September 13, 2022

Ms. Chiquita Brooks-Lasure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **CMS-1772-P**
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1772-P; CY 2023 Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; Rural Emergency Hospitals: Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral; New Service Category for Hospital Outpatient Department Prior Authorization Process; Overall Hospital Quality Star Rating

Dear Administrator Brooks-Lasure:

The undersigned medical specialty societies, comprising physicians who utilize and/or perform interventional spine procedures to accurately diagnose and treat patients suffering from spine pathologies, would like to express our strong support for appropriate access to facet joint interventions. Our societies have a strong record of working to eliminate fraudulent, unproven, and inappropriate procedures. At the same time, we are equally committed to assuring that access to appropriate, effective, and responsible treatments is preserved.

Proposed Addition of a New Service Category: Facet Joint Interventions

This year, CMS has proposed to expand prior authorization requirements by adding a new service category for facet joint interventions performed in the hospital outpatient departments in order to curb what the agency believes may be unnecessary utilization. The societies disagree with this proposal and **strongly urge CMS not to apply the prior authorization requirement to facet joint interventions as this requirement creates an improper and unnecessary burden on the health care delivery system.**

Facet joint interventions are key alternatives to opioid prescription for the management of pain symptoms. Creating barriers to access for this non-opioid alternative will only increase opioid prescriptions and opioid dependence and ultimately result in higher addiction rates, higher costs to Medicare and to society as a whole. Studies have demonstrated that prior authorization creates specifically negative impacts for non-opioid pain procedures and that these increased delays and denials have led to increased opioid prescription rates.[1] **We urge CMS to follow the recommendation of their Opioid Taskforce and allow for smooth access to facet joint**

[1] https://www.ama-assn.org/practice-management/sustainability/prior-authorization-nonopioid-pain-care-prolongs-patient

interventions and other similar non-opioid treatments. Requiring prior authorization of facet joint interventions runs counter to the recommendations of CMS's medical and public health officials and will incur a massive cost to society, patients, and providers, without offering anything other than overestimated cost savings.

We also dispute the CMS claim that prior authorization will reduce unnecessary utilization. There is evidence that prior authorization merely results in delays in appropriate care. While there is evidence that utilization is increasing at significant rates for these procedures, there is considerable evidence to illustrate the costs for patients and practices from prior authorization policies used by private payers.

For example, Karrison *et al.* found that when time spent in acquiring prior authorization is converted to dollars, national time cost to practices of interactions with plans is at least $23 billion to $31 billion each year.[2] This financial burden and cost has only increased in the ensuing twelve years, and we believe this cost to be an unnecessary and unjustified burden for physicians performing facet joint interventions.

Other studies have confirmed and added to the body of evidence showing the detrimental impact of prior authorization burdens to patient access. A 2019 AMA survey found that 64% of patients surveyed experienced at least a one-day delay in scheduling and another 26% experienced delays of three or more days -- with 91% of respondents experienced delays in necessary care. Of physicians surveyed, 24% reported that a delay related to prior authorization led to adverse patient events and 16% reported hospitalizations directly attributable to prior authorization. Furthermore, the same study found that prior authorization efforts add 14.4 hours of staff time per week to their workload with 30% of respondents reporting that their practice has a Full Time Employee (FTE) dedicated to prior authorization. The same survey found the prior authorization burden to have increased significantly over the past seven years, with 86% of respondents reporting increased prior authorization costs to their practice in the previous five years.[3] A study from the Cleveland Clinic estimated their annual costs for prior authorization activities to exceed $10 million a year.[4]

These studies apply to facet joint interventions identified by CMS in the proposed rule and demonstrate that imposing these burdens will result in unnecessary delays for patients in accessing these critical procedures. Numerous studies have found that facet joint interventions are highly efficacious. Significant relief of neck and back pain, improved quality of life, with restoration of function and return to work, as well as decreased utilization of other healthcare resources is an outcome that should be readily available to patients covered by Medicare. When facet interventions are performed in a disciplined, responsible manner, they achieve outcomes that are clinically, socially, and economically worthwhile.[5]

We believe it is essential to continue to increase access to non-opioid pain treatment and facet joint interventions are very important alternatives to opioid prescriptions. We urge CMS to revise

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[2] Health Affairs, 28, no.4 (2009):w533-w543 What Does It Cost Physician Practices To Interact With Health Insurance Plans? Theodore Karrison and Wendy Levinson Lawrence P. Casalino, Sean Nicholson, David N. Gans, Terry Hammons, Dante Morra,

[3] https://www.ama-assn.org/system/files/2020-06/prior-authorization-survey-2019.pdf

[4] https://www.ama-assn.org/practice-management/sustainability/inside-cleveland-clinic-s-10-million-prior-authorization-price

[5] Bogduk N (ed). Practice guidelines for Spinal Diagnostic and Treatment Procedures, 2nd edn. International Spine Intervention Society, San Francisco, 2013.

their proposal to decrease access to facet joint interventions through the imposition of a costly and burdensome prior authorization process.

The undersigned societies appreciate the opportunity to provide these comments. The MPW societies would welcome the opportunity to work with CMS ensure appropriate access to facet joint interventions for Medicare patients. We offer our ongoing input and expertise in this matter. If you have any questions or wish to discuss any of our suggestions, please contact Sarah Cartagena, Director of Health Policy at the Spine Intervention Society, at scartagena@SpineIntervention.org.

Sincerely,

American Academy of Physical Medicine and Rehabilitation

American College of Radiology

American Society of Neuroradiology

American Society of Regional Anesthesia and Pain Medicine

North American Neuromodulation Society

North American Spine Society

Society of Interventional Radiology

Spine Intervention Society