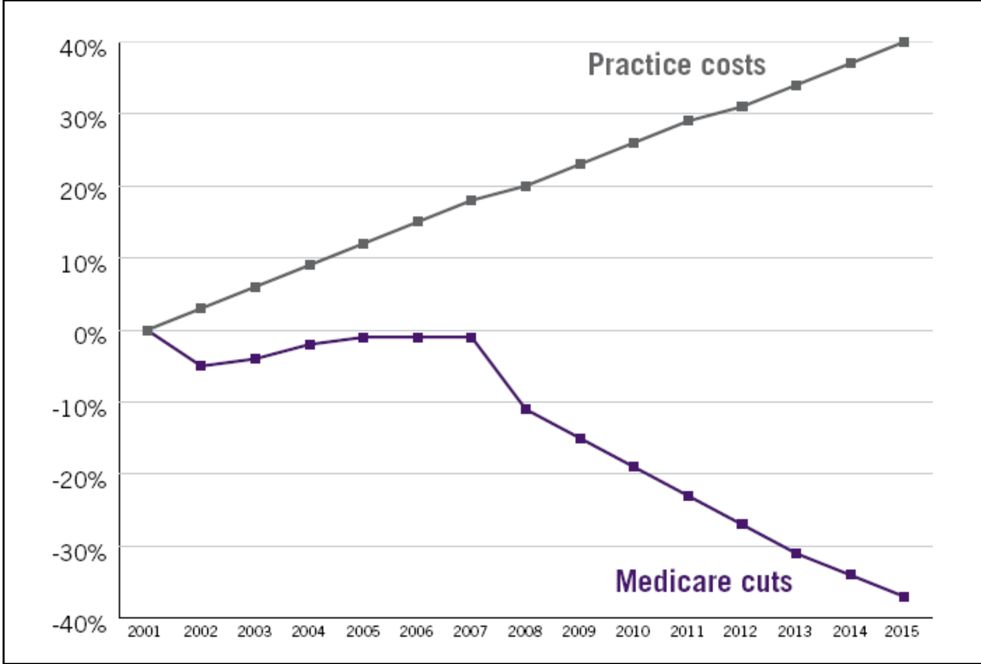
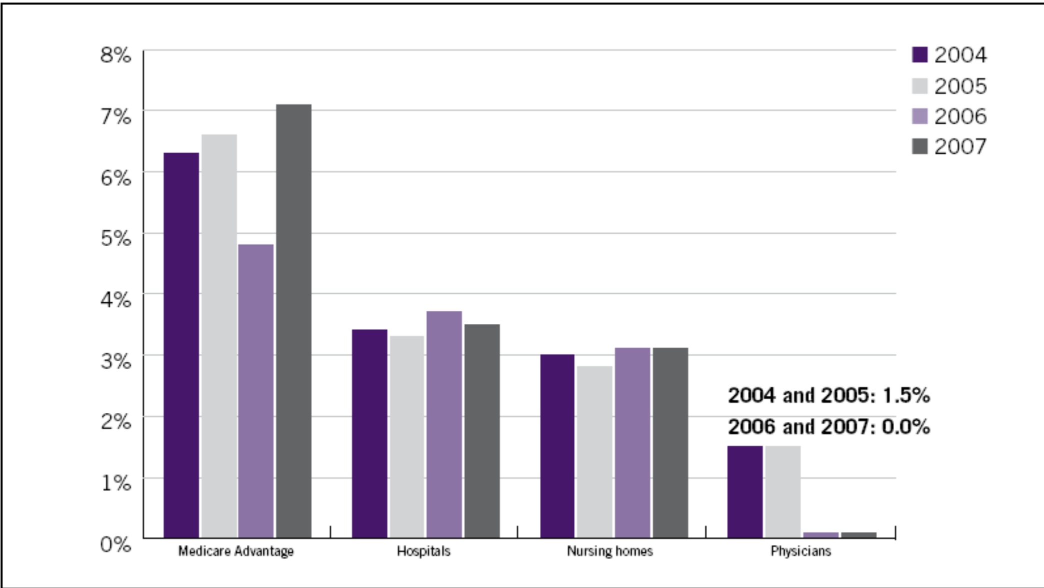
CONSOLIDATED WASHINGTON COMMITTEE REPORT

CODING AND REIMBUSREMENT

Medicare Physician Payment Update/Sustainable Growth Rate (SGR) Formula. Since 2002, Congress has had to take legislative action each year to avoid automatic, formula driven Medicare physician payment cuts under the Sustainable Growth Rate (SGR) formula. Payments will be cut by nearly 40% from 2008 to 2015 unless Congress acts.



Adding insult to injury is the fact that physicians are the only health care provider group that is subject to annual expenditure targets. All other groups receive positive annual payment updates based on some sort of inflationary factor.



During 2006, there were several potential pieces of legislation in play to stop the 5% cut scheduled for January 1, 2007, and ultimately, Congress acted to halt these cuts in the middle of the night in mid-December, with the passage of the Tax Reform and Health Care Act.

- **The Tax Reform and Health Care Act of 2006 (TRHCA)**. Unfortunately, while Congress did act to halt these cuts, they did so in a manner that made this problem much more difficult going forward and included some bitter pills regarding quality reporting initiatives and potential pay for performance in Medicare. Due to these disappointments, and the fact that Congress did not move this legislation in a collaborative manner with stakeholder input, Neurosurgery was unable to endorse the legislation.

  <u>The AANS and CNS did not support this legislation for three primary reasons</u>:

  1. The way in which the payment freeze is financed is extremely problematic and has caused the physicians payment cut to be much larger (10%) for 2008;
  2. The bill extends and makes permanent the recovery audit contractor (RAC) demonstration, thus establishing a major new "fraud and abuse" program;
  3. The new "quality" reporting system is unworkable, overly burdensome and inadequately funded.

  - ***TRHCA and Neurosurgical Payment Rates***. The legislation freezes Medicare physician payments at 2006 levels. The bill also prevents additional cuts (particularly for physicians living in rural areas) due to changes in the geographic practice costs index (GPCIs). Further, the legislation includes an additional 1.5 percent bonus payment for those physicians who report certain quality measures (*see below)* between July 1 and December 31, 2007; though these bonus payments will not be paid until 2008 and it is not clear if they will cover the cost of participating in the program. The bill also includes $1.35 billion for a "Physician Assistance and Quality Initiative Fund" that may be used to reduce the payment cut in 2008 or for quality improvement activities.

    Although the legislation froze the conversion factor at 2006 levels, other changes to the Medicare fee schedule implemented by the Centers for Medicare and Medicaid Services (CMS) will go forward causing reduced fees for many neurosurgical procedures. While the magnitude of these cuts will depend on individual neurosurgical practice models and case-mix, on average, neurosurgeons will be facing a 3 percent Medicare payment cut in 2007. One percent is attributed to changes from the statutory five-year review of work relative values, one percent is due to changes to practice expense values, and one percent is due to statutory reductions in reimbursement for the technical component of imaging services (the Deficit Reduction Act of 2006 required reimbursement for imaging equipment in the office to be no higher than the amount reimbursed in the hospital outpatient department). While it may be small comfort, previous iterations of the legislation and CMS policies could have produced a cut for neurosurgery in the 8% to 12% range. To sum up:

    - 5 year review of work RVUs - 1.0%
    - Practice expenses - 1.0%
    - Imaging cuts - 1.0%

    TOTAL: -3.0%

  - ***TRHCA's Burdensome New "Quality" Program***. The legislation creates a potentially burdensome new quality reporting program, the Physician Quality Reporting Initiative (PQRI), which will likely do little to actually improve quality. The program is on a demonstration basis for the last 6 months of 2007 and has a 1.5% bonus structure. The bonus may be earned if

physicians report to CMS on at least three of the program's quality measures for at least 80% of the cases in which the measures apply. The bonus payment will be a lump sum payment applied to **all** Medicare claims for the six month period if the provider's participation qualifies for the bonus payment, and is subject to a complex cap formula. The program is legislated to extend through 2008 though there is no additional money necessarily allocated for the program in 2008.

In 2008, CMS has broad authority to implement and refine the quality reporting program that could potentially morph into mandatory pay for performance. Although the legislation states that CMS will select measures that have been developed under a consensus-based process and adopted or endorsed by a consensus organization, the AANS and CNS are concerned that this language is too vague and gives CMS free reign over the selection of measures without appropriate oversight, direction and input from physicians.

One positive aspect of the legislation is that in 2008, qualifying measures must also include structural measures (such as the use of electronic health records and e-prescribing technologies) and the Secretary is required to address a mechanism where physicians may utilize appropriate medical registries and outcomes databases.

<u>ACTION TAKEN:</u> The Washington Committee is developing a letter to send to all Members of Congress outlining our concerns with the TRHCA quality reporting and questioning the whole P4P movement. In addition, Washington staff continues to meet with Capitol Hill staff and, with the Alliance of Specialty Medicine, we are drafting legislation to significantly revise the quality provisions of TRHCA and implement a fair process for developing quality measures.

- **Fixing the Physician Payment System.** There is widespread bipartisan support in Congress for "fixing" the physician payment formula. However, medicine faces a tough up-hill battle because repealing the Sustainable Growth Rate (SGR) formula and replacing it with an inflation-based methodology costs approximately $260 billion, while just preventing the 2008 cut alone costs over $20 billion. Further, if Democrats demand that beneficiaries are "held harmless" for resulting Part B premium increases, the price tag is $330 billion! This is likely, particularly since the Part B premium is slated to rise above $100 per month this year. Further complicating our efforts from a budgetary standpoint are the new "pay-go" budget rules the Democrats have implemented which require any additional federal spending to be offset by either increased taxes or decreases in spending, and Democratic leadership has signaled there will not be major new tax increases. Given the demands on the federal budget, particularly in the health care arena, this means very difficult decisions regarding programmatic cuts.

<u>ACTION TAKEN:</u> The Washington Committee is working with the Alliance of Specialty Medicine, the American College of Surgeons and the American Medical Association to identify an alternative to the SGR and to lobby Congress to pass such legislation. One idea that the Washington Committee is promoting is for Congress to return to separate expenditure targets/conversion factors for various Medicare services (e.g., major surgery, office visits, imaging/diagnostic tests, minor procedures, etc.).

- ***Medicare Payment Advisory Commission (MedPAC) Report.*** The Deficit Reduction Act passed in February 2006 mandated that the Medicare Payment Advisory Commission (MedPAC) submit a report to Congress in March 2007 exploring alternatives to the SGR for assessing volume growth and updating physician's Medicare payments. The report was released on March 1, and Congressional health care committees have held a series of hearings on this report.

While Congress required MedPAC to report on five areas that could serve as alternatives to the current SGR formula for controlling volume, the Commission assessed the problem with the SGR in the larger context of the Medicare payment system as well as addressing the statutory requirements of the report. Thus, the report places an emphasis on efficiency and quality in the Medicare program as well as alternatives to the current payment system. The report makes strong statements regarding the need for Medicare to increase the accuracy of payments, the need for more bundling of payments, and the need to create new payment policies that reward providers for efficiency, quality and coordination of care. MedPAC also strongly argues that CMS be better funded so they have the resources to implement all these programmatic changes. MedPAC also addressed the study mandate by dedicating chapters to exploring how volume control targets could be developed at the medical group level, for hospital medical staff, by specialty, by type of service, by geographic areas and for physician outliers.

Partially due to disagreement among Commissioners as to whether Congress should retain an expenditure target for physician services (among other issues), MedPAC did not hold a vote and did not endorse any particular options for SGR reform. Rather, the report lays out two alternative pathways for altering the physician payment program and discusses the pros and cons of each.

1. ***Pathway 1:*** Repeal the Sustainable Growth Rate and, rather than create a new Expenditure Target, Adopt New Approaches for Improving Value to Contain Costs (i.e., Getting more Bang for each Medicare Buck). Under Pathway 1, MedPAC discusses strategies for improving value in the Medicare program including pay for performance, care coordination, bundling, accurate pricing, promoting the use of primary care, and measuring resource use and efficiency.

2. ***Pathway 2:*** Adjusting the Existing SGR by Modifying the Formula and Extend an Expenditure Target to ALL Medicare Providers, not just physicians. Under Pathway 2, the SGR would be altered to avoid the steep cuts realized under the current formula in conjunction with adopting new approaches for improving value. The volume targets would eventually apply to all Medicare providers, be adjusted regionally and provide options for Medicare providers to share in gains from improved efficiency.

In a separate report mandated by Congress annually, MedPAC recommended a physician payment update for 2008. The Commission generally recommends the estimate of medical inflation minus a productivity factor. This year, MedPAC voted to recommend physicians receive a 1.7% update (3% inflation minus a 1.3% productivity factor). Congress is not likely to be that generous given the cost of a freeze (if fully funded) is over $20 billion.

> **<u>ACTION TAKEN:</u> The Washington Committee, under the leadership of Drs. Kusske, Wehby, Boop and Ms. Shoaf, is formulating a draft formal response from Neurosurgery to the MedPAC report on the SGR.**

<u>Medicare Physician Fee Schedule.</u> On December 1, 2006, CMS published the final 2007 Medicare Physician Fee Schedule regulation in the *Federal Register.* The rule made final CMS proposals for the five year review of work relative value units, changes to the practice expense methodology, and other changes to payment under Medicare Part B.

- **Medicare Payment Common Neurosurgical Procedures**. Medicare reimbursement for neurosurgical procedures has gone up and down over the years depending on a variety of factors, including changes in the work, practice expense and malpractice expense RVUs and changes in the conversion factor. Below is a chart of common neurosurgical procedures since the inception of the RBRVS in 1992.

CPT Code	Procedure Description	1992	1997	1999	2001	2002	2003	2004	2005	2006	2007
22554	Ant cerv fusion	$1,354	$1,662	$1,416	$1,443	$1,306	$1,352	$1,312	$1,336	$1,342	$1,221
22612	Lumbar post-lat fusion	1,255	1,801	1,533	1,582	1,449	1,421	1,457	1,498	1,504	1,491
22630	PLIF	1,389	1,705	1,464	1,579	1,471	1,421	1,454	1,478	1,485	1,433
22842	Lumbar pedicle screws	1,414	842	724	825	776	784	805	823	827	764
22845	Ant cerv instrumentation	1,138	761	668	828	744	751	774	787	791	732
22851	Intervert biomech device	N/A	580	484	511	411	415	426	437	438	406
35301	Carotid endarterectomy	1,093	1,436	1,220	1,228	1,061	1,074	1,115	1,129	1,129	1,072
61107	Twist drill- ventric	540	485	391	377	331	346	356	332	334	309
61154	Burr hole for SDH	1,087	1,411	1,160	1,132	994	1,020	1,051	1,081	1,087	1,109
61312	Crani for subdural	1,605	2,065	1,787	1,792	1,598	1,654	1,704	1,732	1,742	1,841
61313	Crani for ICH	1,600	2,086	1,800	1,815	1,620	1,662	1,712	1,742	1,749	1,766
61510	Craniotomy for tumor	1,807	2,405	2,040	2,058	1,840	1,892	1,947	1,978	1,989	1,961
61512	Crani for meningioma	1,913	2,778	2,369	2,486	2,259	2,315	2,368	2,406	2,419	2,343
61697	Brain aneurysm carotid-complex					3,226	3,287	3,385	3,442	3,460	3,715
61698	Brain aneurysm basilar-complex					3,226	3,287	3,385	3,442	3,460	3,899
61700	Brain aneurysm-simple	2,358	3,509	3,059	3,448	3,226	3,287	3,385	3,442	3,460	3,234
61751	Stereotactic biopsy	1,311	1,660	1,376	1,320	1,162	1,175	1,223	1,243	1,250	1,225
61793	Radiosurgery	1,307	1,639	1,290	1,303	1,152	1,165	1,180	1,197	1,206	1,156
61795	Intraop frameless stereotaxis	246	444	331	292	253	255	263	259	260	238
62223	VP shunt	1,044	1,285	1,004	981	868	881	905	914	919	917
62230	Shunt revision	698	875	754	775	690	731	730	741	747	744
62362	Programmable pump implant	N/A	443	408	456	433	440	465	475	477	506
63030	Lumbar discectomy	966	1,205	946	957	874	844	860	883	888	880
63042	Recurrent lumbar disc	1,461	1,763	1,376	1,349	1,214	1,188	1,213	1,245	1,253	1,220
63047	Lumbar laminectomy	1,408	1,408	1,177	1,143	1,037	1,010	1,030	1,047	1,051	1,013
63075	Ant cerv discectomy	1,126	1,609	1,373	1,455	1,338	1,312	1,343	1,363	1,369	1,289
63081	Ant cerv corpectomy	1,685	2,164	1,824	1,818	1,624	1,581	1,621	1,644	1,652	1,634
63650	Perc epidural dorsal column stim	596	647	524	439	369	374	393	396	396	396
64718	Ulnar nerve transposition	435	546	469	475	440	447	482	493	494	510
64721	Carpal tunnel	317	398	349	397	399	387	371	393	394	389
99243	Office Consultation	81	94	103	118	116	117	121	123	123	122
	National Conversion Factor	$31.00	$40.96 (s)	$34.73	$38.26	$36.20	$36.78	$37.34	$37.90	$37.90	$37.90
			$33.85 (ns)								

CPT Coding Issues

- **February 2007 CPT Panel Meeting.** The following code proposals were considered at the February 2007 CPT Editorial Panel Meeting, February 8 through 11:

  - ***Modifier for Reporting to Quality Improvement Database.*** On November 7, 2006, Jeffrey Cozzens submitted a CPT Code Change Proposal to create a new modifier for use when a procedure is entered into a Quality Improvement Database. The proposed wording for the modifier is:

    - -XX Data From Procedure Entered Into Quality Improvement Database -- When data from a procedure, other than E/M service, is entered into a quality improvement database approved by a national specialty society or board, use modifier 1X.

    The proposed modifier is primarily intended to identify when outcomes have been recorded for a particular procedure. The proposal is especially important in light of provisions in the Tax

Relief and Health Care Act of 2006, PL 109-432, which includes a program for data reporting beginning in 2008 in which physicians may report to a data registry such as the Society of Thoracic Surgeons outcomes data base.

The modifier proposal received considerable interest during the CPT Editorial Panel discussion but panel members felt that the issue should be taken up by the AMA Performance Measures Advisory Group (PMAG) to consider the possibility of developing a Category II CPT code for the purpose of reporting to a quality improvement database.

On February 16, 2007, Robert Harbaugh, MD, spoke with Thomas Valuck, MD, JD, Director of the Special Program Office for Value-Based Purchasing at CMS and CMS Medical Officer Mike Rapp, by conference call. Dr. Harbaugh raised the option of using a CAT II code to indicate that a patient was added to a quality improvement registry. CMS staff seemed interested in the proposal.

- ***Posterior Distraction Device Insertion (X-Stop).*** On November, 8, 2006, St. Francis Medical Technology, Inc. submitted a CPT Code Change Proposal to convert the current Category III Tracking Coding for Posterior Distraction Device Insertion (X-Stop) to a Category I CPT Code for consideration at the February 2007 CPT Meeting . However, the day before the proposal was to be considered at the CPT Panel meeting, St. Francis decided to withdraw its code change request.

- ***Modifier -51.*** At the February 2007 panel meeting the CPT Panel accepted a series of codes submitted by Jeffrey Cozzens, MD, to be relocated from Appendix E (modifier -51 exempt) to Appendix D (add on codes), along with the appropriate base codes. The bulk of the changes are considered editorial and will not require consideration by the RUC. However, during the discussion of the list of codes left on the Modifier -51 exempt list, CPT code 20660, *Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)*, was identified as a code that should be reconsidered by the RUC, as it may be coded as a "stand alone" procedure and is not an add-on procedure. AANS/CNS and AAOS agreed to take the code to the RUC.

- ***Osteotomy Codes.*** AANS and CNS joined the North American Spine Society, the Scoliosis Research Society, and the American Academy of Orthopaedic Surgeons in submitting a code change proposal for an editorial change to CPT Codes 22210 through 22226, to insert the words "for correction of deformity." The purpose of the change is to clarify the appropriate use of the osteotomy codes. In addition, the groups submitted a CPT Code Change Proposal for three new codes for osteotomy of the spine.

- **Future CPT Representation.** Samuel Hassenbusch, MD will finish his second term as an AMA CPT Editorial Panel member in October 2007. The AANS and CNS have nominated Jeff Cozzens, MD, the current CPT Advisor for AANS, for this position.

- **Stereotactic Radiosurgery CPT Assistant Article.** On September 12, 2006, AMA CPT staff sent a draft question and answer article clarifying the use of the term "session" from a January 2006 CPT Assistant article written by Jeffrey Cozzens, MD. Dr. Cozzens circulated the draft to the AANS/CNS SRS Task Force leaders for comment and worked with CPT Assistant staff to incorporate revisions. In January 2007, the draft article was referred to the CPT Assistant Editorial Board for review. Should the editorial board propose changes, AANS and CNS will have opportunity to review and comment on the new wording prior to publication.

RUC Issues. The RUC met on January 31 through February 4, 2007. AANS and CNS did not present codes for valuation. Attending for AANS and CNS were Gregory Przybylski, MD, and John Wilson, MD, and Washington Office Staff. The following issues were of interest to neurosurgery:

- **Composition of the RUC.** On February 1, 2007, the Administrative Subcommittee of the RUC voted to add a rotating primary care seat to the committee. Rather than voting on the recommendation, the full RUC on February 4, 2007, asked the subcommittee provide a more details on which specialties would be eligible to hold the seat and if the seat should be a rotating seat. The issue of expanding the RUC has been contentious over the last few years, especially during the last five year review. A vote of 2/3rds is required to pass most proposals at the RUC and the RUC primary care specialties as a block are one vote short of 1/3rd. The AANS and CNS have contended that the RUC is a deliberative expert panel and not a representative body, therefore the most important factor is expertise of the RUC members, rather than proportionate representation. However, the RUC is under outside pressure from MedPAC and others to examine its practices and MedPAC is especially interested in the composition of the RUC. The issue will again be discussed at the RUC Administrative Subcommittee on April 26, 2007.

- **Multispecialty Practice Expense Survey.** Representatives of the Gallup organization conducting the AMA led multispecialty practice expense survey which is currently being pilot tested gave an update to the RUC on the status of the survey. The multispecialty survey will replace the old AMA SMS Survey and is financed by contributions from participating specialties, including the AANS and CNS. Results of the survey are expected in January of 2008.

  <u>ACTION TAKEN</u>: Washington Office Staff has informed AANS and CNS members about the survey via newsletter articles and e-blast notices and encouraged them to participate should they be selected. NERVES has done likewise.

- **April 2007 RUC Meeting.** The next RUC meeting is scheduled for April 25 through April 29, 2007. Washington Office Staff is currently developing RUC surveys for the Osteotomy codes and for CPT code 20660, *Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)*. AANS and CNS RUC advisors will present these codes along with advisors from the American Academy of Orthopaedic Surgeons (AANS) and the North American Spine Society (NASS).

<u>Medicare Coverage Issues</u>. A Medicare coverage decision or a non-coverage decision may be requested by an individual, industry, or organization and CMS is required to examine the evidence presented. In addition, CMS must notify the public of its intent to issue a draft coverage decision (or draft non-coverage decision) and allow a comment period. Customarily, coverage was determined for the most part at the local carrier level and few nation coverage policies existed. However, in recent years there has been a great deal of activity with coverage generated internally and externally. Internally generated activity include the CMS examination of existing covered services such as the review last year of kyphoplasty and vertebroplasty and this year of spinal fusion for degenerative disc disease. In these two cases, a national coverage determination was not issued but CMS indicated that they would like to see more data. Recent requests for non-coverage include the request for non-coverage of lumbar artificial disc replacement by Richard Deyo, MD. Finally, industry seems to be requesting national coverage decisions and reconsiderations more frequently.

CMS seems to be reviewing a greater number of procedures for which Medicare currently provides coverage and the agency seems to be requiring a much higher standard of evidence before it will allow Medicare coverage. This may or may not be appropriate, but given the increased coverage activity, organized medicine may want to revisit issues related to the Medicare coverage process and criteria to ensure that it is reasonable.

<u>ACTION TAKEN:</u> The AANS and CNS considering submitting an AMA Resolution, along with other medical societies, calling for a review of the current Medicare Coverage Policy process and the criteria CMS uses to render non-coverage decisions, especially for procedures that have been covered for many years and are considered standard of care.

- **Neurovascular Coalition.** On February 6, 2007, the Neurovascular Coalition (NVC) met during the International Stroke Conference and CV Section Meeting. The group reviewed a Memorandum of Understanding (MOU) drafted by the American Academy of Neurology. Attending for AANS and CNS were CV Section Chair Gregory Thompson, MD, Joshua Bederson, MD, and John Wilson, MD. The NVC includes representatives of neurosurgery, neuroradiology, interventional radiology, and neurology. In the past this group has been very involved in several Medicare coverage issues, including carotid stents and intracranial stents, but is in the process of reorganizing following a period of inactivity. At the February NVC meeting, the coalition members discussed the recent CMS Decision memo on expanding indications for carotid artery stenting (CAS) and agreed to draft a letter to CMS. On March 2, 2007, several members of the NVC sent a letter to CMS regarding the CAS reconsideration (see CAS coverage discussion below).

  ACTION TAKEN: **The CV Section is review the Neurovascular Coalition Memorandum of Understanding and make a recommendation to AANS and CNS regarding whether to sign the agreement.**

- **Medicare Coverage Advisory Committee Name change and Request for Nominations.** In the January 26, 2007, *Federal Register*, CMS issued a notice of the name change from the Medicare Coverage Advisory Committee (MCAC) to the Medicare Evidence Development and Coverage Advisory Committee (MedCAC). In addition, CMS asked for nominations to Medicare Evidence Development Coverage Advisory Committee (MedCAC). As of May 2007, there will be 28 terms of membership expiring, 2 of which are nonvoting consumer representatives, 1 of which is a nonvoting industry representative and 6 voting patient advocates. Neurosurgeons Kim Burchiel and Steve Ondra are current members of the MedCAC.

  ACTION TAKEN: The Washington Office contacted the AANS and CNS Joint Sections and asked that they each submit names of neurosurgeons to serve on the MedCAC. On March 12, 2007, AANS and CNS sent a letter to CMS coverage staff nominating Drs. Jeff Cozzens, Andy Sloan, and John Wilson.

- **MedCAC Clinical Trial Policy Meeting.** On December 13, 2006, the Medicare Evidence Development and Coverage Advisory Committee (MedCAC, formerly the MCAC) met to consider several questions posed by CMS staff regarding its clinical trial policy. Since 2000, CMS has covered routine patient cost in certain clinical trials, which were deemed qualified. To be qualified the trials had to be approved and funded by a Federal agency or have an IND approval from FDA or an IND exemption. On October 30, 2006, CMS initiated a review of its Clinical Trial Policy (to be renamed Clinical Research Policy) to try to address several issues that have arisen since implementation of the original 2000 policy.

  At the December 13 MedCAC meeting, panel members approved CMS's proposal to add several new "Medicare-specific" standards for coverage, including a requirement that trials be registered on the ClinicalTrials.gov Web site; that the protocol specify the method and timing of the public release of the findings, regardless of outcome; and that the protocol explicitly address the ways in which the trial will impact certain "subpopulations," affected by technology. Details on the policy can be found at:
  http://www.cms.hhs.gov/mcd/viewnca.asp?where=index&nca_id=186&basket=nca:00071R:186:Clinical+Trial+Policy:Open:1st+Recon:8

- **CMS Stops Posting Public Comment on Medicare National Coverage Decisions.** Citing possible issues with the Health Insurance Portability and Accountability Act (HIPPA) patient privacy provisions, CMS stopped posting public comments on pending National Coverage Decisions (NCDs) at the end of 2006. Previously, CMS published comments on the coverage website as they were submitted. Typically comments were submitted electronically, making the posting relatively simple for CMS coverage staff. However, some comments contained patient-

specific information and, therefore, the possible HIPPA issue was raised. CMS has said that it does not have the staff resources to review each comment to make a determination as to whether it contains protected health information before posting. Therefore, until the HIPPA issues are resolved, CMS will no longer post public comments and the only way for individuals to see the comments would be to submit a Freedom of Information Act (FOIA) request.

- **Lumbar Artificial Disc Replacement (LADR)—First Reconsideration.** Following the FDA approval of the ProDisc lumbar artificial disc, CMS issued a reconsideration of its May 16, 2006 National Coverage Decision (NCD Manual Section 150.10). The reconsideration, which was generated internally within CMS rather than at public request, will include an examination of the evidence on the technology resulting from studies of the ProDisc. CMS is expected to issue its decision memorandum on May 28, 2007, following which there will be a 30 day comment period. CMS is expected to issue a final policy on August 26, 2007. Details on the policy are available at: http://www.cms.hhs.gov/mcd/viewnca.asp?where=index&nca_id=197&basket=nca:00292R:197:Lumbar+Artificial+Disc+Replacement+%28LADR%29:Open:1st+Recon:1

- **Intracranial Stents**. On November 1, 2006, CMS released a final Medicare NCD for intracranial stenting, which affirmed its August 9, 2006, proposed decision in which the agency said it would only pay for the procedure when done as a part of an Investigational Device Exemption (IDE) Study. There are no IDE studies currently being conducted. The device was approved by the FDA in August 2005 as a Humanitarian Device Exemption (HDE), which is granted for promising devices that are used for conditions in which patients have no other viable treatment options and for which there are an estimated fewer than 4000 patients with the condition.

  ACTION TAKEN: The AANS and CNS had joined a coalition of specialty societies in sending a letter to CMS sent on September 8, 2006, reiterating support for Medicare coverage for intracranial stent procedures for patients who would otherwise have no treatment options at all.

- **Percutaneous Transluminal Angioplasty (PTA) of the Carotid Artery Concurrent with Stenting--3rd Reconsideration.** On February 1, 2007, CMS issued a coverage decision memorandum expanding coverage for carotid artery stenting (CAS). Key provisions of the CAS Decision Memorandum follow:

  - Restrict the current coverage for patients who are at high risk for carotid endarterectomy (CEA) and have symptomatic carotid artery stenosis > 70% to patients who are less than 80 years of age;
  - Expand coverage to patients who are at high risk for CEA and have asymptomatic carotid artery stenosis >80% and are less than 80 years old;
  - Establish that the surgeon performing the surgical consultation that determines a patient's high risk status must be properly credentialed to perform CEA as determined by the facility;
  - Maintain current coverage for patients at high risk for CEA who have symptomatic carotid artery stenosis between 50-70%;
  - Maintain current coverage for patients who are > 80 years of age with either symptomatic stenosis >70% or asymptomatic stenosis >80% in accordance with the Category B IDE clinical trials regulation (42 CFR 405.201), the clinical trial policy (Medicare NCD Manual 310.1), or the National Coverage Determination on CAS post approval studies (Medicare NCD Manual 20.7B3);
  - CAS for patients who are not at high risk for CEA in the opinion of a surgeon credentialed to perform carotid endarterectomy remains covered only in FDA-approved Category B IDE clinical trials under 42 CFR 405.201 or under the clinical trial policy.

  The decision memorandum is on the web at:
  http://www.cms.hhs.gov/mcd/viewnca.asp?where=index&nca_id=194&basket=nca:00085R3:194:

Percutaneous+Transluminal+Angioplasty+%28PTA%29+of+the+Carotid+Artery+Concurrent+with+Stenting:Open:3rd+Recon:6

ACTION TAKEN: On March 2, 2007, the AANS, CNS, and the AANS/CNS Joint Section on Cerebrovascular Surgery joined several other members of the Neurovascular Coalition in signing a letter to CMS regarding the CAS NCD Reconsideration. On March 3, 2007, a similar letter on behalf of the AANS and CNS was submitted. The letters expressed our disagreement with several provisions of the NCD proposal.

1. First, the groups disagreed with the CMS proposal to limit CAS to patients less than 80 years of age. The group agreed that adverse event rates seemed to be higher in patients over 80 and that such compelling data should be considered when any patient over the age of 80 is evaluated as a potential candidate for CAS, but that the coverage of the procedure should not be disallowed for all patients over 80.
2. Second, the group opposed the CMS proposal to expand coverage for CAS to patients who have asymptomatic carotid artery stenosis of greater than 80%. The group felt that the evidence is currently insufficient to support coverage for such patients.
3. Third, the letter disagreed with the CMS proposal not to cover CAS when an embolic protection device is not used. However, the group did support the requirement for a physician to document the reason that an embolic protection device was not used.
4. Fourth, the group asked that oversight of certification and recertification of facilities must be performed by a neutral body or a body representing all appropriate medical specialties including the clinical neurosciences specialties, rather than solely by the Society for Cardiovascular Angiography and Interventions as proposed.
5. Finally, the group agreed with the recommendation that the surgeon performing the surgical consultation to determine a patient's high risk status must be properly credentialed to perform CEA.

- **Reporting CAS Procedures to Data Registries.** As a condition of Medicare coverage for carotid stent procedures, reporting of data to a data registry was required. Both the Society for Vascular Surgery (SVS) and the America College of Cardiology (ACC) have established registries.

ACTION TAKEN: On February 20, 2007, the AANS and CNS sent a letter to ACC with a signed contract informing them that AANS and CNS would participate in the ACC CARE (Carotid Artery and Revascularization and Endarterectomy) Registry™ for CAS. In the letter, AANS and CNS appointed three neurosurgeons to registry committees: L.N. Hopkins, III, MD to the Steering Committee, Elad I. Levy, MD, to the Research and Publications Committee, and Peter A. Rasmussen, MD, to the Registry and Oversight Committee.

Information on the registry is available at: http://www.accncdr.com/webncdr/CarotidStent/Default.aspx

The ACC invited AANS and CNS representatives to attend a meeting with FDA staff on March 19, 2007 of CAS stakeholders to discuss the possibility of specialty society databases--such as the CARE Registry™, Society of Vascular Surgery (SVS) Registry, and the American College of Radiology (ACR) Registry--being used as a mechanism for streamlining reporting of post-market surveillance data. Washington Office staff attended the meeting at which the three registry societies, FDA, and CMS presented an update on the status of CAS registries, coverage, and studies. Another CAS registry stakeholder meeting may be held in early June during the SVS annual meeting in Baltimore.

- **Vagus Nerve Stimulation for the Treatment of Resistant Depression (TRD)--1st Reconsideration.** On February 5, 2007, CMS issued a Medicare Decision Memorandum regarding Vagus Nerve Stimulation (VNS) for Treatment Resistant Depression (TRD). In its

memorandum, CMS stated that the agency does not believe there is sufficient evidence to conclude that VNS for TRD should be covered. CMS specifically stated in its request for comments, as they have with other coverage decisions, that "CMS is particularly interested in the quality of data and evidence cited in public comments rather than the quantity of comments." Following a review of the public comments, CMS will issue a final decision memorandum. Details on the VNS for TRD policy are available at:
http://www.cms.hhs.gov/mcd/viewnca.asp?where=indexncacomment&nca_id=195&basket=nca:00313R:195:Vagus+Nerve+Stimulation+for+Treatment+of+Resistant+Depression+%28TRD%29:Open:1st+Recon:9

ACTION TAKEN: On March 5, 2007, AANS and CNS submitted comments to CMS supporting coverage of VNS in appropriately selected patients and calling for more study of the promising technology.

- **Blood Brain Barrier Disruption.** On March 21, 2007, CMS issued a determination in which it stated that "there is sufficient evidence to conclude that the use of osmotic blood brain barrier disruption (BBBD) used as part of a treatment regimen for brain tumors in Medicare beneficiaries is not reasonable and necessary under Section 1862(a)(1)(A) of the Social Security Act. Accordingly, we are issuing a national coverage determination (NCD) that states 'The use of osmotic blood brain barrier disruption is not reasonable and necessary when it is used as part of a treatment regimen for brain tumors. This NCD does not alter in any manner the coverage of anticancer chemotherapy.'" The non-coverage decision was initially requested on July 11, 2006 by George Waldman, MD, a Carrier Medical Director for Noridian Medicare Part B Carrier. The link to the CMS Website with the full details and full decision memo is:
https://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=188

  ACTION TAKEN: On August 8, 2007 Ronald Warnick, MD, Chairman of the AANS/CNS Section on Tumors, submitted a comment stating "The intra-arterial delivery of chemotherapy, with or without blood-brain barrier disruption, for the purpose of treating lymphoma is a recognized delivery procedure and is not, in itself, experimental."

- **MCAC Meeting on Spinal Fusion.** On November 30, 2007, the MCAC (former name of the MedCAC) met to discuss and evaluate evidence for spinal fusion for degenerative disc disease. The decision to hold the MCAC meeting came as a result of CMS's artificial lumbar disc non-coverage decision, as spinal fusion was the procedure used as the comparison procedure in studies of the artificial lumbar disc.

  ACTION TAKEN: AANS and CNS participated in a multispecialty effort led by Charles Branch, MD, Chairman of the AANS and CNS Joint Section on Spine. The presentation for the MCAC by the specialty societies, included talks by Drs. Branch and Dan Resnick, MD, from AANS/CNS; Rick Guyer, MD, from NASS; David Polly, MD, from the Scoliosis Research Society; David Wong, MD, from AAOS; and Hansen Yuan, MD, from SAS.

  Kim Burchiel, MD and Steve Ondra, MD served on the MCAC panel. CMS presented MCAC members with a list of questions regarding their assessment of the quality of the clinical data available. Details on the MCAC meeting are available at:
  http://www.cms.hhs.gov/mcd/viewmcac.asp?where=index&mid=37

- **Stereotactic Radiosurgery**

  - ***Wisconsin Physician Services SRS and SRT Proposals.*** On January 17, 2007, Jeffery Cozzens, MD, attended a meeting of the Carrier Advisory Committee (CAC) for Wisconsin

Physician Services, Medicare Carrier for Wisconsin, Illinois, Michigan, and Minnesota. The carrier presented the latest draft of its proposed LCD for cranial SRS and cranial SRT. Dr. Cozzens had circulated the draft policy to the SRS Task Force and to the Coding and Reimbursement Committee in November 2006. On November 5, 2006, Dr. Cozzens sent Wisconsin Physician Services a copy of the AANS/CNS/ASTRO agreed upon definition of SRS and papers highlighting the indications and efficacy for SRS. On January 8, 2007, Dr. Cozzens sent a copy of the Journal of Neurosurgery Article by the AANS/CNS Stereotactic Radiosurgery Task Force. Following a series of state CAC meetings in February, a 45 day comment period will be allowed for the Wisconsin Physician Services proposal.

On February 19, 2007, the AANS/CNS Washington Office learned that the American Society for Therapeutic Radiology and Oncology (ASTRO) had submitted to Wisconsin Physician Services a "model SRS proposal", which was basically the same proposal that was issued by Noridian in the Fall of 2006 and which recommended that reporting of 61793 be limited to once per course of treatment, regardless of the number of lesions treated. In response, Dr. Tippett called Timothy Williams, MD, to express his strong objections to ASTRO's action. Dr. Williams was not aware of the ASTRO letter to the Wisconsin carrier and agreed to send a retraction.

- ***First Coast Service Options, Inc. SRS and SBRT Proposals.*** On January 22, 2007, First Coast Service Options, Inc., a Medicare Carrier in south Florida, issued draft Local Coverage Decisions for SRS and Stereotactic Body Radiation Therapy (SBRT). The drafts did not involved CPT code 61793 but in conversations with the Contractor Medical Director, James Corcoran, MD, AANS/CNS Washington Office Staff learned that Dr. Corcoran was considering issuing a carrier coding clarification for 61793.

  ACTION TAKEN: The AANS and CNS sent a letter on March 13, 2007 to the carrier describing CPT coding policy for 61793 and attaching a copy of the January 2007 SRS Task Force article and the January 2006 AMA CPT Assistant article.

- ***Journal of Neurosurgery Publication of SRS Definition.*** In January 2007, the Journal of Neurosurgery published an article by the SRS Task Force which describes the work of the task force and includes the SRS definition developed by AANS and CNS in coordination with ASTRO. On February 1, 2007, the AANS and CNS were informed by ASTRO staff that ASTRO would publish the SRS definition in its "Red Journal" on March 15, 2007.

- ***New SRS CPT Codes and SRS Practice Survey.*** The SRS Task Force and Washington Office staff developed a survey to evaluate the practice patterns of neurosurgeons performing SRS. The survey was sent via e-mail to all members of the AANS and CNS in a special Washington Committee e-blast and also in the AANS e-blast. Preliminary results were presented to the Washington Committee on February 16, 2007 and it appears that 61793 may not lose any value if we split the code in several parts. The Coding and Reimbursement Committee will continue to work on this project.

Miscellaneous Medicare Physician Payment Issues

- **GAO Report on ASC Payment.** On November 30, 2006, the Government Accountability Office (GAO) issued a report entitled *Medicare: Payment for Ambulatory Surgical Centers Should Be Based on the Hospital Outpatient Payment System* in which it analyzed the use of the Ambulatory Payment Classification (APC) groups used by the Medicare Hospital Outpatient Prospective Payment System (OPPS) for its applicability to Ambulatory Surgery Centers (ASCs) and concluded that such a system would be useful ACS payment. A copy of the report and more details are available at: http://www.gao.gov/highlights/d0786high.pdf