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September 11, 2023

Ms. Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
ATTN: CMS-1786-P
P.O. Box 8013 Baltimore, MD 21244-1850

Submitted electronically via www.regulations.gov

Subject: CMS-1786-P Medicare Program: Calendar Year (CY) 2024 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Payment for Intensive Outpatient Services in Rural Health Clinics, Federally Qualified Health Centers, and Opioid Treatment Programs; Hospital Price Transparency; Changes to Community Mental Health Centers Conditions of Participation, Proposed Changes to the Inpatient Prospective Payment System Medicare Code Editor; Rural Emergency Hospital Conditions of Participation Technical Correction.

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 in the United States, we appreciate the opportunity to comment on the payment and quality provisions of the above-referenced notice of proposed rulemaking.

EXECUTIVE SUMMARY

Reimbursement Issues

Outpatient Prospective Payment System

- **Inpatient Only List.** The AANS and the CNS believe the site of service should be determined by the surgeon in consultation with the patient. We were concerned about the agency's plan to eliminate the Inpatient Only (IPO) list three years ago. We supported the reversal of that policy in favor of a more measured approach. Even when a procedure comes off the IPO list, inpatient admission should remain an option for patients who require that level of care. For CY 2024, we agree with the agency's proposals to add new codes for vertebral body tethering (Current Procedural Terminology (CPT®) codes X114T, 2X002, 2X003, and 2X003) and for Insertion of skull-mounted cranial neurostimulator pulse generator or receiver (CPT code 619X1).
- **Prior Authorization Issues.** While we are pleased that the Centers for Medicare & Medicaid Services (CMS) has not proposed any expansion to the categories of services subject to prior authorization, the AANS and the CNS continue to be disappointed that CMS has not rescinded the action of the previous administration to require prior authorization for cervical fusion with disc removal (CPT codes 22551 and 22552) and implanted spinal neurostimulators (CPT code 63650). This requirement has caused a significant burden and confusion and remains a barrier to timely access to

care for these critical spine procedures and should be rescinded. A survey of our members conducted last year showed delayed patient care, administrative burden and significant cost of useless prior authorization requirements.

- **APC Assignment for New skull-mounted cranial neurostimulator.** The AANS and CNS disagree with the Ambulatory Payment Classifications (APCs) assignments of new category I CPT codes for skull-mounted cranial neurostimulators. These assignments are inconsistent with the work involved in these procedures and with the existing neurostimulator generator CPT codes. Proceeding with these assignments will result in inappropriately low facility reimbursement for these procedures and limit access to care for patients who could benefit from this technology.
- **Payment for Non-Opioid Drugs.** The AANS and the CNS support CMS' proposal to continue to make separate payments for Exparel, Omidria, Xaracoll and Dextenza as non-opioid pain management drugs that function as a supply in a surgical procedure in the ASC setting for CY 2024
- **Comment Solicitation on Non-Opioid Treatments for Pain Relief.** CMS seeks comment on non-opioid treatment for pain relief. The AANS and the CNS have long supported reimbursement for neurological devices such as pain pumps and spinal cord stimulators to treat pain. We urge the agency to eliminate barriers such as prior authorization requirements and lack of coverage for these important devices.

Quality Issues

Outpatient Prospective Payment System Quality Issues

The AANS and the CNS strongly oppose the future reimplementation of the Hospital Outpatient Volume on Selected Outpatient Surgical Procedures (OP-26) measure or the adoption of another volume indicator for quality improvement and accountability.

Ambulatory Surgery Center (ASC) Quality Issues

The AANS and the CNS strongly oppose the future reimplementation of the ASC Facility Volume Data on Selected ASC Surgical Procedures (ASC-7) measure or adopting another volume indicator for quality improvement and accountability.

DETAILED COMMENTS

Reimbursement Issues

Outpatient Prospective Payment System

- **Changes to the IPO List.** The AANS and the CNS believe the site of service should be determined by the operating surgeon in consultation with the patient, carefully considering the individual's clinical status. However, we have heard from some of our members that they have had retroactive denials of payment for inpatient admissions for elderly patients for whom that setting was medically necessary. Therefore, we were pleased to see CMS reiterate that "the absence of a procedure from the list should not be interpreted as identifying that procedure as appropriately performed only in the hospital outpatient setting." Three years ago, we supported CMS rescinding the elimination of the IPO list. Without a clear CMS policy to ensure that physician and patient choice are paramount and payment for inpatient care will be honored based on clinician judgment rather than retroactive review, we support a more measured process for taking procedures off the IPO list.

Given that the inpatient setting is generally the most expensive treatment environment, the AANS and the CNS agree that patients should be offered the option of receiving care in hospital outpatient and ambulatory surgery center settings — provided safety and effectiveness can be assured. However, safety in one outpatient environment does not guarantee universal safety, and elements of care that are demonstrated to promote safe outpatient treatment need to be cataloged and disseminated. **Therefore, we urge CMS to collaborate closely with the physician community to help develop best practices for determining the IPO and the ASC lists.**

For CY 2024 specifically, CMS is proposing to add the following new codes to the IPO List:

- **CPT X114T** (Revision (e.g., augmentation, division of tether), replacement, or removal of thoracolumbar or lumbar vertebral body tethering, including thoracoscopy, when performed)
- **CPT 2X002** (Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to 7 vertebral segments)
- **CPT 2X003** (Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; 8 or more vertebral segments)
- **CPT 2X004** (Revision (e.g., augmentation, division of tether), replacement, or removal of thoracic vertebral body tethering, including thoracoscopy, when performed)
- **CPT 619X1** (Insertion of skull-mounted cranial neurostimulator pulse generator or receiver, including craniectomy or craniotomy, when performed, with direct or inductive coupling, with connection to depth and/or cortical strip electrode array(s))

The AANS and the CNS agree with adding these codes to the IPO list, as these codes are new and represent major procedures.

- **Prior Authorization for Spine and Neurostimulator and Cervical Fusion Procedures.** CMS began requiring prior authorization for select medical procedures performed in the hospital outpatient department four years ago. Three years ago, CMS expanded this requirement to include two new categories of services reimbursed under the Hospital Outpatient Prospective Payment System (OPPS) — cervical fusion with disc removal (CPT codes 22551 and 22552) and percutaneously implanted spinal neurostimulators (CPT codes 63650). **The AANS and the CNS continue to object to expanding prior authorization in the Medicare fee-for-service program — particularly for neurosurgical procedures.** The expansion of prior authorization to cervical fusion and spinal cord stimulators was adopted without adequate transparency regarding the standards used to select the services subject to these burdensome new requirements. Reports from our members and recent survey data confirm that the implantation of prior authorization has caused catastrophic disruption to patient care.

Last year, the AANS and the CNS surveyed our members to better determine their experience with prior authorization for these codes. The results reinforce our assertion that extending burdensome prior authorization requirements has unnecessarily delayed patient care and increased administrative costs without benefitting the Medicare program. We have received numerous reports from neurosurgeons and their staff who have had Medicare Administrative Contractors (MACs) tell them that they may not initiate a request for prior authorization when CMS instructions clearly state that this is required. This discrepancy has caused confusion, frustration and harm to patients.

Our survey results showed:

- + **Significant Delays in obtaining prior authorization from Medicare Administrative Contractors.** 66% of survey respondents have experienced delays over 10 days. Of these,

55% experienced delays from 11-20 days; 25% experienced delays from 21-30 days; and 10% experienced delays of more than 30 days.

+ **Neurosurgical practices have experienced the following issues related to prior authorization for these procedures:**

- Initial denial requiring additional documentation (63%);
- Initial denial requiring peer-to-peer or other higher-level review (42%);
- Final denial requiring the patient to appeal (21%);
- Final denial resulting in the patient abandoning this treatment option (21%);
- Final denial resulting in procedure to be performed at another site of service (8%);
- No denials and the prior authorization process is not overly burdensome (4%); and
- No denials, but the prior authorization process adds unnecessary practice burdens (46%).

- + **Widespread Delays and Disruption and Lack of Awareness from Hospital Staff.** Written comments from our survey respondents emphasized that they have sometimes received denials for prior authorization for the pickiest of bureaucratic reasons that could easily be cleared up with a phone call or e-mail to the practice, such as failure to include a hospital fax number. They note a significant lack of education and support from hospital staff on this issue, and neurosurgeons' office staff have wasted valuable time that would be better spent helping patients. In addition, survey comments note that some MACs do not reimburse the neurosurgeon until the hospital has submitted its claim and CMS has processed it, punishing the neurosurgeon who has complied with all requirements. The agency's prior authorization policy for outpatient spine procedures hurts patients, limits access to needed care, complicates operating room scheduling and reduces hospital efficiency.

In summary, **CMS should eliminate the prior authorization program.** Given its stated goal of reducing physician regulatory burden, the agency must strive to reduce burdensome prior authorization requirements, which have increased significantly over the last several years — delaying or preventing time-sensitive surgical care. Moreover, ongoing studies and our survey described above demonstrate that excessive and unnecessary prior authorization results in:

- + Delays in medically necessary treatment;
- + Patients abandoning treatment;
- + Negative impacts on clinical outcomes; and
- + Serious adverse events, such as death, disability or other life-threatening outcomes.

Furthermore, these prior authorization burdens contradict the agency's goal of reducing opioid prescriptions. Non-pharmacological treatment by neurosurgeons for Medicare beneficiaries with chronic pain offers significant improvement in appropriately selected patients. The AANS and the CNS reiterate our previous comments, which we believe are worth repeating.

Cervical Fusion with Disc Removal (CPT codes 22551 and 22552). We previously objected to the agency's proposal to require prior authorization for cervical fusion with disc removal — CPT codes 22551 and 22552, and again urge the agency to remove these procedures from the codes requiring prior authorization. This procedure can reduce pain and restore mobility for appropriately selected patients, allowing patients a significantly better quality of life. Requiring prior authorization has added additional burdens and delays without any benefits for patients for whom timely access is often of the utmost importance. CMS Recovery Audit Contractor (RAC) policies often push these procedures into the outpatient setting, yet the growth rate is deemed inappropriate when there is a resulting volume increase. Some of these changes are driven by CMS contractors, with

admissions for cervical fusion with disc removal denied *a priori* by some Medicare contractors. This approach denies surgeons the opportunity to choose the best site of service for each patient.

Demanding prior authorization for cervical fusion with disc removal be performed in an outpatient setting, rather than allowing surgeons the option to choose the appropriate site of service for each patient, has delayed care. A better approach would be to enable each surgeon to select the site of service that s/he believes is appropriate for the patient and study the outcomes. CMS should adopt this approach and review several years of data to analyze volume growth and quality of care before implementing prior authorization requirements for these and other Medicare services. We understand this would require a change in CMS contractor policy. However, if the agency collected several years of data, it would obtain more useful information on cost and quality.

One mechanism to support this data collection and review is for CMS to recognize and support participation in physician-led clinical registry programs. In previous years, we have provided details about the American Spine Registry (ASR), a joint initiative by the AANS and the American Academy of Orthopaedic Surgeons. Consistent with the ASR's operating procedures, we would happily share additional data from this excellent resource with CMS.

Implanted Spinal Neurostimulators. (CPT codes 63650). The AANS and the CNS continue to object to prior authorization requirements for percutaneously implanted spinal neurostimulators. Innovation and strong evidence for effectiveness have increasingly made these procedures excellent choices for patients in pain. They offer effective, nonpharmacologic options for appropriately selected patients to treat chronic pain and have been shown to significantly improve pain control and decrease pain-related disability and opioid use. Furthermore, effective pain control achieved through interventional care has also substantially reduced long-term health care utilization. Over the last several years, many high-quality studies have been published demonstrating the effectiveness of neuromodulation in treating chronic pain.

+ **We continue to disagree with the agency's assertion that the increase in the volume of spinal cord stimulation trials and device implantation procedures has been unnecessary.** The agency's baseline for counting the number of spinal cord stimulation procedures two years ago began before 2010 — more than a decade ago. Numerous peer-reviewed studies indicate that this field has seen unprecedented innovation in the last decade. New stimulation waveforms have been developed to give patients better pain control without perceptible paresthesia. New targets — such as the dorsal root ganglion and dorsal horn of the spinal cord — have been investigated and validated. Moreover, new devices allow patients to run multiple stimulation waveforms simultaneously, thus improving their chances for significant long-term pain relief.

Importantly, neurosurgeons have worked diligently for several years in concert with the American Medical Association (AMA), CMS, Department of Health and Human Services (HHS), National Academy of Medicine and numerous other government organizations, private payers and health care organizations to devise solutions to the opioid crisis and the epidemic of opioid-related morbidity and mortality. As stated above, neuromodulation procedures such as spinal cord stimulation are proven to reduce pain, pain-related disability and opioid use. These are non-pharmaceutical, reversible, adjustable and minimally invasive procedures that clearly play an increasing role in managing patients with various chronic pain diagnoses. Imposing prior authorization requirements has resulted in delayed care and denied many Medicare patients the benefits of these procedures, leaving them to continue with ineffective opioid therapies or, worse, to leave them without any good options for managing their chronic pain disability.

Evidence shows that neurostimulation procedures are more effective if employed earlier in the pain syndrome. Delaying utilization of these devices through unnecessary and burdensome prior authorization processes will likely result in patients not obtaining the optimal relief from the

therapy as the treatment will be delayed as the pain syndrome progresses and becomes more refractory. As a result, patients will continue to have more pain-related disability and incur higher healthcare costs over time.

The HHS “Pain Management Best Practices Inter-Agency Task Force Report” emphasizes the importance of multidisciplinary chronic pain care and highlights barriers to accessing optimal pain care. The task force recognizes both the high level of evidence for neurostimulation and barriers “requiring patients and health care professionals to navigate burdensome and variable coverage policies may contribute to slow development, adoption, and implementation of timely and effective pain treatments and may force providers to treat patients in a less-than-optimal fashion. Consistently forcing providers to try a series of non-first-line treatments before authorizing treatment plans can be problematic, hindering appropriate patient care, creating tremendous inefficiency, and resulting in a loss of time and resources.” We believe that placing more roadblocks in the way of patients with chronic pain who wish to access effective opioid-sparing procedures such as neurostimulation only prolongs the opioid crisis, which continues to damage patient lives while not relieving them of their chronic pain. **The AANS and the CNS urge CMS to adhere to the task force’s recommendations and rescind the requirement for prior authorization for percutaneously implanted spinal neurostimulators.**

In summary, we urge CMS to take the following actions:

- + Immediately halt the prior authorization program. At the very least, CMS must closely monitor the implementation of the current prior authorization requirements to correct documented cases of delay and disruption that this policy has caused for hospitals and surgeons but most of all for patients;
 - + Release the MACs’ prior authorization data to improve transparency;
 - + Clarify the process for removing services from the prior authorization requirements; and
 - + Suspend the use of prior authorization for all Medicare fee-for-service programs.
- **APC Assignment for Skull-mounted Cranial Neurostimulators.** We are pleased that the AMA CPT Editorial Panel has created new category I CPT codes for implanting, revising, and removing skull-mounted cranial neurostimulators for treating neurologic disease. This device represents a significant advance in treating medication-refractory epilepsy in that the device constantly monitors a patient’s EEG. It can be “taught” to sense each person’s specific EEG pattern indicative of their seizures. When this pattern is detected, the device can send electrical stimulation to the affected area of the brain, aborting the seizure. Long-term data show that, over time, repeated responsive stimulation leads to reduced seizure frequency and improves the person’s EEG.

Unfortunately, we are disappointed with the proposed APC assignments for these procedures. Before the approval of the new CPT codes, the implantation of this neurostimulator was described under the existing brain neurostimulator CPT code 61886. Importantly, this device is significantly more technically complex and advanced than prior brain neurostimulators. The procedure to revise or remove these new devices is more work-intensive than that for the older, subcutaneous devices. Given this, **we disagree with the assignment of the new CPT codes for replacing and removing skull-mounted neurostimulators to lower APCs than are used for older brain neurostimulators.** The reimbursement for the proposed assignments to APC 5463 or replacement and 5113 for removal of the device is 54% and 78% lower, respectively, than the prior APCs used for these procedures (5465 and 5463, respectively). If these proposed APC assignments are implemented, inadequate hospital reimbursement will result in patients losing access to the procedure, as many with severe neurologic disorders could benefit. CMS does not provide a rationale for these APC assignments to justify the move away from the APCs that are currently being used for these procedures.

Implementing new CPT codes does not alter any aspect of the procedure or device to merit these changes. **We request that CMS rescind these proposed APC assignments and maintain the current APC categories for skull-mounted neurostimulator implant and revision/replacement procedures.**

- **Payment for Non-Opioid Drugs.** The AANS and the CNS support CMS' proposal to continue to make separate payments for Exparel, Omidria, Xaracoll, and Dextenza as non-opioid pain management drugs that function as a supply in a surgical procedure in the ASC setting for CY 2024. These products provide alternatives to opioids and should be reimbursed in a way that does not cause a disincentive to offer them to appropriately selected patients.
- **Comment Solicitation on Non-Opioid Treatments for Pain Relief.** CMS describes its mandate under the Consolidated Appropriations Act, 2023 (CAA 2023), which requires the agency to provide temporary additional payments for non-opioid treatments for pain relief. Because the additional payments are required to begin on Jan. 1, 2025, CMS plans to include its proposals to implement the requirement in its CY 2025 OPSS/ASC proposed rule. The AANS and the CNS have long supported adequate coverage and funding for neurological devices such as pain pumps and spinal cord stimulators that offer long-term non-opioid pain relief. We appreciate the opportunity to provide comments to aid in developing a policy for non-opioid treatments for pain relief.

Neurosurgeons evaluate and manage patients with various chronic pain conditions, such as postsurgical spinal pain syndrome, chronic regional pain syndrome and others. Neurostimulation procedures, such as spinal cord stimulation (SCS), peripheral nerve stimulation, and deep brain stimulation, provide significant pain relief while allowing patients to reduce the use of opioid medications. These procedures often involve a trial period, allowing the physician and patient to evaluate the level of effectiveness before deciding on a permanent implant. Neurostimulation therapies are adjustable by the patient and physician to adapt the therapy as the patient's condition changes over time.

The last decade has seen an unprecedented burst of innovation in the neurostimulation field. However, many roadblocks remain to bring these advances to the bedside to benefit patients suffering from chronic pain. We are encouraged by emerging CMS programs such as transitional coverage of emerging technology (TCET). We realize that TCET is a separate initiative from the one planned for the CY 2025 OPSS ASC proposed rule, and we hope innovative neurological devices will be selected for the TCET program, including neurostimulation to treat pain, and there will be coordination among CMS programs. **The AANS and the CNS recommend that CMS requires manufacturers to collect and regularly report data on outcomes under the TCET pathway to inform decision-making and treatment recommendations.** These data should be prospectively collected and include relevant functional and patient-reported outcome measures.

Given that devices in the TCET pathway will not have long-term evidence of safety and efficacy, it is essential that this information be obtained as a condition for inclusion in the TCET program and that the data be reviewed at regular intervals so that determination of suitability for Medicare National Coverage Determinations can be made. Such collaboration should also involve the relevant physician specialty societies and their experts, and we recommend that the agency consider the valid scientific data provided by specialty society-sponsored registries. This is especially important as some chronic pain conditions are less common; therefore, clinical trials of neurostimulation therapies for these diagnoses involve fewer patients. We urge CMS to consider the prevalence of a diagnosis in evaluating the adequacy of the patient cohort used in these clinical trials. Moreover, consideration should be given to new technology add-on payments and device pass-through payments to facilitate the commercialization of these new technologies in the outpatient and ASC settings.

We provide some additional specific comments on neurostimulation below. We look forward to providing more information over the coming year and in our future comments on the CY 2025 proposed rule.

- **Potential Qualifying Devices.** As we have often stated in our many comments regarding spinal cord stimulators, innovation and strong evidence for effectiveness have increasingly made these procedures excellent choices for patients in pain. They offer effective, nonpharmacologic options for appropriately selected patients to treat chronic pain and have been shown to significantly improve pain control and decrease pain-related disability and opioid use. Furthermore, effective pain control achieved through interventional care has also substantially reduced long-term health care utilization. We believe spinal cord stimulators should be considered qualifying devices for non-opioid pain treatment as the agency develops its plan to meet the CCA 2023 requirement for additional payment for alternatives to opioids for pain.
- **Evidence Requirement for Medical Devices.** The AANS and the CNS are eager to work with the agency to review clinical data and real-world evidence for neurological devices that treat pain. Over the last several years, many high-quality studies have been published demonstrating the effectiveness of neuromodulation in treating chronic pain, including those below:
 - + The SENZA Trial, published in 2015, reports the results of a large, prospective, randomized, controlled trial of high-frequency spinal cord stimulation (SCS) to treat low back and leg pain. In this study, SCS delivered at both standard (60Hz) and high frequency (10Khz) levels produced significant reductions in chronic back and leg pain, with the high-frequency stimulation outperforming lower-frequency stimulation. Concomitant reductions in disability scales were also seen.
 - + A follow-up study published in 2017 shows the durability of substantial treatment effects two years post-implant.
 - + The ACCURATE study, another randomized trial published in 2017, pitted the newer technical of dorsal root ganglion stimulation against traditional SCS to treat lower limb chronic regional pain syndrome. Once again, both therapies significantly reduced patients' chronic pain.
 - + The SunBURST study detailed successful results from a large clinical trial of SCS pulses delivered in short "bursts" rather than constant stimulation.
 - + An observational study (Sharan, et al., 2018) demonstrated that chronic pain patients who undergo SCS could stabilize their opioid requirements despite undergoing dose escalation at the time of implantation.
 - + Finally, SCS allows chronic pain patients on high-dose opioid regimens to reduce their opioid intake after device implantation (Pilitsis, et al., 2018).

Again, as the agency continues to formulate its plan for appropriate reimbursement and increased availability of non-opioid pain treatment for the CY 2025 proposed rule, the AANS and the CNS are uniquely positioned to help, as we have a long history of innovation in chronic and acute pain care.

Quality Issues

Hospital Outpatient Quality Reporting (OQR) Program

CMS proposes to re-adopt, with modification, the Hospital Outpatient Procedure Volume Data measure beginning with the voluntary CY 2025 reporting period and mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination. This measure covers nine categories:

Cardiovascular, Eye, Gastrointestinal, Genitourinary, Musculoskeletal, Nervous System, Respiratory, Skin and Other. Data surrounding the top five most frequently performed procedures among hospital-based outpatient departments (HOPDs) in each category would be collected and publicly displayed for this proposed measure. The top five procedures in each category would be assessed and updated annually as needed to ensure data collection of the most accurate and frequently performed procedures. While CMS recognizes that it can determine facility volumes for procedures performed using Medicare Fee-For-Service claims, it clarifies that the HOPD Procedure Volume measure specifications also include reporting data for non-Medicare patients. A version of this surgical procedure volume measure was previously adopted for use in the Hospital OQR, beginning with the CY 2014 payment determination. However, the measure was removed beginning with the CY 2020 payment determination due to a lack of evidence to support the measure's link to improved quality outcomes and because measuring the number of surgical procedures did not offer insight into the facilities' overall performance or quality improvement related to surgical procedures. In this rule, CMS reverses course, stating that "many studies in recent years have shown that volume does serve as an indicator of quality of care."

While the AANS and the CNS appreciate the agency's desire to provide patients with more complete information to inform health care decisions, **we strongly oppose volume measures for quality improvement and accountability**. As we have expressed in previous comments, we are concerned about the accuracy of utilization data and the potential misinterpretation or misuse. High volume is not, in all situations, a clear indicator of high-quality or high-value care. If measured in isolation, irrespective of the clinical appropriateness of the procedure for a specific patient and the patient's ultimate outcome, then it is not a reliable indicator of quality and could result in misleading information for providers and patients. We are also concerned that volume measures could create perverse incentives for providers to perform non-indicated procedures. Considering the recent progress in developing outcomes and other more robust measures, it seems like a step backward to adopt a volume measure for this program.

Additionally, as we stated last year, reporting volume by procedure type is not so simple. Many services and diagnoses are distributed over large groups of procedure or diagnostic codes. Therefore, even if a facility regularly performs a service, a volume measure may incorrectly identify it as having little to no experience if no single code exceeds a minimum threshold.

In general, we do not believe that volume data is well understood by the average Medicare consumer or an appropriate metric for facility accountability. **If CMS insists on adopting a volume measure for surgical procedures, then we strongly recommend that it only use this measure for confidential facility-level feedback and not tie it to payment or public reporting.**

Ambulatory Surgical Center Quality Reporting (ASCQR) Program

Like its proposal related to the Hospital OQR Program, CMS proposes to re-adopt the ASC Procedure Volume Data with modification, with voluntary reporting beginning with the CY 2025 reporting period and mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination. This measure covers six categories: Gastrointestinal, Eye, Nervous System, Musculoskeletal, Skin, and Genitourinary.

As stated above, the AANS and CNS oppose using volume measures in the ASCQR program or any of CMS' quality programs. We refer CMS to our comments above related to the Hospital OQR Program.

Conclusion

Thank you for the opportunity to share our comments on this topic. The AANS and the CNS appreciate the dedication and professionalism of CMS staff. We urge the agency to do all it can to maintain appropriate reimbursement for neurosurgical service and reduce burdensome regulations.

Sincerely,



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