AMERICAN ASSOCIATION OF
NEUROLOGICAL SURGEONS
KATIE O. ORRICO, *CEO*
5550 Meadowbrook Drive
Rolling Meadows, IL 60008
Phone: 888-566-AANS
Fax: 847-378-0600
info@aans.org

President
JACQUES J. MORCOS, MD
Houston, Texas

CONGRESS OF
NEUROLOGICAL SURGEONS
REGINA SHUPAK, *CEO*
10 North Martingale Road, Suite 190
Schaumburg, IL 60173
Phone: 877-517-1CNS
FAX: 847-240-0804
info@cns.org

President
ALEXANDER A. KHALESSI, MD
San Diego, California

September 9, 2024

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
ATTN: CMS-1807-P
P.O. Box 8016
Baltimore, M.D. 21244-1850

Submitted electronically via www.regulations.gov

Subject: CMS-1807-P Medicare and Medicaid Programs; CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments

Dear Administrator Brooks-LaSure:

On behalf of the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), representing more than 4,000 neurosurgeons nationwide, we appreciate the opportunity to comment on the payment and quality provisions of the above-referenced notice of proposed rulemaking.

EXECUTIVE SUMMARY

CODING AND REIMBURSEMENT ISSUES

Conversion Factor

The AANS and the CNS are deeply concerned about the overall 2.8 percent decrease in the Calendar Year (CY) 2025 conversion factor. We urge CMS to take all possible actions to provide a positive update to the Medicare conversion factor in 2024.

Global Surgical Codes

With respect to CMS policy regarding Global Surgical Codes, the AANS and CNS note the following:

- **Transfer of Care Modifiers.** We do not support the expansion of Modifiers -54, -55, and -56 beyond their current usage.
- **New E/M "G" Code to Report Post-operative Care.** We oppose the creation of the new GPOC1 code for physicians other than the operating surgeon to report services provided in the post-operative portion of a global period.

- **Increasing the E/M Values in the Global Periods** As we have for many years, we continue to urge CMS to immediately increase the 10- and 90-day global codes to reflect the proportionate increase in value for evaluation and management (E/M) codes to maintain the relativity of the fee schedule and comply with the Medicare statute prohibiting specialty payment differentials. This is the only action that CMS should take regarding the surgical global periods at this time.

Practice Expense (PE) Relative Value Units (RVUs)

- **Low Volume Overrides.** We support the AMA/Specialty Society Relative Value Scale Update Committee (RUC) recommendations for low-volume services, including a specialty override for anterior arthrodesis CPT Code 22808 from neurosurgery to orthopaedic surgery.

- **Medicare Economic Index and AMA PPI Survey.** We support the AMA Physician Practice Information (PPI) Survey and are pleased that CMS has agreed to delay changes in the Medicare Economic Index (MEI) until the survey is complete and results can be analyzed and reviewed by stakeholders.

CMS Valuation of Specific Codes

- **CMS Acceptance of RUC-Recommended Values**. We appreciate the agency's acceptance of the majority of RUC-passed values, which are based on valid, clinically relevant information that preserves relativity. We believe the RUC is the entity best positioned to provide recommendations to CMS on resource inputs for work, PE and professional liability valuations and to establish values for E/M and other physicians' services.

- **MRI Guided Focused Ultra Sound (MRgFUS).** We urge CMS to restore the RUC-passed work value of 18.95 for the new MRgFUS service.

- **Potentially Misvalued Procedure**.

    - **Osteotomy Codes**. We disagree with the request to designate osteotomy CPT codes 22210, 22212, 22214, and 22216 as potentially misvalued at this time.

    - **S.I. Joint Fusion.** We urge CMS not to price sacroiliac joint arthrodesis procedure CPT code 27279 in the non-facility/office setting.

Telehealth

- **Neurostimulator Programming via Telehealth.** We request that CMS place neurostimulator programming services, described by CPT codes 95970, 95971, 95972, 95983, and 95984, on the list of services permanently approved for provision via telehealth.

QUALITY ISSUES

- We strongly oppose the adoption of the arbitrarily constructed Surgical Care Merit-Based Incentive Payment System (MIPS) Value Pathway (MVP).

- We also oppose the use of Q459: Back Pain After Lumbar Surgery in MIPS since improving back pain is typically not the primary goal of lumbar fusion surgery.

- We support CMS's commitment to integrating more patient-reported outcome measures (PROMs) into CMS quality reporting programs and Innovation Center models. We urge CMS to find a balance between the use of more universally applicable tools such as PROMIS®, as well as more specific measures that are more appropriate for specific patient populations.

- For organized neurosurgery's position on other quality issues addressed in this rule, please refer to the comment letters submitted by the Alliance of Specialty Medicine and the Physician Clinical Registry Coalition (PCRC).

DETAILED COMMENTS

CODING AND REIMBURSEMENT ISSUES

Conversion Factor

The AANS and the CNS echo the comments of the AMA, the Alliance of Specialty Medicine, the American College of Surgeons (ACS), and the majority of medical specialty societies expressing our deep concern regarding the overall decrease in the CY 2024 conversion factor. At a time when physicians face continued challenges from the aftermath of the COVID-19 pandemic and steep inflation, a cut in the conversion factor is particularly distressing. While physicians are subject to yet another decrease, CMS has finalized sizeable increases in most other Medicare payment systems for 2025. This included increases of 2.9 percent for inpatient hospitals, 3.0 percent for inpatient rehabilitation facilities, and 3.7 percent for Medicare Advantage plans. Like these other Medicare providers, physicians' practice costs have increased considerably over the past several years. However, unlike other providers, our updates do not meaningfully consider the increase in practice costs.

Global Surgical Codes

For over a decade since the largely discredited 2012 HHS OIG Report on the number and level of E/M visits in global surgical procedures, CMS has spent time and resources on attempts to dismantle this long-standing payment convention for surgery. CMS has made a number of efforts to seek data on E/M visits provided to patients after having a procedure reported within a global period. In previous detailed comments, including our September 2019 response to the CY 2020 Medicare Physician Fee Schedule proposed rule, we provided a thorough review of concerns regarding data CMS received from its contracts with RAND to help the agency collect data on postoperative visit services provided by surgeons in the global periods. We agree with the ACS, the AMA, the RUC, and other stakeholders that the RAND process was poorly structured and difficult to operationalize. Moreover, the analysis relied on flawed and incomplete data that were never validated. We continue to strongly oppose any changes to global code payment based on the RAND reports.

As CMS notes, MACRA continues to prohibit the agency's previous proposal to convert all 10- and 90-day globals to 0-day globals. We believe the RUC process is the most effective and efficient way to review the valuation for procedures, including those reported with global periods. To the extent there may be specific outlier global surgical procedures that have not recently been reviewed by the RUC, CMS can follow well-established precedent by identifying those specific codes as potentially misvalued and allow the RUC to conduct a thorough review without implementing burdensome disruptions to surgeons and their patients.

In the CY 2025 proposed rule, CMS has offered a new approach for gathering data on services provided to patients receiving procedures with a global period. We offer comments on those specific proposals below:

Transfer of Care Modifiers. CMS proposes a requirement for practitioners to use the "transfer of care modifiers" for all 90-day global surgical packages in any case where a practitioner plans to furnish only a portion of a global package (including but not limited to when there is a formal, documented transfer of care as under current policy, or an informal, non-documented but expected, transfer of care). The AANS and the CNS believe that transfers of care are rare but may occur in a situation in which a patient travels to undergo a procedure in a major medical center and returns to their hometown before the end of the global period. This would be known ahead of time, and using a modifier would be in keeping with current policy. We find the "informal, non-documented but expected, transfer of care" wording vague and the definition of "informal transfer of care" unclear. When neurosurgeons provide care to patients with highly complex disorders of the brain and spine, the care generally includes the pre-operative, intra-operative, and post-operative periods for 90 days. Neurosurgeons are subject to medical liability for those patients. Medicare patients often have multiple morbidities and may see many physicians; however, attending neurosurgeons assume responsibility for all the care associated with the procedure they have performed. Suppose a primary care physician sees a patient during a 90-day period for another condition unrelated to a procedure previously performed by a neurosurgeon on that same patient. In that case, that does not preclude the need for the patient to see the neurosurgeon during the post-operative period. **The AANS and the CNS agree with the comments of the AMA and the ACS that the proposed expansion of the use of the transfer of care modifiers to report "informal, non-documented but expected transfer of care" is poorly defined, making its value uncertain and, to the extent it drives changes in claims data if finalized, will not result in accurate, complete, and actionable data.**

Should CMS proceed with this policy, the transfer of care modifier should not be appended to services that have the multiple procedure reduction modifier -51. Modifier 51 already reduces the payment for the second and subsequent services to remove the payment for post-operative care. Again, we urge CMS not to proceed with this proposed policy and to work closely with the surgical community and the AMA RUC to address concerns regarding E/M services in the global periods.

Add-On Code for Post-Operative Services. CMS proposes the establishment of a new E/M add-on code, GPOC1, "that would account for resources involved in post-operative care for a global surgical package provided by a practitioner who did not furnish the surgical procedure and does not have the benefit of a formal transfer of care." As noted above, neurosurgeons typically provide the full spectrum of care to their surgical patients, including post-operative follow-up care to Medicare beneficiaries. It is not appropriate or relevant to create a new G code to reimburse a non-surgeon for follow-up care following major surgery as there is no corresponding guidance for what threshold must be crossed for the E/M visit to be truly "addressing" a surgical procedure. As you know, it is not uncommon for a non-surgeon to care for a patient regarding a different and wholly unrelated health concern who also happens to be in the 90-day global period. As part of the code descriptor, CMS includes the work to "*Research the procedure to determine expected post-operative course and potential complications."* In addition, CMS states that in order to bill the add-on code, it would expect "the documentation in the medical record to indicate the relevant surgical procedure, to the extent the billing practitioner can readily identify it…" The AANS and the CNS **oppose the creation of a G code to pay for a "post-operative follow-up visits." CMS has acknowledged that the provider billing the add-on code might not even know what the exact surgical procedure was.** Unless there is a formal transfer of care, we do not believe that another physician should be providing care directly related to the operative procedure. If the physician determines care for a condition other than the surgery is made more complex because the patient has

undergone surgery, the current E/M visit structure more than adequately accounts for the additional time and complexity. Given the above, this proposal does not make sense, nor would it result in useful data. **A new G code is not warranted, and we urge CMS not to finalize the creation of the GPOC1 code.**

CMS Failure to Increase E/M Values in Global Surgical Payment. In 2021, CMS took an unprecedented step and decided not to apply the increased values in the RVU of the E/M services to the CPT codes in the global surgical package. However, E/M services comprise up to 40% of the RVU for any particular CPT code. By not increasing the values of the E/M portion of the global surgical codes, those codes are now untethered from the valuation of the E/M services. The result is a loss of relativity within the fee schedule. With the refusal to incorporate E/M updates into the global procedures, CMS unilaterally decided to pay physicians of different specialties dissimilar rates for the same work, violating the Medicare statute against specialty payment differentials.

We, along with the ACS, the AMA, the RUC, and virtually all other medical specialty societies, have urged CMS to apply E/M office visit increases to the visits bundled into global surgery payments. The surgical specialties participated in the RUC survey for these codes, and their data were the same as, and often greater than, primary care and other specialties. CMS has emphasized the robust survey utilized in the valuation of E/M office visits, and this survey demonstrates what the law requires: all physicians should receive the same payment for the same service. In 2024, CMS updated the work RVUs and work times of maternity procedures with an "MMM" global period to reflect any relevant E/M updates associated with the MMM global period. However, CMS continues to stay silent on the issue of incorporating E/M increases into the global surgical periods.

The AANS and the CNS continue to urge CMS to apply the RUC-recommended changes to the E/M component of the 10- and 90-day global surgery codes to maintain the relativity of the fee schedule and to comply with the Medicare law's prohibition on specialty payment differentials. We believe this step should be taken before any other requirements for global surgical services should be undertaken.

Practice Expense

Low Volume Overrides. The AANS and the CNS appreciate CMS' policy of using expected specialty overrides for certain low-volume services. The RUC performed an analysis to identify all codes that meet the criteria to receive a specialty override under this CMS policy and drafted updated recommendations for CY 2025. The specialty assignments for these codes are intended to appropriately represent the professional liability risk that is inherent in the code itself and reflected in the professional liability risk of a single specialty. The purpose of assigning a specialty to these codes is to avoid the major adverse impact on professional liability insurance (PLI) and practice expense (PE) relative value units (RVUs) that result from errors in specialty utilization data magnified in representation (percentage) by small sample size. Further, the impact of these errors on the performing specialties can be severe due to the true overall code utilization being related to non-Medicare beneficiaries (frequently children). In addition, the proposed specialty overrides are intended to appropriately represent the expected indirect practice expense for each service. Specifically for neurosurgery, we agree with the RUC recommendation to change the specialty designation for anterior arthrodesis CPT Code 22808 from neurosurgery to orthopaedic surgery.

PPIS Survey and the MEI. The AANS and the CNS appreciate and support the CMS decision to defer implementation of Medicare Economic Index (MEI) changes to the distribution of relative value unit components (work, practice expense, and professional liability insurance) within the RBRVS. We agree

that CMS should allow for the review of data from the Physician Practice Information (PPI) Survey before implementing re-weighting, which would result in significant redistribution within physician payment.

The PPI Survey, which closed on August 31, 2024, collects information on physician and other health care professional compensation, practice costs, and direct patient care hours worked. The AMA will collaborate with Mathematica to analyze the data and plans to share information with CMS in early 2025. The survey collects information to utilize in a payment system based on relative costs between physician specialties and other healthcare professionals. We add our objection to that of the AMA and other specialty societies to the CMS comment in the proposed rule implying that a letter signed by more than 170 national medical specialty societies, professional organizations, and all state medical societies to encourage participation might somehow create bias in the survey. We believe it is important for our members to understand our support of the PPI Survey. This letter was consistent with similar previous letters encouraging individuals receiving the survey to complete it. It did not provide any information that could be construed as coaching or leading answers.

We are concerned about the work CMS' has contracted with the RAND Corporation to analyze and develop alternative methods for measuring PE and related inputs for implementation of payment updates under the PFS, including an analysis of the updated AMA PPI Survey data as part of the work on a revised PE methodology. In addition, we would support a CMS review for updating direct practices expense inputs (i.e., clinical labor, supplies, and equipment) at least every five years. We are understandably wary of RAND's work product, given the very flawed reports on global surgical packages. In the CY 2023 MPFS, CMS finalized a policy to rebase and revise the MEI to reflect more current market conditions faced by physicians in furnishing services. As part of this policy, CMS sought to dramatically shift payment allocation away from physician earnings (work) to PE — 47.3 percent physician work, 51.3 percent PE, and 1.4 percent PLI — using non-AMA data from 2017 and many specialties, including neurosurgery, would have faced steep payment cuts as a result. In our August 31, 2022, letter responding to policies in the CY 2023 MPFS proposed rule, we noted many flaws with the non-AMA data used in that proposal. We urged CMS then, as we continue to do now, to delay implementation of the MEI update until the AMA PPI Survey data is available.

We urge CMS to collaborate with the AMA in its physician practice expense data collection effort to ensure consistency and reliability in physician payment. Updating the MEI weights should be postponed until new AMA survey data are available and reviewed by all stakeholders.

CMS Valuation of Specific Codes

The AANS and the CNS appreciate the agency's acceptance of the majority of RUC-passed values, which are based on valid, clinically appropriate information that preserves relativity. We believe the RUC is the entity best positioned to provide recommendations to CMS on resource inputs for work, PE and professional liability valuations and to establish values for E/M and other physicians' services. The AANS and the CNS, along with virtually all specialties, have representation in the RUC process and invest significant time and resources in providing expert advice to CMS. This process is widely recognized as open and transparent, with active participation from CMS staff. If the Agency has concerns about the relative value of services paid under the PFS, they should be addressed through appropriate channels, including the AMA RUC process.

In addition, we join the AMA in expressing concern regarding the significant increase in the number of proposed HCPCS Level II (or "G") codes that create considerable administrative burdens for physicians and other qualified health care professionals who report medical services to both Medicare and commercial payers. In most cases, we believe the agency should work with the AMA CPT Editorial Panel

when new codes are required. The CPT Editorial Panel process brings the majority of interested stakeholders together to provide the expertise and analysis needed to describe and codify physician services. We are pleased that the CPT Editorial Panel recently expanded to include two new seats for representatives from the U.S. Food and Drug Administration (FDA) and the Centers for Disease Control and Prevention (CDC), which, along with representation from CMS, provides important coordination with government agencies to foster our common goal to more quickly bring innovation to physicians and patients, based on sound medical literature and coding conventions that make sense to physicians and medical coders. Again, the CPT Editorial Panel process is structured so that every health care interested party group (including the national medical specialty societies, federal agencies, commercial payers, and industry representatives) has an opportunity to provide iterative review and comment on code change applications.

Below are comments on specific codes of concern for neurosurgery:

CPT Code 6XX00, Magnetic Resonance Image Guided High-Intensity Focused Ultrasound (MRgFUS) Intracranial Ablation

In September 2023, the CPT Editorial Panel created a new Category I code to describe magnetic resonance image-guided high intensity focused ultrasound (MRgFUS) intracranial ablation for the treatment of a severe central tremor that is recalcitrant to other medical treatments. Neurosurgeons typically perform this service without the involvement of a radiologist. This new code replaces the existing Category III code, 0398T.

The AANS and the CNS held a virtual meeting with CMS staff last month to review the reasons why the proposed reduction to the RUC-passed value for this new code is not appropriate. We appreciated the opportunity to highlight the intensity and complexity of the procedure in our meeting and the opportunity to provide comments below.

For CPT code 6XX00, CMS disagrees with the RUC recommended work RVU of 18.95 and proposes a work RVU of 16.60 which reflects a direct crosswalk to code 61626 *Transcatheter permanent occlusion or embolization (e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; non-central nervous system, head or neck (extracranial, brachiocephalic branch)* (work RVU = 16.60, 173 minutes intra-service, and 303 minutes total time) which is below the survey 25th percentile. CMS offers support for the recommended work RVU by proposing reference codes 33889 *Open subclavian to carotid artery transposition performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision, unilateral* (work RVU = 15.92, 150 minutes intra-service time, and 298 minutes total time) and 33894 *Endovascular stent repair of coarctation of the ascending, transverse, or descending thoracic or abdominal aorta, involving stent placement; across major side branches* (work RVU = 18.27, 134 minutes intra-service time, and 284 minutes total time). The reference codes are based on intra-service time and total time alone to support their recommended work RVU and do not take into consideration the greater complexity and intensity of the MRgFUS procedure, CPT code 6XX00.

The AANS and the CNS disagree with the CMS crosswalk to code 61626 as it was deemed “Do Not Use To Validate For Physician Work” in the current RUC database. The physician time was assigned by HCFA in 1992, and that code had never been previously surveyed. Additionally, this code has now just been revised by the CPT Editorial Panel and surveyed by the RUC for the CPT 2026 cycle. Therefore, it should not be used as a crosswalk during the re-review process. Moreover, while the proposed rule states that the procedure described by CPT code 61626 “describes a similar tumor destruction service”

to the one described by the new 6XX00 code, thus justifying the use of 61626 as an appropriate crosswalk, this is not the case. CPT code 6XX00 describes a procedure that requires multiple neurologic (motor and sensory) exams of an awake patient, repeated multiparameter (time, power, temperature limits) treatment dose adjustments, and results in permanent destruction of a functional brain region. None of these are characteristics of the procedure described by CPT code 61626.

Further, we disagree with the CMS reference code 33889 as it is notably similar in time, however, as we discussed in our meeting with CMS last month, CPT code 33889 is much less intense/complex to perform compared to the surveyed code. Moreover, the procedure described by CPT code 33889 is rarely performed (a total of 86 claims in 2022 and no more than 113 in any year since 2012 listed in the RUC database). In addition, the RUC determined the work RVU value for CPT code 33889 (zero-day global period) by starting with the value of another CPT code with a 90-day global period and removing the RVUs for the postoperative visits. Determining the RVU values in this manner makes this an inappropriate comparison code for the new CPT code 6XX00. Notably, the surveyed code 6XX00 describes a procedure that involves controlled lesioning of deep brain structures under real-time MRI with required repeated physician monitoring of the trial and permanent lesion creation, supervision of real-time MRI thermometry, and interaction with and repeated neurologic examination of an awake patient, justifying the increased intensity of work compared to reference code 33889.

Additionally, we appreciate that CMS has acknowledged the appropriate comparison of code 33894 in accordance with the RUC recommendation. The RUC recommended work RVU is valued appropriately higher than this comparison code given the higher intra-service and total time to perform the service described by CPT code 6XX00. The procedure described by the surveyed code requires 30 minutes of positioning time (compared to 15 minutes for code 33894) due to the complexity and time needed to precisely place a stereotactic frame, move the patient to the MRI scanner, and attach the frame/patient to the ultrasound transducer and position the intracerebral target appropriately within the transducer array. As previously stated, the intra-service time of the new code is higher than that of code 33894 due to the repeated neurologic examinations of the awake patient by the surgeon and subsequent treatment planning/decision-making/treatment time.

The key references service codes 61736 *Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; single trajectory for 1 simple lesion* (work RVU = 19.06, 180 minutes intra-service, and 353 minutes total time) and 61737 *Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; multiple trajectories for multiple or complex lesion(s)* (work RVU = 22.67, 235 minutes intra-service, and 474 minutes total time) are strong comparisons to the surveyed code. The survey respondents indicated that the surveyed code was overall identical or more intense/complex to perform compared to the key reference services. We continue to assert that the surveyed code 6XX00 is more appropriately valued as more intense than these reference codes due to the need for repeated neurologic assessments of the awake patient during treatment planning and delivery. Moreover, the reference codes involve time for opening/closing that is of lower intensity than the treatment and not required as part of the work for the surveyed code, meaning that essentially all of the reported intra-service time of the surveyed code is the actual treatment time.

Again, we thank CMS staff for meeting with us last month and for the opportunity to emphasize the time and, especially, the intensity and complexity of this important procedure. **We urge CMS to accept a work RVU of 18.95 for CPT code 6XX00.**

Osteotomy Codes

CPT codes 22210, 22212, 22214, 22216

In the CY 2012 PFS final rule, CMS finalized a process for the public to nominate potentially misvalued codes. In the CY 2015 PFS final rule, CMS modified this process whereby the public and interested parties may nominate potentially misvalued codes for review by submitting the code with supporting documentation by February 10th of each year.

In each proposed rule, these nominations are displayed on the CMS public website, including the submitter's name, their associated organization, and the submitted studies for full transparency. CMS evaluates the supporting documentation submitted with the nominated codes and assesses whether the nominated codes appear to be potentially misvalued codes appropriate for review under the annual process. In each PFS proposed rule, CMS publishes the list of nominated codes and indicates for each nominated code whether the Agency agrees with the code's inclusion as a potentially misvalued code. The public has the opportunity to comment on these and all other proposed potentially misvalued codes. Then, in each year's final rule, CMS finalizes the list of potentially misvalued codes.

For CY 2025, CMS received a public nomination from an interested party for CPT codes 22210 (*Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; cervica*l) (090 day global code), 22212 (*Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; thoracic*) (090 day global code), 22214 (*Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar*) (090 day global code), and 22216 (*Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; each additional vertebral segment [List separately in addition to primary procedure]*) (add-on ZZZ), as potentially misvalued for six reasons: (1) incorrect global period; (2) incorrect inpatient days; (3) incorrect intraservice work description; (4) overvalued intraservice times; (5) changed surgical practice; and (6) incorrect use of posterior osteotomy codes.

Based on these six reasons provided by the nominator, CMS proposes to consider this code family as potentially misvalued and requests comments on a broader understanding of these codes. Additionally, the Agency seeks input on current standard billing practices. For example, information on whether the standard of practice has evolved over time.

We disagree that this family of codes is potentially misvalued, and we appreciate the opportunity to provide the following comments on the public nomination from an interested party.

Public Nominator's Reason #1: Incorrect global period
The nominator stated that these posterior osteotomies are always performed as an optional addition to a spinal fusion and should be valued as add-on services and not as 90-day global services. We reviewed the CMS claims data and found that a significant majority of claims for codes 22210-22214 are reported without a modifier indicating these codes are the primary or index procedure and not add-on services. Further, CMS noted that no references were provided by the nominator to support the statement that the service is always performed as an optional addition to a spinal fusion. **Reason #1 is not supported.**

Public Nominator's Reason #2: Incorrect inpatient days
The nominator stated that the average hospital stay for scoliosis fusion with osteotomy is less than the currently included inpatient days. As CMS notes, the majority of literature submitted by the nominator presented outcome information on adolescent patients, which may be different from the Medicare population. We agree with the Agency that literature was selectively provided to only include information about pediatric patients. **Reason #2 is not supported.**

Public Nominator's Reason #3: Incorrect intraservice work description

The nominator stated that the intraservice work description for code 22216 describes the removal of the pedicle, which is not a typical part of a Ponte/Schwab II osteotomy. The original DOW from the 22210-22214 family notes that a portion of the pedicle may be removed. These descriptors do not report that the entire pedicle is removed, only enough bone to provide adequate decompression of the nerve roots at the level where the osteotomy is being formed. Complete resection of the involved vertebral body's pedicle would not be routine when performing a posterior element osteotomy. However, complete resection of the pedicle is not included in the original DOW for these codes; this operative procedure has not changed. **Reason #3 is not supported.**

Public Nominator's Reason #4: Overvalued intraservice times
The nominator asserted that intraservice times were too high, particularly for these osteotomy services furnished with scoliosis fusion procedures. CMS questioned this assertion and indicated that the literature cited by the nominator all referred to pediatric deformity procedures and may not be reflective of adult spinal surgery practice. We reviewed the data in the letter and found that the average time of 3.6 minutes cited for performing an osteotomy in the nominator's letter is unreasonably low. Several studies indicated that non-randomization allowed surgeon-specific factors to potentially confound the results as one reason for not observing longer surgical times in patients who underwent Ponte osteotomies. The nominator provided no studies to support a typical scoliosis fusion time in adults. **Reason #4 is not supported.**

Public Nominator's Reason #5: Changed surgical practice
The nominator also asserted that surgical practice for these procedures has evolved, indicating that 30 years ago, osteotomies were infrequently performed and usually reserved for addressing completely ankylosed or fused spinal segments. The nominator further asserted that contemporary surgical techniques often involve posterior osteotomies to release multiple stiff vertebral segments, thereby enhancing coronal correction and reducing thoracic hypokyphosis, resulting in notable shifts in the trends regarding the utilization of osteotomies. This information comes from select articles that are again related to adolescent idiopathic scoliosis. For example, the study sample in one article indicated over 60% were aged 7-12. When looking at the Medicare-aged claims, we do not find an unexpected increase in utilization. With a better understanding of spinal alignment parameters and with the growth of the Medicare patient population, more osteotomy procedures are being performed, but not at a significant rate of change. In fact, Medicare utilization has flattened over the past eight years. **Reason #5 is not supported.**

Public Nominator's Reason #6: Incorrect use of posterior osteotomy codes
Lastly, the nominator suggested incorrect usage of posterior osteotomy codes, noting instances where facet/soft tissue releases, such as Schwab type I osteotomies, are inaccurately reported with this family of codes. According to the nominator, isolated partial facetectomy and soft tissue release are already included in spinal fusion procedures and should not be separately billed with an osteotomy code.

We acknowledge that previously, osteotomy codes may have been inappropriately reported concurrent with interbody fusion procedures (22630/22633) after CMS restricted the ability to report decompression (63047) at the same level as a lumbar interbody fusion. To remedy this and to improve coding accuracy, new codes were created specific for a decompression when performed at the same level as an interbody fusion (63052-63053). Implementation of these new codes has been difficult due to an erroneous NCCI edit that precluded the use of the code 63052 with 22630/22633. This error by NCCI has been corrected, but this may have slowed implementation of the new codes. We anticipate that with correct coding (using 63052), we will see a decrease in the use of osteotomy codes at the same level as

interbody fusions. This will decrease the use of the lumbar osteotomy codes overall. **Reason #6 is not supported.**

Additionally, CMS has noted that code 22210 is reported with code 22600 (Arthrodesis, posterior or posterolateral technique, single interspace; cervical below C2 segment) approximately 83 percent of the time and questions whether there should be consideration of consolidating individual services into bundled codes. Code 22210 is a very low volume code (< 400) and utilization has been stable over time. Although this low volume code may be reported often with 22600, the reverse view is that only 1.6% of code 22600 procedures also involve 22210. Further, there still would be a need to maintain the stand-alone code 22210.

In summary, the six reasons provided by the nominator that codes 22210-22216 are potentially misvalued have been demonstrated to be invalid. **We strongly urge CMS not to finalize these codes as potentially misvalued based on this incorrect information.**

Sacroiliac Joint Fusion Code

For the second year, CMS received a comment nominating CPT code 27279 *(Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device)* as misvalued. Specifically, the commenter is asking CMS to price the service in the non-facility setting in addition to the facility setting. CMS has expressed concerns about whether this 90-day surgical service can be safely and effectively furnished in the non-facility/office setting (for example, in an office-based surgical suite). In addition, the AMA CPT Editorial Panel will be considering several proposals aimed at better defining sacroiliac joint fusion procedures, a process that may provide helpful information to CMS on this topic. **We continue to agree with the agency's concern and urge CMS not to price CPT code 27279 in a non-facility/office setting.**

Telehealth

Telehealth for Neurostimulation. AANS/CNS members and our patients have experienced the benefits of utilizing telehealth for the programming of deep brain and spinal cord neurostimulation systems (DBS and SCS). Despite the safe and effective provision of these services via telehealth for several years, CMS continues to maintain these codes on the list of provisional telehealth services, rather than move them to the list of services for permanent provision via telehealth. When DBS and SCS programming are provided via telehealth, patients save hours of driving time and waiting time in physician offices. Moreover, many of our patients are disabled due to chronic pain, advanced Parkinson's disease, or dystonia. It can be a tremendous financial and physical hardship for these patients to travel to their expert center for programming. Moving these services to the permanent telehealth services list would be a substantial benefit to our patients. **We request that CMS place DBS and SCS programming services, described by CPT codes 95970, 95971, 95972, 95983, and 95984, on the list of services permanently approved for provision via telehealth.**

QUALITY ISSUES

Merit-Based Incentive Payment System (MIPS)

Surgical Care MIPS Value Pathway (MVP). The AANS and CNS are extremely disappointed that CMS proposed this MVP despite engaging in numerous communications throughout the past year with our specialty and other impacted surgical specialties, during which all impacted stakeholders expressed

strong concerns about the construction of this MVP. CMS' failure to address any of our concerns, and its decision to put forth the same set of disjointed quality measures that were included in the candidate MVP when it was first released for public feedback in early 2024,[1] makes us question the valurole, and purpose of the MVP Candidate Feedback Process.

As we previously expressed in letters and in meetings with CMS, our primary concern with the Surgical Care MVP is that it attempts to lump numerous unrelated surgical specialties (e.g., general surgery, neurosurgery, cardiac surgery, breast surgery) into a single MVP. This is just as arbitrary as lumping all medical specialties together, is inappropriate from a clinical perspective. and provides little added value — beyond the current MIPS specialty quality measure sets — in terms of assisting surgical specialists and their patients with identifying the most relevant MIPS measures. According to the CMS MVP guiding principles, "MVPs should consist of limited, connected, complementary sets of measures and activities that are meaningful to clinicians, which will reduce clinician burden, align scoring, and lead to sufficient comparative data."[2] As currently constructed, this MVP will not satisfy any of those goals. Instead, it will create confusion and discourage movement into MVPs among surgeons, who might assume that CMS plans to evaluate their performance against other unrelated surgical specialties, pitting one specialty against another.

Although CMS has confirmed that it will score MVP participant performance based on the individual measures they report (i.e., by comparing them only to other clinicians who report on the same measure), CMS also states on the Quality Payment Program (QPP) website that MVP participants will "also receive comparative performance feedback that will show how other clinicians reporting the same MVP scored."[3] CMS further clarifies that "comparative feedback will highlight how your performance compares at the *category level* [emphasis added] to other clinicians reporting the same MVP."[4] If CMS finalizes the Surgical MVP in its current form, this would mean that a spine surgeon using the MVP, for example, would receive feedback comparing their performance in the quality and cost category to a breast surgeon's performance, even though their category scores would be based on an entirely different set of measures. We recognize that this feedback would be informational only, but it would also be entirely meaningless and if anything, cause confusion among recipients and further erode trust in what is already a program of questionable value. ***We request that CMS provide us with an explanation as to what role such performance feedback comparisons would serve and what value such a hodgepodge of measures would provide to clinician participants and their patients***.

Adding to our frustration regarding the arbitrary construction of this MVP is that CMS did not consult organized neurosurgery, or collectively contact the affected surgical specialties, prior to assembling the MVP to assess the appropriateness of this strategy. One of CMS's finalized MVP development criteria is that an MVP "be developed collaboratively across specialties in instances where the MVP is relevant to multiple specialties."[5] There was nothing collaborative about the development of this MVP. If CMS adhered to its MVP development criteria, it would have realized early on that that there are more clinically appropriate strategies for constructing MVPs for different surgical specialties than arbitrarily combining various surgical procedures under the broad umbrella of "surgery."

[1] The only difference in the list of quality measures included in the proposal is the addition of measure Q226: Preventive Care and Screening: Screening and Cessation Intervention.
[2] https://qpp-cm-prod-content.s3.amazonaws.com/uploads/623/MVPs%20Overview%20Fact%20Sheet.pdf
[3] https://qpp.cms.gov/mips/mips-value-pathways?option=Implementing+MVPs
[4] https://qpp.cms.gov/mips/mvps/learn-about-mvp-performance-feedback

[5] https://qpp-cm-prod-content.s3.amazonaws.com/uploads/623/MVPs%20Overview%20Fact%20Sheet.pdf

We are also confused by statements made by CMS elsewhere in this rule. In the Request for Information (RFI) on Transforming the QPP section, where CMS discusses the future of MVPs, the Agency states that it does not anticipate the development of MVPs for each surgical subspecialty or type of surgical procedure; rather, it intends to maintain broader surgical MVPs inclusive of surgeries that are *clinically related* yet support multiple subspecialties and/or procedures within the surgery specialty. They cite, as an example, that lumbar surgical measures may be included within MVPs for orthopedic surgeons and neurosurgeons but would not comprise a standalone MVP solely focused on lumbar surgery. Conversely, an Improving Spine Care MVP could be developed that encompasses multiple procedures and aspects of care that could support use by multiple specialties, such as orthopedic surgeons and neurosurgeons. These statements are reasonable and make clinical sense. However, these statements also contradict what we are seeing in the proposed Surgical Care MVP.

In its 2024 MFPS proposed rule comment letter, the AANS and the CNS suggested that CMS instead add measures Q461: Leg Pain After Lumbar Surgery and Q471: Functional Status After Lumbar Surgery to the existing Rehabilitative Support for Musculoskeletal (MSK) Care MVP, and to drop the title's reference to "rehabilitative support," to make it more relevant to spine surgeons and more reflective of real-world, multi-disciplinary and team-based MSK care. We also suggested the addition of other quality measures that would be relevant for a broader MSK MVP, including:

- Q039: Screening for Osteoporosis
- Q126: Diabetic Peripheral Neuropathy - Neurological Evaluation
- Q134: Screening for Depression and Follow-up Plan
- Q178: Functional Status Assessment for RA patients
- Q226: Tobacco Screening and Cessation
- Q418: Osteoporosis Management in Women with Fracture

Again, we would be happy to work with CMS and our other spine care colleagues to collaboratively construct a more focused spine care MVP.

In addition to the arbitrary construction of the Surgical Care MVP, we also have strong concerns about specific measures included in the MVP. For example, we continue to oppose the use of Q459: Back Pain After Lumbar Surgery in this MVP, but also in traditional MIPS. As we have highlighted numerous times, improving back pain is typically not the primary goal of lumbar fusion surgery and, therefore, not a clinically appropriate yardstick of success. Put another way, a lumbar spine operation may still be high-quality from a technical and clinical standpoint, even if the patient's back pain remains constant.

The AANS and the CNS are also concerned that the Surgical MVP includes what CMS misperceives as broad, cross-cutting surgical measures that apply across surgical specialties, such as Q355: Unplanned Reoperation within the 30-Day Postoperative Period and Q357: Surgical Site Infection. As we have raised in the past, a closer inspection of the measure specifications reveals that they do not reflect the range of surgical procedures captured by the Surgical Care MVP. For example, none of the CPT codes representing neurosurgical procedures are included in the denominator of either measure. As a result, most neurosurgeons could not even report these measures, which would make it more challenging for them to satisfy the MVP quality measure requirements. This is yet another concern underlying our conclusion that this MVP is, unfortunately, unreasonable rather than a truly useful quality measurement and improvement tool.

In addition, we remind CMS of other related limitations of Q355 and Q357. Although the title and description of these two measures seem to suggest that they are broadly applicable across surgical

specialties, the denominator codes are almost exclusively focused on general surgery. Even the debridement codes, for example, are not generally applicable across surgical specialties and instead concentrate on debridement involving genitalia and the abdominal wall. In the rare instances where there are more specialty-specific codes, they are not clinically appropriate. For example, the random collection of vascular surgery procedure codes does not capture any of the major procedures a vascular surgeon performs. There is also a considerable range in procedural complexity captured by these measures, from the insertion of lines/ports/feeding tubes (relatively minor procedures) to pelvic exenterations and complex tumor resections (more major, high-risk procedures), yet no risk adjustment to account for this variability. As a result, the measures result in faulty performance comparisons of infection and return to the operating room across common/simple and rare/high-risk procedures, which raises major questions about the validity of these measures. Unfortunately, CMS seems to assume that Q355 and Q357 are broadly applicable across surgical specialties based on their titles alone. ***We request that CMS conduct a comprehensive re-evaluation of these measures to address these serious concerns. We also remind CMS of the importance of considering the actual specifications of a measure and its clinical context when populating MVPs (and when attempting to pair quality and cost measures) rather than making assumptions simply based on a measure's title***.

Importantly, the AANS and CNS are concerned that there is a lack of internal consistency between the quality and cost measures included in the Surgical Care MVP related to lumbar fusion. For example, quality measures Q461: Leg Pain After Lumbar Surgery, Q471: Functional Status After Lumbar Surgery and Q459: Back Pain After Lumbar Surgery each capture lumbar fusion or discectomy/laminectomy without fusion. On the other hand, the cost measure, Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels, only focuses on fusions. Furthermore, the lumbar fusion quality measures are evaluated at one year post-operation, whereas the lumbar fusion acute episode cost measure ends at 90 days post-operation. As a result, these quality and cost measures are misaligned, do not evaluate the same patient populations in the same manner, and will not result in accurate assessments of value. This disparity creates an incentive to delay care, such as physical therapy, until after the acute cost measurement episode has ended.

Finally, we would like to use this opportunity to point out other limitations related to the spine measures included in this candidate MVP. For example, for Q471: Functional Status After Lumbar Surgery, the only acceptable functional assessment tool that can be used to satisfy the measure is the Oswestry Disability Index. ***The AANS and the CNS urge CMS to work with the measure developer to incorporate other, more appropriate functional outcome measures from tools such as PROMIS® (Patient-Reported Outcomes Measurement Information System), into Q471***. We also remind CMS that all three spine surgery measures included in this MVP continue to lack a benchmark (at least according to the most recent 2023 historic benchmark file). CMS recently instituted a policy that assigns a clinician 0 points for reporting on a measure that lacks a benchmark. The uncertainty and risk associated with selecting measures that lack a benchmark provide little incentive for clinicians to report on these measures. ***As we have requested in the past, we strongly urge CMS to adopt scoring policies that incentivize the reporting of non-benchmarked measures that are not brand new to the program in order to build a foundation of data needed to produce reliable benchmarks for these long unused measures.*** For example, CMS should consider extending the new measure scoring floor to existing measures that have been in the program for multiple years and are caught in this endless cycle of non-use. Expanding this policy would also help CMS better identify what barriers are contributing to the non-use of these measures.

Overall, CMS's stated goal of the MVP framework is "to align and connect measures and activities across the MIPS performance categories of quality, cost, and improvement activities for different specialties or conditions…. [in order to] streamline MIPS reporting, reduce complexity and burden, and

improve measurement."[6] CMS's MVP development criteria also emphasizes that MVPs have "a clearly defined intent of measurement, have measure and activity linkages, and be clinically appropriate."[7] ***As outlined in this comment letter, the AANS and CNS view the proposed Surgical MVP as failing to meet any of CMS's stated MVP goals or criteria.***

Proposed Changes to the Neurosurgical Specialty Set. ***As discussed earlier, we oppose the use of Q459: Back Pain After Lumbar Surgery in MIPS since improving back pain is typically not the primary goal of lumbar fusion surgery and, therefore, not a clinically appropriate yardstick of success.***

Request for Information (RFI) on Principles for Patient-Reported Outcome Measures in Federal Models and Quality Programs. CMS discusses its commitment to elevating the patient voice and integrating more patient-reported outcome measures (PROMs) and patient-reported outcome performance measures (PRO-PMs) into CMS quality reporting and payment programs, as well as CMS Innovation Center models. CMS notes that a potential path forward is the development of an accessible and unified database of PROMs/PRO-PMs used in programs and payment systems in health care by federal, state-based, and commercial payers, as well as healthcare systems. The PROMs in this database could serve as a resource for the subsequent development of PRO-PMs. CMS also presents a set of illustrative guiding principles, which discuss considerations for the selection and implementation of PROMs and PRO-PMs, including data infrastructure, measure testing, feasible clinical implementation, measure accessibility, patient engagement, and equity. CMS seeks feedback on these principles and ways to accelerate the development and use of PROMs and PRO-PMs, including how to balance the use of broad PRO-PMs that might be applicable across multiple clinical contexts compared to condition-specific PROMs and PRO-PMs that can be more tailored to a given clinical situation, but lead to a greater number of tools in use across measures and health care providers. CMS highlights the PROMIS® suite of tools as an example of a current unified and non-proprietary repository that is widely available to clinicians and healthcare systems, but also seeks feedback on other examples.

In general, the AANS and CNS support CMS's guiding principles and in general, support enhanced reliance on PROMs and PRO-PMs to capture surgical efficacy and to ensure more patient-centered care. We also agree with CMS that widespread adoption of PROMs and PRO-PMs hinges on a data infrastructure that allows them to be integrated into clinical workflow with minimal cost and administrative burden and with data seamlessly shared across different healthcare settings and systems.

While the AANS and CNS appreciate the value of more universally applicable tools such as PROMIS®, it is important to ensure a role for other tools and measures that might be more appropriate for specific patient populations.

Other Quality Topics. The AANS and CNS refer CMS to the comment letter submitted by the Alliance of Specialty Medicine, which reflects organized neurosurgery's feedback on other proposed quality policies, including the future of MVPs, the MIPS performance threshold, data completeness thresholds for the quality category, the revised topped out measure scoring proposal, modifications to the Cost category scoring methodology, proposed changes to the manner in which CMS conducts Qualifying Participant in Advanced APM (QP) threshold determinations and other policies. We also refer CMS to the comment letter submitted by the Physician Clinical Registry Coalition (PCRC), which reflects our views on policies that would impact Qualified Clinical Data Registries (QCDR).

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[6] https://qpp-cm-prod-content.s3.amazonaws.com/uploads/623/MVPs%20Overview%20Fact%20Sheet.pdf

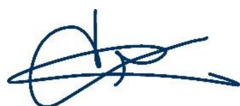
[7] https://qpp-cm-prod-content.s3.amazonaws.com/uploads/623/MVPs%20Overview%20Fact%20Sheet.pdf

CONCLUSION

The AANS and the CNS appreciate the opportunity to provide feedback on these coding, payment, and quality provisions in the CY 2025 Medicare PFS proposed rule. We urge CMS to take all necessary steps to prevent Medicare payment reductions and to work with the medical community and Congress to fix this broken system.

Thank you for considering our comments. We appreciate the expertise, hard work, and dedication of CMS leaders and staff. We look forward to collaborating on these and other policy matters to ensure timely patient access to quality care.

Sincerely,



Jacques J. Morcos, MD
President
American Association of Neurological Surgeons

Alexander A. Khalessi, MD
President
Congress of Neurological Surgeons

Staff Contacts:

Payment-Related Issues
Catherine Jeakle Hill
Director, Regulatory Affairs
AANS/CNS Washington Office
Phone: 202-446-2026
Email: chill@neurosurgery.org

Quality-Related Issues
Rachel Groman, MPH
Vice President, Clinical Affairs and Quality Improvement
Hart Health Strategies
Phone: 202-729-9979 ext. 104
Email: rgroman@hhs.com