

AMERICAN ASSOCIATION OF
NEUROLOGICAL SURGEONS

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American
Association of
Neurological
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CONGRESS OF
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January 3, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: Payment Policies Under the Physician Fee Schedule, Five-Year Review of Work Relative Value Units, and Other Revisions to Part B for CY 2012 CMS-1524-FC; CMS-1436-F

Dear Acting Administrator Tavenner:

The American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS) appreciate the opportunity to provide comments regarding the regulations cited above, published in the *Federal Register* on November 28, 2011.

Evaluation and Management Code Review

We are pleased that CMS will not ask the AMA/Specialty Society Relative Value Scale Update Committee (RUC) to revalue evaluation and management codes (E/M) codes, as originally suggested in the proposed rule. We agree with CMS that several on-going initiatives involving primary care such as the CMS Center for Innovation Comprehensive Primary Care Initiative, and care coordination demonstration projects should be assessed before a wholesale re-review of E/M services.

Refinement Panel Process

The AANS and CNS supported the proposal by CMS in the 2011 Medicare Physician Fee Schedule (MPFS) final rule to make the refinement process more transparent. However, other than publishing the August 2011 panel results, CMS did not fulfill its promise to improve the refinement process. In fact, CMS has indicated its intention to limit access to the process in the future. We are deeply disappointed that the agency chose to ignore the majority of the recommendations of the refinement panels. We are particularly concerned about CMS' refusal to accept the refinement recommendations for codes for which CMS says it has an established policy, such as the codes that were identified by the "site of service" screen. CMS has not provided adequate data to support this policy. If refinement panel recommendations are uniformly overturned on the basis of pre-existing CMS policy, there is no utility in the panels for CMS or physicians. We urge CMS to revisit this position and to carefully assess refinement panel recommendations for all codes for which specialty societies request re-review. Refinement panel recommendations should not be ignored due to CMS "policy". CMS has not provided adequate justification for these actions and we therefore urge CMS to reconsider and accept the values recommended by the objective refinement panels.

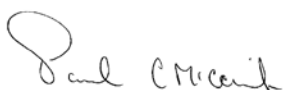
In addition, CMS states in the final rule that it will require new data, not presented at the RUC, to consider codes for the refinement process in the future. While we agree that physician societies should be permitted to submit additional data when available, we do not agree with limiting the opportunity for refinement only to those specialties that have information not presented at the RUC. In many instances, there is no additional information to provide to a refinement panel because all available data has been presented to the RUC. The refinement process provides an opportunity for specialty societies to present all available data on procedures under consideration to a panel of objective experts, as a form of appeal. For twenty years, refinement panels have been an important mechanism for review of CMS decisions. We applaud the publication of the results of the refinement panels. We believe CMS should provide rationales supported by data to explain their decisions to reject refinement panel results. Finally, we completely disagree with the agency's proposal to limit access to the refinement process to only those specialties presenting information not shared at the RUC.

CMS policy on valuing surgical procedures with 23-hour stays

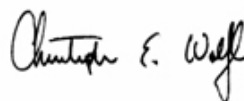
The AANS and CNS support the AMA RUC policy of recognizing the time the physician spends in the hospital taking care of the surgical patient. The content of the care does not vary with the outpatient or inpatient designation by the hospital. The same evaluation and management services are provided to these patients regardless of "observation" status. We do not agree that there is a decrease in the time and/or intensity of services for these patients. CMS disagreed with the RUC recommended values for many surgical codes and rejected refinement panel recommendations for higher values because CMS believes "that it is reasonable to expect that there have been changes in medical practice for these services, and that such changes would represent a decrease in physician time or intensity or both. However, the AMA RUC-recommendation and refinement panel results do not adequately reflect a decrease in physician work." The same reductions in work values for E/M codes for non-surgical follow-up of patients on observation status have not been implemented. The result of these actions is differential payments for follow-up of patients on observation status depending on which types of physician provide the follow-up. CMS provides no logical or data-driven basis to support this differentiation. CMS should value care provided to patients on observation status uniformly regardless of the type of physician providing the care.

Thank you for your time and attention.

Sincerely,



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American Association of Neurological Surgeons



Christopher E. Wolfla, MD, President
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