by 6%</td>
<td>Key Code (36475) Cut by 12.33%</td>
</tr>
<tr>
<td>ERSD / Dialysis Vascular Access</td>
<td>Black and Latino patients start dialysis with a fistula less frequently despite being younger²</td>
<td>Key Code (36902) Cut by 18%</td>
<td>Key Code (36902) Cut by 5%</td>
<td>Key Code (36902) Cut by 8%</td>
<td>Key Code (36902) Cut by 5%</td>
<td>Key Code (36902) Cut by 5%</td>
<td>Key Code (36902) Cut by 4.77%</td>
</tr>
<tr>
<td>Cancer / Radiation Oncology</td>
<td>Black men are 111 percent more likely to die of prostate cancer; Black women are 39 percent more likely to die of breast cancer³</td>
<td>Key Code (G6015) Cut by 15%</td>
<td>Key Code (G6015) Cut by 3%</td>
<td>Key Code (G6015) Cut by 5%</td>
<td>Key Code (G6015) Cut by 3%</td>
<td>Key Code (G6015) Cut by 4%</td>
<td>Key Code (G6015) Cut by 2.71%</td>
</tr>
<tr>
<td>Peripheral Artery Disease / Revascularization</td>
<td>Black Medicare beneficiaries are three times more likely to receive an amputation⁴ Latinos are twice as likely⁵</td>
<td>Key Codes (37225-37221) Cut by 22%</td>
<td>Key Codes (37225-37221) Cut by 8-20%</td>
<td>Key Codes (37225-37221) Cut by 8%</td>
<td>Key Codes (37225-37221) Cut by 4-6%</td>
<td>Key Codes (37225-37221) Cut by 5-6%</td>
<td>Key Codes (37225-37221) Cut by 11.88-19.60%</td>
</tr>
<tr>
<td>Fibroid / Uterine Fibroid Embolization</td>
<td>Uterine fibroids are diagnosed roughly three times more frequently in Black women⁶</td>
<td>Key Code (37243) Cut by 21%</td>
<td>Key Code (37243) Cut by 6%</td>
<td>Key Code (37243) Cut by 7%</td>
<td>Key Code (37243) Cut by 5%</td>
<td>Key Code (37243) Cut by 7%</td>
<td>Key Code (37243) Cut by 6.16%</td>
</tr>
</tbody>
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**Evaluation and Management Services**

**Office/Outpatient E/M Visit Complexity Add-On Code**

**Proposed:** In the CY 2021 MPFS final rule, CMS created code G2211 *(Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient’s single, serious condition or a complex condition. (add-on code, list separately in addition to office/outpatient evaluation and

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³ *Cure, Cancer Care Color: Investigating Racial Disparities in Cancer Care*. Katherine Malmo, 16 February 2021
⁴ *Dartmouth Atlas, Variation in the Care of Surgical Conditions: Diabetes and Peripheral Arterial Disease*, 2014
⁶ *University of Michigan, Understanding Racial Disparities for Women with Uterine Fibroids*, Beata Mostafavi, 12 August 2020
management visit, new or established). The Consolidated Appropriations Act of 2021 put a moratorium on Medicare payment for this service under the MPFS before January 1, 2024.

**Impact:** With the moratorium over, code G2211 is available for payment when added-on to other outpatient/office (O/O) E/M visits. The guidance provided within the proposed rule regarding the use of G2211 is limited and open to interpretation. It also does little to distinguish it fully from the already revised O/O E/M visits, which went into effect in CY 2021. Even the American Medical Association (AMA) has concerns about the ambiguity, calculated utilization rate, and examples presented for this code. While it is nice to give the benefit of the doubt to the practitioners that they will be able to appropriately utilize this service, each time it is billed, it comes at the expense and work of interventional radiologists who are funding this code.

**SIR’s Comments:** SIR requests CMS not implement payment for HCPCS G2211, complexity add-on code to office/outpatient E/M visits, instead institute an indefinite self-imposed moratorium for payment of this code. CY 2024 is the first full year in which there is no public health emergency (PHE) related to the COVID-19 pandemic, many physicians and physician practices are still recovering from the impact of the last four years. Loss of personnel, inflation, continued payment cuts, and overall exhaustion have taken their toll.

The inevitable is upon us as practices can no longer stay open, feel the push by CMS to be acquired by hospitals and disincentivize providers from opening office-based labs in disadvantaged communities. Recent survey results indicate 8 percent of interventional radiology, vascular surgery, and interventional cardiology physicians and physician offices were closed, sold or the physicians retired in 2021 and 2022 due to ongoing payment cuts. The attempts at site-neutral payments and ensuring beneficiaries have access to equitable care, based on cost, distance, and experience is creating an unbalanced market.

As stated previously, this is directly impacting Medicare beneficiaries. The proposed payment rates for the same CPT® codes for the critical procedures most impacted and outlined previously in this comment letter, supports paying more for these procedures is not an issue for CMS.

The CY 2024 proposed payment rates in the outpatient hospital setting are more than the proposed rates in office/OBL. In the ambulatory surgery center (ASC), some are proposed to pay more than offices while others are lower but not by any significant amount, and this does not include the physician’s payment. As stated previously, the concept of establishing equitable and site neutral payments for the same services regardless of setting, which has been something CMS has continue to state is a focus, appears to be false. It appears the focus is to push all specialized care to facility settings and only support non-specialized care such as wellness visits, simple or routine visits with primary care etc. physicians in an office-based setting. This will further decrease availability of care for many Medicare beneficiaries for life saving and improved quality of life procedures, especially those performed by interventional radiologists.

SIR also requests CMS find a more equitable solution to budget neutrality which does not require specialized care continuing to support budget shortfalls, year after year. Seeking input from stakeholders on creating payment policies which address the complexity and valuation issues related to practice expense, specifically supplies and equipment. Finding alternative means to ensure site neutrality so providers are not incentivized to overinflate value and migrate services to only settings which pay the most, at the expense of beneficiaries and other practitioners.

**Specific Codes and Code Set Valuations**

**Dorsal Sacroiliac Joint Arthrodesis (CPT® code 2X000)**

**Proposed:** In September 2022, Category III code 0775T (Arthrodesis, sacroiliac joint, percutaneous, with image guidance, includes placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s]) was recommended, and approved, for deletion due to the creation of a new Category I CPT® code 2X000 (Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intraarticular implant(s) (eg, bone allograft[s], synthetic device[s]), without placement of transfixation device).

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7 John Blebea, MD, MBA et al. Multi-Societal Survey on the Impact of Medicare Cuts to Physician Reimbursement, Presented at the 2023 Outpatient Endovascular and Interventional Society Annual Meeting
For CY 2024, CMS proposed the RUC-recommended work RVU of 7.86 for CPT® code 2X000, and the RUC-recommended direct PE inputs without refinement.

**SIR’s Comments:** SIR appreciates CMS’ proposal to accept the RUC recommended values for CPT® 2X000.

**Ultrasound Guidance for Vascular Access (CPT® code 76937)**

**Proposed:** In September of 2017, codes 36572 and 36573 were created and codes 36568, 36569 and 36584 were revised, respectively. These codes provided bundled services for the insertion of a peripherally inserted venous catheter (PICC) that could be performed either by a physician without imaging guidance, or a radiologist with imaging guidance. Since code 76937 (Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)) was bundled with PICC services, the specialty societies proposed to review this code after 2 years when more data was available. CPT® code 76937 was reviewed at the October 2022 RUC meeting.

For CY 2024, CMS proposed the RUC-recommended work RVU of 0.30 for CPT® code 76937. In addition, CMS proposed the RUC-recommended direct PE inputs.

**SIR’s Comments:** SIR appreciates CMS’ proposal to accept the RUC recommended values for CPT® 76937.

**CPT® code 27279**

**Proposed:** A request was made of CMS to establish value and payment in the nonfacility setting for the 090-day surgical global period CPT® code 27279 (Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device). The nominator indicates it can be done safely and effectively in the nonfacility setting and that this procedure has a low risk profile, like kyphoplasty (CPT® codes 22513, 22514, and 22515), which is currently furnished in the nonfacility setting.

**SIR’s Comments:** SIR believes the procedure represented by CPT® code 27279 can safely and effectively be provided in an appropriately equipped office-based lab (OBL) to manage any of the acute complications that might arise during performance of the procedure. These OBLs are equipped and managed like ambulatory surgical centers (ASCs) which currently provide this procedure. CPT® code 2X000 (Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intraarticular implant(s) (eg, bone allograft[s], synthetic device[s]), without placement of transfixation device), discussed previously, is a similar service assigned 090-day global surgical period. Additionally, with the added setting available to provide this procedure, it would open options to beneficiaries for receiving care which may be more convenient and accessible.

**Quality Payment Program (QPP)**

**MIPS Value Pathways (MVPs) and Quality Measures**

**Proposed:** CMS has proposed to move forward with expanding MVPs to include 5 new topics beginning with the 2024 performance year. Topics include women’s health; infectious disease; quality care for ear, nose, and throat; rehabilitative services for musculoskeletal care; and mental health and substance use disorders.

**Impact:** SIR acknowledges that there are challenges within the MIPS program however, we encourage MVPs to remain voluntary and for CMS not to sunset MIPS until there are viable options available to all specialties. SIR believes additional quality measures relevant to interventional radiology can further demonstrate the specialty’s high-quality care and reduce costs. It is imperative for SIR to be involved in CMS measure development on clinical topics where interventional radiologists are part of the care team, such as in the diagnosis and treatment of infectious disease, women’s health, and in musculoskeletal care.

**SIR Comments:** SIR supports the expansion to include 5 new MVPs for the 2024 performance year. The addition of the Focusing on Women’s Health MVP is supported by SIR and has the potential to align with priorities identified within the specialty, including improving patient outcomes and appropriate coverage, reimbursement, and access for uterine artery embolization. As CMS shifts from MIPS to MVPs, SIR recommends that measures such as QID 465 Uterine Artery Embolization (UAE) Technique: Documentation of Angiographic Endpoints and Interrogation of
Ovarian Arteries be included in the Focusing on Women’s Health MVP to ensure that they are carried forward as traditional MIPS is sunset. SIR appreciates the continued collaboration with CMS and ability to provide feedback which meaningfully impacts the QPP program. SIR has submitted comments on measures that CMS is currently developing and/or re-evaluating and should continue to be included in the measure development and evaluation process. SIR has an appointed representative contributing to the non-pressure ulcer measure for the Wave 6 MACRA workgroup and will continue to participate in measure development opportunities as they arise. Currently SIR’s stewarded quality measures for interventional radiology include Uterine Artery Embolization (UAE) Technique: Documentation of Angiographic Endpoints and Interrogation of Ovarian Arteries, Clinical Outcome Post Endovascular Stroke Treatment, Door to Puncture Time for Endovascular Stroke Treatment, Varicose Vein Treatment with Saphenous Ablation: Outcome Survey, Appropriate Assessment of Retrievable Inferior Vena Cava (IVC) Filters for Removal.

**Data Completeness**

**Proposed:** The data completeness threshold for the 2024 performance period has been increased from 70% to 75% for the 2024 and 2025 performance years with incremental increases for subsequent performance periods.

**Impact:** SIR recognizes the importance of data completeness to effectively assess a clinician's performance on quality measures and prevent selection bias as much as possible. SIR is committed to developing VIRTEX, its clinical data registry. SIR supports working with CMS to leverage platforms to enhance data completeness. VIRTEX centers on quality improvement, efficient resource use, patient-reported outcomes and satisfaction, and enhanced technology to care for patients with specific medical conditions. VIRTEX will leverage clinical information from EHRs and other registries, in addition to claims data, to form a complete vision of patient care events. The VIRTEX registry will house quality and cost measures based on clinical pathways and patient-reported outcome measures (PROM) for diagnosing and treating specific medical conditions. SIR is interested in discussing the measure development process with CMS and supporting a more cost-effective approach to creating quality measures.

**SIR Comments:** Interventional radiologists (IRs) are uniquely positioned to work within a variety of clinical settings and places of service. An IR may provide care to the same patient at multiple in-patient and out-patient facilities, each with EHR and documentation systems that frequently are not interoperable. As a result, data completeness may be compromised. In addition, patients who are transferred from one facility to another may experience an incomplete transfer of data resulting from variations in EHR vendors and gaps in interoperability. SIR highlights that this requirement may not account for this variation in the type of practice settings that interventional radiologists often practice. SIR recommends that the data completeness threshold be maintained at the current 70% for 2024 and then be reevaluated. SIR encourages that a date farther than CY 2027 be selected before incrementally increasing to the proposed 80% threshold.

SIR appreciates the opportunity to provide meaningful feedback to the CMS MPFS proposed rules, including opportunities to improve quality, patient outcomes, and efficiencies in the Medicare program via MVPs. If you have any questions, please feel free to contact SIR’s Senior Manager of Health Policy and Economics, Ashley Maleki, at amaleki@sirweb.org or (703) 844-0378.

Sincerely,

Alda L. Tam, MD, MBA, FSIR
President, Society of Interventional Radiology
Cc: Keith M Hume
Executive Director, Society of Interventional Radiology