American Urological Association

BOARD OF DIRECTORS

Officers

Scott K. Swanson, MD
President

Raju Thomas, MD
President-elect

John H. Lynch, MD
Immediate Past President

John D. Denstedt, MD
Secretary

David F. Green, MD
Treasurer

Thomas F. Stringer, MD
Treasurer-elect

Section Representatives

Kurt A. McCammon, MD
Mid-Atlantic

E. Ann Gormley, MD
New England

Reza Ghavamian, MD
New York

James C. Ulchaker, MD
North Central

Barry A. Kogan, MD
Northeastern

Anthony Y. Smith, MD
South Central

Martin K. Dineen, MD
Southeastern

Eric J. Zeidman, MD
Western

Headquarters

Michael T. Sheppard, CPA, CAE
Chief Executive Officer

1000 Corporate Boulevard
Linthicum, MD 21090

U.S. Toll Free: 1-866-RING-AUA (1-866-746-4282)
Phone: 410-689-3700
Fax: 410-689-3800
Email: AUA@AUAnet.org
Websites: AUAnet.org
UrologyHealth.org
UrologicHistory.museum

September 10, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244

Re: 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,

The American Urological Association (AUA) appreciates the opportunity to provide comments on the Calendar Year (CY) 2022 Medicare Physician Fee Schedule (PFS) proposed rule. The AUA is a globally-engaged organization with more than 22,000 physician, physician assistant, and advanced practice nursing members practicing in more than 100 countries. Our members represent the world's largest collection of expertise and insight into the treatment of urologic disease. Of the total AUA membership, more than 15,000 are based in the United States and provide invaluable support to the urologic community by fostering the highest standards of urologic care through education, research and the formulation of health policy.
The AUA respectfully submits comments to Centers for Medicare & Medicaid Services (CMS) on the following provisions of the proposed rule:

I) Proposed Update to Direct Practice Expense Clinical Labor Rates
II) Telehealth and Other Services Involving Communications Technology
III) 010-day and 090-day Global Period Codes Policies
IV) CY 2022 Identification and Review of Potentially Misvalued Services
V) Proposed Valuation of Specific Codes for CY 2022 (Periurethral Adjustable Balloon Continence Devices)
VI) Split (or Shared) Evaluation and Management (E/M) Visits
VII) Quality Payment Program Provisions

American Urological Association

Update to Direct Practice Expense Clinical Labor Rates

CMS proposes to update the clinical labor rates used in the direct Practice Expense (PE) inputs formula that is used to calculate Medicare payment for services on the PFS. CMS notes that the clinical labor rates have not been updated since CY 2002 at which point CMS updated the rates using Bureau of Labor Statistics (BLS) wage data (CMS used Salary Expert – an online project of the Economic Research Institute – for clinical labor types not referenced in BLS data). CMS proposes to use the average (mean) hourly wage instead of the median. **We disagree that the mean is the correct data to use for the following reasons:**

1) The clinical staff time for codes is always based on the typical or median when survey data are used. The most recent example of this is the clinical staff times assigned to activities for the office and other outpatient E/M visit code set updated for CY 2021; median survey times were recommended by the RUC and approved by CMS.

2) The BLS survey data include rates for many "industries", including hospitals, physician offices, nursing care facilities, and government services. The data for registered nurses show that government and hospital pay rates are significantly higher than physician office pay rates. This discrepancy is consistent for other clinical staff types. By proposing the mean salary instead of the median salary, equal weight is placed on the higher salaries in facility and government settings, even though the majority of clinical labor changes will impact pricing for non-facility settings. We wish to highlight that the median rate will reflect the typical rate, and no additional code-level work would be required because the BLS tables all list the median statistic. **We recommend that CMS use the BLS median wage rate to update clinical labor pricing.**

To account for employers' cost of providing fringe benefits, such as sick leave, CMS proposes to use the same benefits multiplier of 1.366 that was utilized in CY 2002. We disagree with this proposal as this multiplier is not accurate according to current BLS data. The most recent news release bulletin for "Employer Costs for Employee Compensation" indicates that the private industry worker's median and mean benefit cost was 29.6 percent. We believe that the private industry workers rate is appropriate as it eliminates overemphasis on non-healthcare wages, such as those for farmers and federal employees.

We recommend that CMS use the current fringe benefit multiplier of 1.296 in the calculation to update clinical labor rates.

In its discussion, CMS notes that it initiated a similar update to the supply and equipment prices used in the direct PE inputs formula based on the results of a market research survey in CY 2019; the supply and equipment prices had not been updated since 2004-2005. CMS implemented a four-year phase-in for the supply and equipment prices update that will be complete in CY 2022. The updates to the supply and equipment prices were minimal as highlighted by CMS in the proposal.

CMS correctly notes that updating supply and equipment prices without updating clinical labor rates – which have not been updated since CY 2002 – would potentially create market distortions in the direct PE inputs formula. The AUA agrees that the prevailing market rates and prices for direct PE inputs should be kept up to date to as reasonable a degree as possible so that Medicare payment rates for services on the PFS accurately reflect the direct PE input costs associated with providing a service.

Given the budget neutral nature of the direct PE inputs formula, the significant increases in clinical labor rates as proposed automatically necessitate similar cuts elsewhere in the direct PE inputs formula to maintain budget neutrality. The direct scaling factor is proposed to decrease -24% from 0.5916 in 2021 to 0.4468 in 2022 (the practice expense component of the MPFS comprises approximately 45% of the total physician payment and that percentage is fixed). We acknowledge that CMS is restrained in its ability to change the budget neutral nature of this formula; however, the proposed increase in the clinical labor rates results in a significant shift of RVUs that were previously directed to supplies and equipment. Stated another way, Medicare will now reimburse 44 cents on the dollar instead of 59 cents on the dollar for supply and equipment costs.

The AUA would highlight the enormous negative impact that this shift will have on numerous urological services performed in a non-facility setting, particularly device-intensive procedures where the cost to the physician to deliver the service would be greater than the proposed reimbursement rate; these services generally require minimal clinical labor but rely heavily on the use of supplies and equipment *(for a list of these services, please see Appendix A*).

As illustrated in *Appendix A*, 39 urology-focused procedures performed in a non-facility setting are estimated to experience payment reductions of greater than 10% compared with CY 2021 payment rates, largely as a result of the proposed update to the clinical labor rates in the direct PE inputs formula set to begin in CY 2022. **The AUA feels strongly that these anticipated payment reductions are unacceptable and would ultimately be detrimental to the Medicare patients who rely on receiving these procedures in the non-**

facility setting particularly in rural and underserved areas. The policy, as proposed, could shift a number of services, namely device-intensive procedures, to the more costly hospital setting in these areas. The 2020 AUA Census found at least one practicing urologist in only 38% of all counties in the United States. This shortage is most acutely felt by those living in rural communities, where only 2% of practicing urologists work. Reducing payment rates to the extent illustrated in *Appendix A* will potentially render it cost prohibitive for urologists to perform these procedures in a non-facility setting and thus further exacerbate this shortage in urological care.

The AUA would also point out that the ongoing COVID-19 Public Health Emergency (PHE) has been incredibly taxing for physicians and other practitioners in all care settings. According to a recent American Medical Association (AMA) study, Medicare spending on urology was 19% percent ($171 million) lower than expected during the period of January 2020-June 2020.[1] As the country and medical professionals continue to respond to the COVID-19 PHE, notably the current Delta variant surge, the financial outlook for practices – specifically non-facility practices – remains unstable. In addition to the recent hardship that urologists (and all other physicians and other practitioners) have faced due to the COVID-19 PHE, CMS also has proposed a 3.89% reduction in the Medicare conversion factor that the AUA acknowledges is almost entirely a result of the lapsing statutory increase enacted under the Consolidated Appropriations Act, 2021. The AUA recognizes CMS' ability to mitigate this cut is limited because of the budget neutral nature of the PFS and an act of Congress would be required to prevent it, but we do request this policy be considered in the full context of proposed PFS changes.

Taken together, the negative impacts of the ongoing COVID-19 PHE, the proposed reduction in the Medicare conversion factor, and the proposed update to clinical labor rates in the direct PE inputs formula will have a disastrous impact on urological practice in the non-facility setting. CMS notes that it implemented a four-year phase-in for its supply and equipment price update and likewise considered implementing a similar four-year phase-in for the clinical labor rates update. **The AUA strongly urges CMS to delay implementation of the updated clinical labor rates for one year to better understand the impact these changes will have on practices. Barring that, the AUA suggests implementing a four year phase-in for the clinical labor rates update and to hold practices harmless for the first year of this phase-in as they continue to navigate the simultaneous impacts of the COVID-19 PHE and the proposed reduction to the Medicare conversion factor. The AUA also suggests a process for a more regular review occurring every five years to ensure predictability in changes and to lessen the degree of difference between review periods.**

---

[1] Gillis, PhD, Kurt. *Changes in Medicare Physician Spending During the COVID-19 Pandemic.* American Medical Association. Policy Research Perspectives. 2021. Web: https://www.ama-assn.org/system/files/2021-03/prp-covid-19-medicare-physician-spending.pdf.

Given the impact of this change on device-intensive procedures, the AUA respectfully requests that CMS consider implementing a device offset similar to that employed in the hospital outpatient setting to protect patient access to procedures in the physician office setting and support continued service innovation in this setting.

Telehealth and Other Services Involving Communications Technology

CMS proposes several changes to its policies around telehealth services, including the extension of payment for Category 3 telehealth codes through CY 2023 and permitting the home as an originating site for mental health telehealth services as enacted in the Consolidated Appropriations Act, 2021 (CAA).

Category 3 Telehealth Services Extension to CY 2023

In the CY 2021 PFS, CMS created a new category (Category 3) of criteria for adding services to the Medicare telehealth services list on a temporary basis following the end of the COVID-19 PHE. This new category describes services that were added to the Medicare telehealth services list 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 under CMS' Category 1 or Category 2 criteria. Given the uncertainty around the duration of the COVID-19 PHE, CMS proposes to retain all services added to the Medicare telehealth services list on a Category 3 basis until the end of CY 2023, allowing for continued data collection on their use and for stakeholders to take the steps necessary to have these services added to the telehealth list permanently.

The ability to provide these services via telehealth through the end of CY 2023 will mitigate the uncertainty around the ability to provide care to at-risk populations (e.g., those over age 65 or those with one or more co-morbidities that put them at higher risk for severe COVID-19 disease) and will preserve and even broaden access to care for individuals in rural and underserved communities. This is particularly relevant to the practice of urology: as noted in the preceding section of this letter, the 2020 AUA Census found at least one practicing urologist in only 38% of all counties in the United States. This shortage is most acutely felt by those living in rural communities, where only 2% of practicing urologists work. **The AUA commends CMS for retaining these Category 3 services on the telehealth list through the end of CY 2023 and urges CMS to continue to collect and analyze data to inform their future inclusion on the telehealth services list on a Category 1 or Category 2 basis after CY 2023.**

Mental Health Telehealth Services Policy

CMS proposes to implement several telehealth-related policy provisions of the CAA related to mental health services and to make certain regulatory changes to its definition of interactive telecommunications system. These provisions include:

- Implementing the CAA's amendments to the Medicare statute that broaden the scope of services for which the geographic restrictions under the Act do not apply and for which the patient's home is a permissible originating site to include telehealth services furnished for the purpose of diagnosis, evaluation, or treatment of a mental health disorder, effective for services furnished on or after the end of the COVID-19 PHE (a provider must have furnished an in-person service or item in the six months prior to the telehealth visit in order to be eligible to bill Medicare for the telehealth service).

- Amending the definition of interactive telecommunications system to include audio-only communications technology when used for the diagnosis, evaluation, or treatment of mental health disorders furnished to established patients when the originating site is the patient's home, the distant site physician or practitioner has the technical capability at the time of the service to use an interactive telecommunications system that includes video, and the patient is not capable of, or does not consent to, the use of video technology for the service.

The AUA applauds CMS for its thoughtful approach to implementing the statutory changes under the CAA and fully supports the expansion of telehealth benefits in this manner, particularly with respect to the home as an originating site of care. We understand that CMS was limited in the scope of its telehealth proposals by the statutory language of the CAA and that mental health services present unique challenges in the provision of care that make them particularly good candidates to be rendered via telehealth. In fact, according to a recent AMA study, mental health services and opioid-use disorder therapy and counseling services continued to see high rates of telehealth utilization compared with other types of services through the period of June 30, 2020.[2] The aforementioned policy changes offer a strong foundational framework for the future provision of other types of telehealth services should Congress further expand the CMS' statutory authority in this area. CMS cited the data collected on the delivery of mental health services using the audio-only modality during the PHE in its proposal. The AUA believes telehealth using both simultaneous audio-visual and audio-only technology is an important tool to expand access and improve health outcomes for Medicare beneficiaries and encourages CMS to share this telehealth data with stakeholders to inform our future

[2] Gillis, PhD, Kurt. Changes in Medicare Physician Spending During the COVID-19 Pandemic. American Medical Association. Policy Research Perspectives. 2021. Web: https://www.ama-assn.org/system/files/2021-03/prp-covid-19-medicare-physician-spending.pdf.

policy recommendations in this area. **The AUA urges CMS to continue to perform analyses on the adoption and efficacy of mental health services billed as telehealth to inform and implement future expansions of telehealth services (including audio-only services) to other areas of patient care, including appropriate urological services, as CMS' statutory authority allows.**

We would point out, however, that exposure to housing instability increases the likelihood of mental health diagnoses (and that this is a bi-directional phenomenon)[3] and that individuals who receive mental health services via telehealth (especially those without access to video technology) are more likely to face housing instability that would place their physical location outside of the confines of what would normally be considered the home. We also would point out that beneficiaries will likely be unaware of what constitutes the definition of the word "home" under the CMS' guidance and that an expansive definition of the word should be used (e.g., must the beneficiary be in the confines of a four-walled residence to be considered home? Would the beneficiary be considered to be at home if they chose to discuss private medical information in a yard or in a car?). Should the definition be too narrow, unreasonable burden would be placed on providers to verify a patient's location prior to service delivery. **The AUA would urge CMS to provide a clear and expansive definition of the word "home" with respect to the provision of telehealth and audio-only mental health services**.

010-day and 090-day Global Period Codes Policies

The AUA urges CMS to incorporate the recent changes to the office/outpatient visit Evaluation and Management (E/M) codes into the 010-day and 090-day global period surgical codes. CMS has failed to incorporate the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC)-recommended work and time incremental increases for the revised office/outpatient E/M codes into the global codes in both the CY 2021 and CY 2022 Medicare PFS rules. While CMS did finalize adjustments for other bundled services, such as maternity codes, in the CY 2021 Medicare PFS rule, organized medicine has been united in its recommendations that CMS incorporate the incremental revised office/outpatient E/M values into all of the 010-day and 090-day global surgical package codes.

By not applying the revised E/M values into the 010-day and 090-day global period codes, CMS risks:

[3] Ankur Singh, Lyrian Daniel, Emma Baker, Rebecca Bentley. *Housing Disadvantage and Poor Mental Health: A Systematic Review*. American Journal of Preventive Medicine. Volume 57, Issue 2. 2019. Pages 262-272. https://www.sciencedirect.com/science/article/abs/pii/S0749379719301709

1) **Disrupting the relativity in the fee schedule**: Applying the RUC-recommended E/M value increases to stand-alone E/M codes, select global codes (e.g., monthly end-stage renal disease and bundled maternity care), and select bundled services (e.g., monthly psychiatric management), but not to the E/M codes that are included in the global surgical package will disrupt the relativity between codes across the Medicare PFS, which was mandated by Congress, established in 1992, and refined over the past 27 years.

2) **Creating specialty differentials**: Per the Medicare statute, CMS is prohibited from paying physicians differently for the same work, and the "Secretary may not vary the . . . number of relative value units for a physician's service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician."[4] Failing to adjust the global codes is tantamount to paying some doctors less for providing the same E/M services, in violation of the law. In the CY 2021 PFS proposed rule, CMS points to the method of valuation (i.e. building block vs. magnitude estimation) for a rationale as to why some bundled services should be increased in value to reflect the revised office/outpatient E/M values, while global codes should not. However, this statutory prohibition on paying physicians differently for the same work applies regardless of code valuation method and the incremental increases should apply to all physicians.

We strongly urge CMS to apply the RUC-recommended changes to the E/M component of the global codes to maintain the relativity of the fee schedule congruent with the revaluation of the office and outpatient E/Ms.

CY 2022 Identification and Review of Potentially Misvalued Services

In *CY 2022 Identification and Review of Potentially Misvalued Services*, CMS notes that a stakeholder nominated CPT code 55880 *Ablation of malignant prostate tissue, transrectal, with high intensity-focused ultrasound (HIFU), including ultrasound guidance* as potentially misvalued as it has not been valued in the non-facility/office setting. CMS notes that the stakeholder did not include in their submission detailed recommendations for items, quantities, and unit costs for the supplies, equipment types, and clinical labor (if any), that might be incurred in the non-facility/office setting, all of which are key factors when determining valuation or misvaluation.

CPT code 55880 underwent RUC review in October 2019 and was reviewed and valued in the CY 2021 PFS final rule. The AUA would note that CPT code 55880 is currently on the

[4] 42 U.S. Code §1395w-4(c)(6).

RUC's New Technology list and will be up for RUC review in 2022 for valuation in the CY 2024 Physician Fee Schedule. **The AUA does not believe this service should be considered potentially misvalued at this time and looks forward to engaging through the RUC process at the appropriate time to ensure the correct valuation of CPT code 55880 in both the facility and non-facility settings.**

Proposed Valuation of Specific Codes for CY 2022 – Periurethral Adjustable Balloon Continence Devices

CMS agrees with the RUC recommendation to assign contractor pricing for four new Category I CPT codes used to report periurethral adjustable balloon continence devices: CPT codes 53XX1 (*Periurethral transperineal adjustable balloon continence device; bilateral insertion, including cystourethroscopy and imaging guidance*), 53XX2 (*Periurethral transperineal adjustable balloon continence device; unilateral insertion, including cystourethroscopy and imaging guidance*), 53XX3 (*Periurethral transperineal adjustable balloon continence device; removal, each balloon*) and 53XX4 (*Periurethral transperineal adjustable balloon continence device; percutaneous adjustment of balloon(s) fluid volume*). **The AUA thanks CMS for accepting the RUC recommendation and would reiterate the important role that the RUC process plays in the accurate valuation of CPT codes in the PFS.**

Split (Shared) Evaluation & Management Visits in the Facility Setting

CMS describes its current policy of split (or shared) billing in the facility setting that allows a physician to bill for an E/M visit when both the billing physician and a non-physician practitioner (NPP) in their group each perform portions of the visit, but only if the physician performs the substantive portion of the visit. When the physician bills for such a split (or shared) visit, the Medicare Part B payment is equal to 80 percent of the payment basis under the PFS which is the lesser of the actual charge or the fee schedule amount for the service. If the physician does not perform a substantive portion of such a split (or shared) visit and the NPP bills for it, the Medicare Part B payment is equal to 80 percent of the lesser of the actual charge or 85 percent of the fee schedule rate.

CMS proposes to define a split (or shared) visit as an E/M visit in the facility setting that is performed in part by both a physician and a non-physician practitioner who are in the same group, in accordance with applicable laws and regulations. CMS also proposes to define split (or shared) visits as those that:

- Are furnished in a facility setting by a physician and an NPP in the same group, where the facility setting is defined as an institutional setting in which

payment for services and supplies furnished incident to a physician or practitioner's professional services is prohibited.

- Are furnished in accordance with applicable law and regulations, including conditions of coverage and payment, such that the E/M visit could be billed by either the physician or the NPP if it were furnished independently by only one of them in the facility setting.

CMS further proposes to define *substantive portion* as "more than half of the total time spent by the physician and non-physician practitioner performing the visit". CMS also proposes that the distinct time of service spent by each physician or NPP furnishing a split (or shared) visit would be summed to determine total time and who provided the substantive portion (and therefore bills for the visit) and proposes a listing of activities that could count toward total time for purposes of determining the substantive portion.

The AUA has concerns with the CMS' proposals related to documenting time in order to determine which provider performed the substantive portion of a split (or shared) visit. CMS makes multiple references to recent changes to the CPT E/M Guidelines; notably, a physician or NPP can now select the level of an E/M visit based on either time or medical decision-making (MDM) under the latest CPT E/M Guidelines. By forcing the physician or NPP to precisely document their time to determine which provider performed the substantive portion of the split (or shared) visit, the proposal, if implemented, essentially restricts the physician or NPP to choosing the level of the split (or shared) visit based on time and removes their ability to do so based on MDM.

The AUA disagrees with the CMS' assertion that, "practitioners are likely to increasingly time their visits for purposes of visit level selection independent of our split (or shared) visit policies" and would reiterate that this proposed policy restricts the ability of the physician or NPP to exercise their clinical judgment in choosing the level of the E/M visit. Requiring the physician or NPP to precisely document their time and activities also creates an administrative burden that detracts from the physician or NPP providing patient care. **The AUA urges CMS to allow the physician or NPP to select the level of the split (or shared) visit based on MDM which CMS itself recognizes in the proposed rule as a possibility.**

Quality Payment Program Proposed Provisions

CMS proposes numerous policy changes regarding the Quality Payment Program, including the establishment of MIPS Value Pathways (MVPs) and the sunset of the traditional MIPS program following the 2027 performance year.

American Urological Association

The AUA thanks CMS for delaying the implementation of MVPs until 2023 and appreciates CMS' recognition that it would be challenging to implement such changes in 2022 as providers continue to respond to the COVID-19 pandemic. Additionally, the AUA supports CMS' focus on the development and implementation of MVPs and favors this framework that links measures and activities across the four MIPS performance categories in an attempt to create a more coherent program. The AUA agrees that MVPs will facilitate the collection of more meaningful and comparable performance data using fewer, but more relevant, measures while minimizing measure selection bias which will better enable providers and CMS to improve the quality of care delivered to patients.

The AUA supports CMS' view that multiple types of MVPs will be required and agree that there should be flexibility in the number and type of measures included in an MVP. We suggest that CMS should not limit the number of measures or activities to 10, but instead, allow up to 15-20 each, depending on the topic, with the goal of parsimony. We also encourage CMS to consider the potential impact of requiring reporting of only four quality measures and clarifying whether providers will have the option of reporting more than four. We agree on the goal of including at least one outcome measure in each MVP, along with the use of a high priority measure(s) if a relevant outcome measure is not available.

We also support the possible inclusion of QCDR measures in MVPs. However, we urge CMS to clarify what it means for a QCDR measure to be "fully tested at the clinician level" (beyond a simple reference to the CMS Measure Blueprint), including what constitutes acceptable testing. Furthermore, we ask that CMS develop a transparent and consistent process for evaluating testing approaches and results, providing feedback, and allowing appeals.

Regarding the inventory of population health measures, we highlight the need for more specialty-relevant population health measures, as the currently included and proposed, respectively, measures of hospital readmission and admission may not be as relevant as desired for urologists.

The AUA agrees with the need for routine maintenance of MVP measures on an annual basis, as well as with the possibility for adding or deleting measures from an MVP. We encourage CMS to consider how best to align this maintenance process to other required activities, such as the annual QCDR self-nominations process.

Regarding the portfolio of MVPs, we applaud the proposal of seven new MVPs for potential implementation in Performance Year (PY) 2023. The AUA looks forward to working with CMS in the near future on developing a urology-specific MVP(s) that reflect the scope of practice in the specialty. We urge CMS to provide regular guidance on the processes

regarding development and approval and to share lessons from early adopters of the currently proposed MVPs.

Regarding the timeline for transition to MVPs, we applaud CMS for its recognition of the challenges associated with measure and MVP development and implementation, as well as operational limitations and overall capacity for change. We believe that announcing mandatory MVP reporting and sunsetting of the traditional MIPS program as of the 2028 performance year is premature. We suggest delaying announcement of a definitive transition date for at least three years. This would allow time for the development and testing of needed specialty-specific measures and the development of the MVPs themselves, as well as to identify and address, sufficiently, the operational difficulties that will result when initial MVPs are implemented.

Finally, the AUA is committed to reducing health disparities in urologic care, including reducing disparate outcomes among patients with bladder, prostate, and kidney cancer. Data collection across CMS programs can help identify inequitable health outcomes and guide interventions to reduce the burden of urologic disease. The AUA supports the use of other variables beyond dual eligibility (e.g., race, ethnicity, disability, language) to identify other facets of inequality that may result in poorer outcomes for patients. However, we believe it is premature to mandate inclusion of health equity measures in the foundational layer of MVPS. Instead, AUA urges CMS to more clearly define health equity measures, focus on robust data collection efforts for use in such measures, and supports the development of measures that are reliable, valid, and useful measures of health equity. Once such measures have been developed, and then implemented in the traditional MIPS program, inclusion in the foundational layer of MVPs can and should be considered.

We are grateful to CMS for the opportunity to provide these comments on the CY 2022 Medicare PFS proposed rule and welcome the opportunity to continue to work together on these important policy issues. Please contact Raymond Wezik, AUA Director of Policy and Advocacy, at rwezik@auanet.org with any questions.

Sincerely,

Eugene Rhee, MD, MBA
Chair, Public Policy Council

Appendix A: Urology Payment Rates for Medicare Physician Services under the CY 2022 Proposed Physician Fee Schedule

2022 Proposed Physician Fee Schedule (CMS-1751-P)											
Payment Rates for Medicare Physician Services - Urology											
CPT Code	CPT Short Descriptor	NON-FACILITY (OFFICE)					FACILITY (HOSPITAL)				
		2022		2021		% payment change 2021 to 2022	2022		2021		% payment change 2021 to 2022
		RVUs	Payment CF=$33.5848	RVUs	Payment CF=$34.8931		RVUs	Payment CF=$33.5848	RVUs	Payment CF=$34.8931	
11981	Insert drug implant device	2.95	$99.08	3.05	$106.42	-6.91%	1.85	$62.13	1.87	$65.25	-4.78%
11982	Remove drug implant device	3.32	$111.50	3.44	$120.03	-7.11%	2.16	$72.54	2.20	$76.76	-5.50%
11983	Remove/insert drug implant	4.20	$141.06	4.26	$148.64	-5.11%	3.01	$101.09	3.04	$106.08	-4.70%
50200	Renal biopsy perq	14.73	$494.70	16.30	$568.76	-13.02%	3.75	$125.94	3.69	$128.76	-2.18%
50382	Change ureter stent percut	27.96	$939.03	32.53	$1,135.07	-17.27%	7.35	$246.85	7.36	$256.81	-3.88%
50384	Remove ureter stent percut	24.03	$807.04	27.23	$950.14	-15.06%	6.61	$222.00	6.62	$230.99	-3.89%
50385	Change stent via transureth	27.97	$939.37	32.55	$1,135.77	-17.29%	6.37	$213.94	6.33	$220.87	-3.14%
50386	Remove stent via transureth	20.62	$692.52	23.17	$808.47	-14.34%	4.75	$159.53	4.68	$163.30	-2.31%
50387	Change nephroureteral cath	15.34	$515.19	17.30	$603.65	-14.65%	2.43	$81.61	2.41	$84.09	-2.95%
50389	Remove renal tube w/fluoro	11.36	$381.52	12.50	$436.16	-12.53%	1.55	$52.06	1.55	$54.08	-3.75%
50433	Plmt nephroureteral catheter	31.88	$1,070.68	35.20	$1,228.24	-12.83%	7.45	$250.21	7.35	$256.46	-2.44%
50434	Convert nephrostomy catheter	25.64	$861.11	28.20	$983.99	-12.49%	5.62	$188.75	5.53	$192.96	-2.18%
50592	Perc rf ablate renal tumor	77.14	$2,590.73	94.20	$3,286.93	-21.18%	10.09	$338.87	9.92	$346.14	-2.10%
50593	Perc cryo ablate renal tum	103.63	$3,480.39	126.49	$4,413.63	-21.14%	13.45	$451.72	13.23	$461.64	-2.15%
50606	Endoluminal bx urtr rnl plvs	14.78	$496.38	17.42	$607.84	-18.34%	4.35	$146.09	4.34	$151.44	-3.53%
50693	Plmt ureteral stent prq	27.93	$938.02	31.47	$1,098.09	-14.58%	5.98	$200.84	5.88	$205.17	-2.11%
50694	Plmt ureteral stent prq	31.50	$1,057.92	35.00	$1,221.26	-13.37%	7.80	$261.96	7.69	$268.33	-2.37%
50695	Plmt ureteral stent prq	37.85	$1,271.18	42.23	$1,473.54	-13.73%	10.01	$336.18	9.91	$345.79	-2.78%
50705	Ureteral embolization/occl	51.26	$1,721.56	58.03	$2,024.85	-14.98%	5.14	$172.63	5.09	$177.61	-2.80%
50706	Balloon dilate urtrl strix	23.57	$791.59	27.43	$957.12	-17.29%	5.25	$176.32	5.25	$183.19	-3.75%
51727	Cystometrogram w/up	3.05	$102.43	3.08	$107.47	-4.69%	3.05	$102.43	3.08	$107.47	-4.69%
51728	Cystometrogram w/vp	3	$100.75	3.01	$105.03	-4.07%	3	$100.75	3.01	$105.03	-4.07%
51729	Cystometrogram w/vp&up	3.64	$122.25	3.67	$128.06	-4.54%	3.64	$122.25	3.67	$128.06	-4.54%
52000	Cystoscopy	6.73	$226.03	6.91	$241.11	-6.26%	2.36	$79.26	2.33	$81.30	-2.51%
52007	Cystoscopy and biopsy	12.60	$423.17	14.19	$495.13	-14.53%	4.86	$163.22	4.80	$167.49	-2.55%
52010	Cystoscopy & duct catheter	10.81	$363.05	11.86	$413.83	-12.27%	4.86	$163.22	4.78	$166.79	-2.14%
52204	Cystoscopy w/biopsy(s)	10.61	$356.33	11.69	$407.90	-12.64%	4.16	$139.71	4.09	$142.71	-2.10%
52214	Cystoscopy and treatment	20.59	$691.51	22.98	$801.84	-13.76%	5.09	$170.95	5.12	$178.65	-4.31%
52224	Cystoscopy and treatment	21.55	$723.75	23.92	$834.64	-13.29%	5.89	$197.81	5.90	$205.87	-3.91%
52240	Cystoscopy and treatment	NA	NA	NA	NA	NA	11.42	$383.54	11.34	$395.69	-3.07%
52287	Cystourethroscopy, with chemodenervation bladder	10.99	$369.10	11.41	$398.13	-7.29%	4.93	$165.57	4.91	$171.33	-3.36%
52310	Cystourethroscopy, with removal of ureteral stent	9.17	$307.97	9.19	$320.67	-3.96%	4.44	$149.12	4.38	$152.83	-2.43%
52332	Cystoscopy with stent insertion	11.23	$377.16	13.09	$456.75	-17.43%	4.58	$153.82	4.50	$157.02	-2.04%
52441	Cystourethro w/implant	34.38	$1,154.65	41.08	$1,433.41	-19.45%	6.14	$206.21	6.08	$212.15	-2.80%
52442	Cystourethro w/addl implant	23.70	$795.96	29.26	$1,020.97	-22.04%	1.46	$49.03	1.49	$51.99	-5.69%
52601	Prostatectomy (turp)	NA	NA	NA	NA	NA	21.53	$723.08	21.23	$740.78	-2.39%
52647	Laser surgery of prostate	43.79	$1,470.68	48.78	$1,702.09	-13.60%	19.30	$648.19	18.94	$660.88	-1.92%
52648	Laser vaporization of prostate (PVP)	45.26	$1,520.05	50.30	$1,755.12	-13.39%	20.54	$689.83	20.17	$703.79	-1.98%
53850	Prostatic microwave thermotx	38.77	$1,302.08	46.24	$1,613.46	-19.30%	10.70	$359.36	10.31	$359.75	-0.11%
53852	Prostatic rf thermotx	37.91	$1,273.20	44.92	$1,567.40	-18.77%	11.43	$383.87	11.04	$385.22	-0.35%
53854	Trurl dstrj prst8 tiss rf wv	45.50	$1,528.11	54.11	$1,888.07	-19.06%	11.44	$384.21	11.05	$385.57	-0.35%
53855	Insert prost urethral stent	17.59	$590.76	21.86	$762.76	-22.55%	2.39	$80.27	2.39	$83.39	-3.75%
53860	Transurethral rf treatment	64.00	$2,149.43	71.09	$2,480.55	-13.35%	6.62	$222.33	6.47	$225.76	-1.52%
54640	Suspension of testis	NA	NA	NA	NA	NA	12.86	$431.90	12.67	$442.10	-2.31%
55250	Removal of sperm duct(s)	9.75	$327.45	10.42	$363.59	-9.94%	6.92	$232.41	6.66	$232.39	0.01%
55866	Laparo radical prostatectomy	NA	NA	NA	NA	NA	42.30	$1,420.64	41.95	$1,463.77	-2.95%
55873	Cryoablate prostate	154.60	$5,192.21	186.69	$6,514.19	-20.29%	22.67	$761.37	22.28	$777.42	-2.06%
55874	Tprnl plmt biodegrdabl matrl	76.39	$2,565.54	93.45	$3,260.76	-21.32%	4.87	$163.56	4.77	$166.44	-1.73%
55880	Abltj mal prst8 tiss hifu	NA	NA	NA	NA	NA	28.95	$972.28	28.57	$996.90	-2.47%
57282	Colpopexy extraperitoneal	NA	NA	NA	NA	NA	20.64	$693.19	20.42	$712.52	-2.71%
57283	Colpopexy intraperitoneal	NA	NA	NA	NA	NA	20.78	$697.89	20.56	$717.40	-2.72%
57425	Laparoscopy surg colpopexy	NA	NA	NA	NA	NA	28.84	$968.59	28.65	$999.69	-3.11%
58353	Endometr ablate thermal	25.42	$853.73	30.29	$1,056.91	-19.22%	6.88	$231.06	6.79	$236.92	-2.47%
58356	Endometrial cryoablation	45.87	$1,540.53	54.78	$1,911.44	-19.40%	10.40	$349.28	10.47	$365.33	-4.39%
58558	Hysteroscopy biopsy	36.04	$1,210.40	42.87	$1,495.87	-19.08%	6.84	$229.72	6.78	$236.58	-2.90%
58563	Hysteroscopy ablation	56.77	$1,906.61	64.72	$2,258.28	-15.57%	7.29	$244.83	7.24	$252.63	-3.08%
58565	Hysteroscopy sterilization	45.84	$1,539.53	54.33	$1,895.74	-18.79%	13.61	$457.09	13.43	$468.61	-2.46%
74425	Urography antegrade rs&i	0.71	$23.85	0.71	$24.77	-3.75%	0.71	$23.85	0.71	$24.77	-3.75%
90912	Bfb training 1st 15 min	2.37	$79.60	2.38	$83.05	-4.15%	1.27	$42.65	1.26	$43.97	-2.99%
90913	Bfb training ea addl 15 min	0.97	$32.58	0.94	$32.80	-0.68%	0.70	$23.51	0.71	$24.77	-5.11%