September 12, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1772-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted electronically at http://www.regulations.gov

RE: 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 [CMS-1772-P]

Dear Administrator Brooks-LaSure:

The American Society of Regional Anesthesia and Pain Medicine (ASRA Pain Medicine) is a voluntary organization representing chronic and acute pain medicine physicians both nationally and internationally. In particular, we are highly dedicated to the use of evidence-based, medical therapies in treating patients with chronic and acute pain when appropriate. Our membership, of over 5,000 practitioners, includes solo practitioners, small group practice members, and practitioners in large private and academic healthcare systems. We strongly support the efforts of the Centers for Medicare and Medicaid Services (CMS) to improve quality of care and patient outcomes.

However, we are very concerned about the proposal in the calendar year (CY) 2023 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) proposed rule to expand the hospital outpatient department (OPD) prior authorization process to include facet joint interventions. ***ASRA Pain Medicine strongly opposes CMS' proposed addition of facet joint interventions to the OPD prior authorization process, and further urges CMS to halt its overreliance on prior authorization for OPD procedures and instead pursue other, more targeted and less burdensome options for curbing inappropriate utilization.***

Prior authorization restricts patients' access to medically necessary services and increases the risk that they do not receive care in a timely manner, while at the same time diverting physician and staff time and resources away from patient care to address administrative paperwork and significantly

contributing to physician and staff burnout. To illustrate, an American Medical Association (AMA) 2021 survey of physicians[1] found that prior authorization delayed patient access to necessary care (for 93 percent of respondents) and sometimes, often, or always led to treatment abandonment (for 82 percent of respondents). Clinical outcomes were also negatively impacted according to the vast majority of physicians surveyed (91 percent). Additionally, 88 percent of respondents describe the burden associated with prior authorization as high or extremely high.

Experience with the existing OPD prior authorization process is consistent with these findings. For example, our members report that the prior authorization process has been fraught with failure for many services that now require prior authorization (for example, botulinum toxin injections for migraine, or CPT 64615), leading to significant restrictions in patients' access to care and, as a result, unnecessary pain and suffering. In part, this appears to be due to lack of Medicare investment in the prior authorization program, which has resulted in a fragmented and disjointed process that leads to severe delays in care. Expanding the use of prior authorization for OPD services, therefore, would further harm patients and increase burden for a physician and staff work force that is already under-valued and stretched too thin.

We also note that CMS' proposal is in conflict with CMS' stated commitment to addressing the ongoing opioid crisis, given that facet joint interventions offer a proven non-opioid option for diagnosing and managing chronic cervical/thoracic and back pain arising from facet joints. CMS states very plainly in its Opioid Epidemic Roadmap[2] that the agency "*has a vital role in addressing the opioid epidemic"* and is focused on prevention and treatment efforts. CMS describes the need to "*manage pain using a safe and effective range of treatment options that rely less on prescription opioids,"* as well as "*ensure access to treatment across CMS programs" and "give patients options for a broader range of treatments."* By imposing a prior authorization requirement for facet joint interventions, CMS is impeding beneficiary access to an evidence-based, medically necessary treatment that has been shown to have a significant and profound impact on managing chronic pain.

We therefore urge CMS not to finalize its proposal to expand the OPD prior authorization process to include facet joint interventions. Furthermore, we strongly recommend that CMS pursue alternative strategies for addressing concerns with overutilization that may be more targeted and less burdensome. For example, CMS could limit prior authorization requirements to outlier providers only, or those with high error rates.

Should CMS move forward and finalize its proposal, ***we emphasize the need to ensure that review of prior authorization requests for facet joint interventions should be conducted by board-certified pain medicine specialists.*** Too often, reviewers do not have the experience or knowledge to effectively assess the clinical need for a given intervention, further contributing to delay or denial of medically necessary care.

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[1] American Medical Association. 2022. 2021 AMA prior authorization (PA) physician survey. Accessed from https://www.ama-assn.org/system/files/prior-authorization-survey.pdf on August 29, 2022.
[2] Centers for Medicare and Medicaid Services. 2020. CMS Roadmap: Strategy to Fight the Opioid Crisis. Accessed from https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Opioid-epidemic-roadmap.pdf on August 29, 2022.

Conclusion

ASRA Pain Medicine appreciates your consideration of our comments on the updates to the CY 2023 OPPS/ASC proposed rule. We look forward to working with CMS to achieve our shared goals of advancing high-quality of care and improving health outcomes for Medicare beneficiaries. As part of this important work, we will continue our commitment to promoting use of evidence-based, non-opioid pain management techniques in the treatment of acute and chronic pain and safe use of opioids according to evidence-based guidelines in patients for whom it is medically appropriate. If you have any questions about these comments or other issues of concern, please do not hesitate to contact Angela Stengel at 412-471-2718 or astengel@asra.com.

Sincerely,

Samer Narouze, MD PhD