AMERICAN SOCIETY OF PLASTIC SURGEONS ®
THE PLASTIC SURGERY FOUNDATION ®

Executive Office
444 East Algonquin Road • Arlington Heights, IL 60005-4664
847-228-9900 • Fax: 847-228-9131 • www.plasticsurgery.org

June 1, 2023
HCPCS Committee
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted electronically via: HCPCS@cms.hhs.gov

RE: Reconsideration of S codes Associated with Breast Reconstruction Procedures

Members of the CMS HCPCS Committee:

The American Society of Plastic Surgeons (ASPS) appreciates the opportunity provided by CMS to comment on the HCPCS committee's reconsideration of its decision to delete three existing HCPCS Level II Codes associated with microsurgical breast reconstruction surgery, S2066, S2067, and S2068 (Agenda Item HCP210813XRPKE). ASPS is the largest association of plastic surgeons in the world, representing more than 8,000 members and 93 percent of all board-certified plastic surgeons in the United States. Our mission is to advance quality care for plastic surgery patients and promote public policy that protects patient safety. Ensuring access to the full range of post-cancer reconstruction options is a vital part of that mission.

As you know, over the past year, a number of commercial health insurance companies have introduced categorical changes to their coverage policies for microsurgical breast reconstruction, under which some private practice surgeons who do substantial amounts of microsurgical breast reconstruction saw very large reductions in their reimbursement for the procedure. Direct reports from our members, numerous media stories, and a recent survey by the American Society for Reconstructive Microsurgery all show that these categorical reductions in private payer valuation of microsurgical breast reconstruction are triggering disturbing losses in access to this type of care.

This eroding access can be reversed, and we are tremendously appreciative that CMS is taking steps to try to facilitate that process. ASPS is deeply concerned that the private insurance industry is treating the sunset of the S-codes as an opportunity to reclassify microsurgical breast reconstruction as a lower-level procedure. There should be no difference between payers' internal value for the procedure variations

covered under S2066-68 and their value for CPT® 19364 with the transition in coding. The same perforator flap techniques are covered under both types of code. The clinical resources and level of surgical skill required do not change simply because the procedure is described with a different code. Yet, we hear from our microsurgeon members – particularly those in private, community-based practices – that private insurance companies are not transferring the current value for microsurgical breast reconstruction along with the change in the code used to report it; instead, they are shifting to a lower value wherever there is a lower value associated with CPT® 19364. We believe this approach is clearly out of step with CMS's expectations, and we point to the following comments from the Agency's summary for this agenda item as evidence (emphasis added):

> "On February 16, 2022, after receiving public comment, CMS decided to discontinue HCPCS codes S2066, S2067, and S2068 on December 31, 2024. Our typical approach is to establish or discontinue codes on the next quarter. However, we established a transition period to allow time for any entities that currently list these codes in their written policies or contracts to make any necessary updates, including facilitating a transition period for negotiations between providers and payers."

No such transition has occurred. What the Agency describes above is a process of individual payers working with the individual surgeons with whom they have existing S-code contracts to transfer their existing agreements to function under CPT® 19364. However, payers are not attempting to work with individual contracted physicians and are instead making unilateral changes that require all physicians to accept the same reimbursement under CPT® 19364. In fact, we have heard from several members with a practice focused on microsurgical breast reconstruction that some payers are not engaging with them when they try to reestablish agreements for breast microsurgery. For these reasons, we respectfully request that CMS explicitly state within the HCPCS committee materials and in public communications at large that the Agency expects that a process of direct engagement between individual surgeons and individual payers should occur to transition or renegotiate contracts for microsurgical breast reconstruction.

We are hopeful that CMS's attention to this issue and any steps it may take after the June 1st HCPCS meeting will encourage payers to begin engaging with our member breast microsurgeons, and we are hopeful that this engagement will result in current agreements being honored and maintained. To that end, we offer the following input regarding the specific questions the Agency posed in the meeting agenda item for this topic:

1) Should CMS extend the scheduled end date of December 31, 2024, for HCPCS codes S2066-S2068? If so, for how long?

2) Should CMS retain HCPCS codes S2066-S2068 and not end their availability on December 31, 2024? In particular, we seek input from private payers about whether they would continue to use S2066-S2068 in lieu of other codes, such as CPT® code 19364.

ASPS has a similar perspective on both of these questions: we believe they represent excellent options to help forestall massive reductions in the value of microsurgical breast reconstruction and encourage extensive direct engagement between individual providers and individual private payers to effect a true transition wherever a company wishes to shift from using the S-codes to CPT® 19364. However, they also represent decisions that would help create an environment that facilitates appropriate valuation of microsurgical breast reconstruction, not an actual solution to guarantee it. Ultimately, it is up to private payers to take that step.

With regard to the option of extending the sunset date for the S-codes, we believe that this would have to be done on an indefinite basis and that CMS should expressly continue their availability for no less time than what it takes to fully and appropriately transition every existing S-code agreement to a CPT® 19364-based agreement.

Regarding the option of keeping the S-codes permanently, we believe our members who currently have S-code-based agreements would be pleased with that option. It would certainly be the most efficient approach because it would obviate the need for individuals to work payer by payer to transition their contracts for microsurgical breast reconstruction to CPT® 19364. It would also reduce potential administrative complexity for any payers that feel the need to institute proprietary coding mechanisms to indicate which perforator flap technique is used in a breast reconstruction. However, we do not believe such proprietary coding schemes are an absolute necessity for the appropriate usage of CPT® 19364 because there is more than a decade of precedent of commercial health insurers successfully using CPT® 19364 to appropriately reimburse plastic surgeons for a variety of perforator flap breast reconstruction techniques.

3) Are any parties approaching the CPT® Editorial Panel to seek revisions or refinements to the CPT® code set? Are any parties approaching another body, such as the AMA/Specialty Society RVS Update Committee (RUC)? If so, how long may be necessary for this process to occur and be allowed for any subsequent transition period, if any revisions are made by the CPT® Editorial Panel or other entity? In other words, if revisions or refinements are sought, how long would it be beneficial for codes S2066-S2068 to remain effective?

ASPS is not seeking revisions or refinements to the CPT® code set. The breast reconstruction code family was reviewed in full in 2020. The specific revisions to CPT® 19364 were appropriate because they reflected – as noted by the Agency in the summary for this agenda item – how the code was used extensively in practice for more than a decade. Additionally, the 2021 change to CPT® 19364 did not result in a change to the RUC value of the procedure, which ASPS also believes is appropriate.

Ultimately, while we do not inherently oppose the idea of tying adjustments to the S-codes to the timeline associated with any CPT or RUC processes that other parties might initiate, we do not think it is the most logical step. The access issue is not centered on how Medicare values CPT® 19364. Rather, it is centered on how the commercial health insurance industry values the code. No change in the CMS RVUs occurred, but a change in how private payers reimburse occurred. Revising the description of the CPT® code, creating new CPT® codes, or even increasing the value of CPT® 19364 – an outcome we project as highly unlikely – is far from guaranteed to impact private payer behavior.

It is also important to recognize that CMS valuation of physician work is focused on only the time and intensity of a service. In this situation, we do not believe the time and intensity are significantly different enough across the spectrum of abdominal-based and/or alternative site-based free flaps used in breast reconstruction to be easily distinguished between the numerous procedures and variations of free flaps used in breast reconstruction. In addition, this type of distinction is not one that can be easily made within the CPT structure given the typical structure of similar codes used for other flaps reported for non-breast reconstruction procedures. However, private insurers have other factors that are critical in their reimbursement schedules, including both long-term costs (i.e., after the global period) for a procedure and the need to have adequate reimbursement in order to ensure compliance with network adequacy requirements. We believe it is for these two reasons that private insurers have honored the S-codes in their agreements. There are long-term benefits secondary to decreased abdominal wall morbidity for muscle-sparing flap harvest techniques that lower the risk of later costs for abdominal bulging and weakness. Perhaps more important for private insurers is the requirement for network adequacy. Patients, by law, should have access to all of their reconstructive options. Given the more specialized nature of this procedure, the potential costs to an insurer to have enough in-network options for microsurgical breast reconstruction will likely vary based on geographic area and patient access metrics. Current utilization of the S-codes allows for this adjustment to be enacted.

Thank you for your attention to this matter and for seeking ideas to help this situation. Microsurgical breast reconstruction has excellent clinical outcomes, tremendous patient-reported satisfaction, and the potential to introduce long-term saving in the healthcare system. There are already too few plastic surgeons offering this type of breast reconstruction because of insufficient reimbursement, and a mass devaluation of microsurgical breast reconstruction will result in a catastrophic loss of patient access to the procedure, particularly for people who are served by doctors in small practices located in areas where networks are already thin. We hope that CMS continues to explore our proposals to ensure this tragic loss of access does not happen. As you engage in that work, ASPS remains committed to doing anything it possibly can to support your efforts.

Sincerely,

Greg Greco, DO, FACS
President, ASPS