In the wake of the US Centers for Medicare and Medicaid Services (CMS) 2022 Medicare Physician Fee Schedule (MPFS) Final Rule,\textsuperscript{1,2} which effectively reduced physician reimbursement for ablation of supraventricular tachycardia (SVT) and atrial fibrillation (AF) by \textasciitilde30\%, the Heart Rhythm Society (HRS) Health Policy Committee organized a survey of physician reaction to these reimbursement changes. The survey’s results are published in this issue of Heart Rhythm Journal.\textsuperscript{3} As members of the 2021–2022 HRS Health Policy Committee, we would like to offer our perspective on what has happened as well as to summarize our ongoing advocacy efforts.

Background of CMS reimbursement for ablation

The past 30+ years have witnessed a significant evolution of cardiac ablation procedures as well as physician payment models in the United States. In 1992, CMS was mandated by Congress to base physician payment on the resource-based relative value scale,\textsuperscript{4,5} which sets the relative value unit (RVU) as the currency of physician work effort. On this basis, CMS established the MPFS (which is updated yearly), cataloging RVUs for every Current Procedural Terminology (CPT) code.\textsuperscript{6} The Relative Value Scale Update Committee (RUC) was created by the American Medical Association (AMA) to develop and update relative value recommendations for both new and previously valued procedures/services.\textsuperscript{7,8} The CPT Editorial Panel and the RUC each meet on a regular basis to complete these recommendation updates, and while doing so they are aided by advisors from constituent societies of the AMA House of Delegates, including HRS. Historically, CMS final rules have been closely aligned with the recommended RVU valuations.

Before 2020, CPT codes regarding cardiac ablation were last updated in 2013 to support AF ablation (code 93656) as a distinct service from SVT ablation (93653), among other changes. Left atrial recording (93621) and 3-dimensional (3D) mapping (93613) had been established as distinct add-on procedures occasionally performed with SVT ablation, and 3D mapping and intracardiac echocardiography (93622) also were add-on procedures for AF ablation. In 2020, an automatic screen brought to CMS’s attention that these previously “add-on” procedures were now being performed concomitantly in \textasciitilde70\% of the primary cases. The add-on codes were therefore mandated by CMS to be bundled into the respective primary ablation CPT codes (ie, SVT ablation would now include left atrial recording and 3D mapping and AF ablation would now include 3D mapping and intracardiac echocardiography), and the entire ablation code family was then sent to the RUC for updated RVU recommendations before CMS Final Rule.

Although the RUC methodology accounts for many things, a primary factor for determining relative value is procedure “intraservice” time, with the intensity of the procedure and typical patient complexity as other important factors. These measures are obtained via surveys sent to a random selection of physicians who perform the procedure in question. For the ablation codes, the survey was completed by members of HRS and the American College of Cardiology (ACC),
showing an overall reduction in procedure times compared to the prior survey from 2013 (eg, median time for SVT ablation reduced from 180 minutes not including bundled services to 125 minutes including bundled services and median time for AF ablation from 240 minutes not including bundled services to 210 minutes including bundled services). Although some reduction in procedure times was expected, the size of the reduction was surprising—especially considering the new bundling of services. HRS Advisors to the RUC recommended a repeat survey to ensure accuracy, emphasizing that the new bundling of services might not have been apparent because of otherwise unchanged CPT codes (93653 and 93656). The RUC accepted this recommendation to conduct a second survey and provided interim value recommendations in the meantime. However, CMS did not accept the RUC-recommended interim values and instead made the decision to simply keep the same values assigned to SVT and AF ablation codes, effectively eliminating the bundled services’ value. This decision remained in the 2022 MPFS Final Rule despite strong opposition from HRS, ACC, RUC, and other partners including physicians, patient advocacy groups, and industry.

Reimbursement reductions of this magnitude usually would be phased in gradually over several years. However, because the primary ablation codes’ values were otherwise the same as before, leading to the appearance that there was no reduction at all, the dramatic cut took effect abruptly. In combination with other universal and statutory reductions in Medicare reimbursement related to the RVU conversion factor, budget sequestration, and PAYGO, these changes led to a ~30% reduction in reimbursement for 2022 compared with 2021. The second survey from HRS/ACC evaluating ablation work returned similar results of reduced procedure times, even accounting for newly bundled services. The RUC then made final recommendations to be considered by CMS for its 2023 MPFS Final Rule, which will be published later this year.

Uncertainties are inherent in any survey methodology, including surveys conducted via the RUC process. It can be especially challenging for physicians to estimate time required for separate vs bundled services. Over the past decade, advances in technology and efficiencies in technique have streamlined the procedural workflow. However, in this era of competitive publishing and industry-driven technology adoption, and perhaps fueled by social media, one wonders whether some survey responses regarding procedural times reflected the ideal scenario rather than the typical scenario, leading to artificially low assigned service time.

**HRS survey**

The results of the HRS survey of cardiac electrophysiologists (EPs) reflects the real consequences, both financial and emotional, felt by our members and colleagues in the United States. It needs to be said that these reimbursement reductions occurred on top of the trauma we have collectively experienced over the past 2 years during the coronavirus disease 2019 pandemic. While EP physicians remain clearly dedicated to treating our patients with heart rhythm disorders, the survey also reflects the economic reality for US physicians—for most of whom either part or all of their income is based on RVUs. These CMS changes ultimately reflect how society values our work, which remains technically challenging and often carries considerable risk. We all are witnesses to how arrhythmia care has changed: from ablation as a last resort treatment to now first-line treatment for many patients. The economics of ablation perhaps reflect the price of progress for EP physicians, like other “products” in the marketplace: With efficiencies in workflow and proliferating alternatives, ultimately, consumer prices drop.

The real-world consequences of these changes to reimbursement remain uncertain. According to the HRS survey, a significant number of respondents have seen or expect to see reductions in practice staffing and an alarming majority expects to reduce teaching time and/or to change their own career plans because of reduced income. Some may choose against performing more complex procedures, or even against training to perform such procedures, because of lower reimbursement. Importantly, this survey did not address directly the reimbursement cuts’ impact on trainees who will decide in the coming years whether to dedicate their careers to EP, especially after considering the lengthy and arduous training process in the United States. Given all these factors, there is a real possibility that CMS reimbursement changes could lead to reduced patient access to ablation therapy, and even to expert EP care in general.

**HRS outlook**

HRS remains dedicated to its mission “to improve the care of patients by promoting research, education, and optimal health care policies and standards.” The reality reflected in the survey is simultaneously sobering and energizing: we recognize the importance of HRS’s advocacy efforts, and as stewards of these efforts, the HRS Health Policy and Regulatory Affairs Committee is dedicated to understanding our fellow HRS members’ concerns and to voicing these needs.

Regarding the 2022 MPFS, HRS has continued to engage with CMS, most recently with a letter in partnership with ACC, detailing our strong and justified opposition to the 2022 changes and advocating remedial action. As a result of advocacy from the entire field of medicine, additional reduction in the MPFS conversion factor and other “sequestration” reductions were significantly mitigated for 2022. We continue to work through the AMA House of Delegates at the CPT and RUC to support appropriate valuation. Although our most recent experience at the RUC led to disappointing reductions by CMS, the RUC process remains our best opportunity in the complex landscape of US health care to engage CMS. Finally, we remind our fellow HRS members that these changes in physician payment do not alter the overall value of ablation procedures to hospital systems.

One encouraging finding from the HRS survey was that many respondents volunteered to help with future advocacy efforts. Future health policy sessions at HRS meetings surely
will attract added attention and constructive dialogue. With renewed energy and added resources from HRS leadership, the HRS Health Policy and Regulatory Affairs Committee will (1) continue to engage and advocate at every regulatory and reimbursement agency as they pertain to EP work, (2) support our members and colleagues with the shared goal of maximizing patients’ access to care for heart rhythm disorders, and (3) educate our members about the relevant processes so that you can remain engaged.

References