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September 8, 2015

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1631-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1631-P Medicare Program; Payment Policies Under the Physician Fee Schedule (PFS) and Other Revisions to Part B for CY 2016

Dear Mr. Slavitt:

On behalf of 4,000 practicing neurosurgeons in the United States, the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS) appreciate the opportunity to comment on the payment provisions of the above referenced Centers for Medicare and Medicaid Services' (CMS) 2016 Medicare Physician Fee Schedule (MPFS) Notice of Proposed Rulemaking (NPRM). We have submitted comments related to the quality issues in a separate comment letter.

EXECUTIVE SUMMARY

Professional Liability Insurance (PLI) Relative Value Units (RVUs)

- The AANS and CNS are concerned about the projected one percent decrease in reimbursement for neurosurgery due to changes in the Malpractice RVU calculation. The reported 8 percent decrease in neurosurgical malpractice premiums does not reflect the experience of our expert panels or the reports from our state and national grassroots organizations.
 - We question the sample size used and the methods by which practicing neurosurgeons were identified for inclusion, and there are no descriptions from CMS about how this data was gathered.
 - We urge the agency to be certain that data provided on PLI premiums are accurate and provide greater transparency regarding the methods for calculating PLI RVUs.
- **Proposed Annual Update of PLI RVUs**
 - As the specialty with the highest professional liability insurance premiums, neurosurgery supports using the most current PLI premium information available. However, updates based on data that is only collected every five years only increases the potential that unreliable data will have long-lasting consequences.

- **PLI Determination for Low Volume Codes**

- The AANS and CNS agree with the agency’s decision to maintain code-specific “overrides” when the claims data are inconsistent with a specialty that could be reasonably expected to furnish the service.
- We agree with the RUC that the agency should publish the list of codes for which it has decided to “override” the dominant specialty in order allow stakeholders adequate opportunity for review and comment.

Validating RVUs of Potentially Misvalued Codes

- **High Expenditure Codes**

- The AANS and CNS strongly oppose CMS’ intention to value the ZZZ add-on codes in Table 8. We agree with the RUC comments that evaluation of these codes is not necessary at this time and echo the RUC’s request that CMS remove five add-on services from this list.
- Since 10- and 90-day global services were excluded from the query to generate this list of high expenditure procedures, the associated add-on code services should also be excluded (CPT codes 22614, 22840, 22842, 22845, and 33518).

Improving the Valuation and Coding of the Global Services Package

- **Review of 10- and 90-Day Global Packages**

- The AANS and CNS strongly supported legislation to prevent CMS from eliminating the 10- and 90-day global periods. We believe the goals of the agency to ensure correct valuation of these services can be met without scrapping the long standing and well understood practice of the global surgery payment.
- We ask CMS to work with the RUC and specialty societies to find efficient and effective ways to keep the global packages, while valuing them fairly.

Elimination of the Refinement Process

- The AANS and CNS are pleased to see that the proposed rule includes as many of the 2016 recommended code values as possible and look forward to 2017 and beyond when the vast majority of the proposed values will be included.
- We oppose the elimination of the refinement process and urge CMS to maintain a transparent appeal or additional review process to allow specialties to have a full and fair hearing.
- We agree with the RUC that the complete elimination of the refinement process decreases CMS accountability to its stakeholders who do not agree with the Agency’s decisions.

Separate Payment for Collaborative Care

- The AANS and CNS strongly objected to the elimination of payment for consultation codes several years ago, and at that time made the point that these codes were important for inter-specialty collaboration and continuity of care.
- If separate payment for collaborative care is developed, we support criteria that would allow codes to be reported by the consulted specialist.

Target for Relative Value Adjustment for Misvalued Services

- The AANS and CNS agree that savings from all codes valued as a result of the misvalued services screens, not just the codes listed on the screens, should be credited toward the savings target.

- We believe that selection of the codes to be included for review beyond the codes identified by the screens should be determined by the pertinent specialty society, as they are the best determiners of which code make up a family of codes.

Phase-in of significant RVU Reductions

- The AANS and CNS support the requirement that significant reductions should be phased-in over a two-year period to allow physicians to plan for, and adjust to, these changes.
- We urge CMS to reconsider its proposal to adopt a 19 percent reduction as the maximum one-year reduction and to phase-in any remaining reduction in the second year of the phase-in period. Instead, we urge CMS to adopt a 50 percent phase-in approach, whereby one-half of the reduction would be applied in each of the two years.

Medicare Private Contracting/Opt-out

- The AANS and CNS are long-time proponents of private contracting for Medicare patients and are pleased to see that the agency finalized regulatory language allowing physicians to opt-out of Medicare without the requirement to file an affidavit every two years to remain in an opt-out status.

COMMENTS

Professional Liability Insurance (PLI)

The AANS and CNS are concerned that the impact of CMS changes regarding professional liability insurance (PLI) is estimated by CMS to have a negative one percent impact on neurosurgery. We understand that CMS has said that the decrease “relates to a technical improvement that refines the MP RVU methodology, which we are proposing to make as part of our annual update of malpractice RVUs. This technical improvement will result in small negative impacts to the portion of PFS payments attributable to malpractice for gastroenterology, colon and rectal surgery, and neurosurgery.” However, we would like to see more details on how the specialty impacts were determined.

While we appreciate the assertion that it may be difficult to obtain premium data for neurosurgery, we believe the agency must thoroughly vet the methodology used by the contractor that would show an eight percent decrease in PLI premiums for neurosurgery. According to CMS, premium data for neurosurgery were only available from 24 states; therefore the agency did not have sufficient data to calculate a national average premium amount for neurosurgery for purposes of updating the malpractice RVUs. As a proxy, CMS used blended data for neurology (surgical) and neurosurgery, claiming premiums are similar. This crosswalk may be superior to merely cross-walking neurosurgery, but this creates a “blended” assessment of surgical and non-surgical specialties that likely bears little relation to reality for neurosurgery. Similarly, the PLI risks for these specialties remain distinct.

The eight percent decrease in neurosurgical malpractice premiums cited in the CMS contractors report does not reflect the experience of many of our neurosurgeon colleagues. We therefore question the size and geographic distribution of the sample used to reach this assessment. It is possible that a small sample may be producing poor representation of the true cost of PLI for neurosurgeons. We urge CMS to review the data, continue to try to obtain premium data for neurosurgery in as many states as possible, and to share the data with us in order for the agency and the specialty to determine its accuracy.

Proposed Annual Update of PLI RVUs

CMS proposes for CY 2016 to begin conducting annual PLI RVU updates to reflect changes in the mix of practitioners providing services, and to adjust PLI RVUs for risk. However, premium data will still be

collected every five years. As the specialty with the highest professional liability insurance premiums, neurosurgery supports using the most current PLI premium information available. Furthermore, as mentioned above, the accuracy and reliability of the data is essential, and annual updates based on data that is only collected every five years only increases the potential that unreliable data will have long-lasting consequences. We question a data collection process that shows an eight percent drop in PLI premiums for neurosurgery and we would ask the agency to revisit this data, as it does not reflect our experience.

PLI Determination for Low Volume Codes

The issue of valuing PLI RVUs for low volume codes has long been a concern for neurosurgery. Some code are so rarely performed or have such low Medicare volume for a particular year that the dominant specialty may not accurately reflect the risk. We agree with the agency's decision to maintain code-specific "overrides" when the claims data are inconsistent with a specialty that could be reasonably expected to furnish the service. CMS has said that their updated methodology for determining PLI values annually will eliminate the use of the list of crosswalks developed for this purpose by the RUC. We agree with the RUC that the agency should publish the list of codes for which it has decided to "override" the dominant specialty in order allow stakeholders adequate opportunity for review and comment.

Validating RVUs of Potentially Misvalued Codes

High Expenditure Codes

We are keenly aware that CMS is required by Congress to develop a process for validating the RVUs under the MPFS and the agency has entered into contracts with outside entities as part of efforts to comply — including one contract with the Urban Institute to develop time estimates and work validation and a second contract with the RAND Corporation.

However, the AANS and CNS strongly oppose CMS' intention to value the ZZZ add-on codes in Table 8. We agree with the RUC comments that evaluation of these codes is not necessary at this time, given that the associated 10- and 90-day global services were appropriately excluded by the agency. Again, since 10- and 90-day global services were excluded from the query to generate this list of high expenditure procedures, the associated add-on services (CPT codes 22614, 22840, 22842, 22845, and 33518) should also be excluded.

Improving the Valuation of the Global Surgical Package

Review of 10- and 90-Day Global Packages

The AANS and CNS strongly supported legislation to prevent CMS from eliminating the 10- and 90-day global periods. The goal of ensuring that services with global periods are accurately valued can be achieved without completely overhauling the existing payment structure, which could lead to disaggregation and fragmentation of patient care and is completely contrary to current trends toward bundling. To that end, we had submitted detailed comments on this subject in response to CMS' previous proposal and we urge the agency CMS to keep those comments, and the comments of the RUC, in mind as it develops a new approach to assessing evaluation and management work in the global periods.

As has been pointed out by the RUC, there are currently 4,256 CPT codes with surgical global packages in the Medicare payment schedule. Of the 473 services which have a 10-day global period, the average number of post-operative office visits included in the global package is one. Additionally, of the 3,783 services which have a 90-day global period, the average number of post-operative office and hospital

visits is three. Furthermore, according to 2014 Medicare utilization, there are only 108 10-day and 152 90-day global codes performed more than 10,000 times. The risks and negative consequences of doing away with the global period far outweigh the benefits and we continue to urge the agency work with surgical specialty societies and the RUC to validate the codes without abandoning the global packages

Elimination of the Refinement Process

The AANS and CNS supported the change in the Medicare Physician Fee Schedule publication schedule for new and updated RVU values. We are pleased that CMS was able to include some proposed values in the 2016 Medicare PFS proposed rule and look forward to next year when virtually all of the values will be included. We appreciate the agency's willingness to alter the schedule and process by which it publishes proposed values.

Nevertheless, we remain concerned about the proposal to eliminate the refinement process without consideration for a replacement appeals process. Despite the agency's contention that refinement was never intended as an appeal or second review, the reality is that having a refinement panel of Carrier Medical Directors, clinical experts, and CMS staff to reconsider proposed values did sometimes result in appropriate changes. Thus, the refinement panel became a *de facto* appeals process because no other opportunity existed for appealing CMS decisions. While we are hopeful that the change in the timing publishing proposed values will help with transparency and preparation for changes, this does not obviate the need for a dedicated and transparent appeal or additional review process to allow specialties to have a full and fair hearing. We agree with the RUC that the complete elimination of the refinement process decreases CMS accountability to its stakeholders who do not agree with the agency's decisions.

Separate Payment for Collaborative Care

The AANS and CNS recognize that inter-professional consultation is essential and this was one of the reasons that we opposed the elimination of payment for consultation codes several years ago. CMS notes in the proposed rule that the management of Medicare patients who, given their age, often have multiple chronic conditions may require extensive discussion, information-sharing and planning between the patient's primary care physician and a specialists. Thus, should CMS develop new codes for consultation, we would support criteria that allowed the codes to be reported by the specialist consulted.

In discussions about the development of ways to accurately account for the work of inter-professional collaborative care, we urge the agency to fully recognize the need to appropriately value the work of the specialist. For example, a neurosurgeon may examine a patient with back pain for whom spinal surgery is appropriate, but certain other health issues such as obesity, diabetes control, and smoking cessation must first be addressed. It is not uncommon for the neurosurgeon to consult with the patient's primary care physician to follow up until the patient has addressed the other conditions and is a candidate for surgery. Such work should, therefore, be appropriately compensated.

Target for Relative Value Adjustment for Misvalued Services

As we have stated above, the AANS and CNS realize that the agency is required by law to identify savings from misvalued services. We agree that savings from all codes valued as a result of the screens, not just the codes listed on the screens, should be credited toward the savings target. However, we believe that selection of the codes to be included for review beyond the codes identified by the screens should be determined by the pertinent specialty society, as they are the best determiners of which code make up a family of codes. We share the RUC's view that CMS should establish a transparent process for the target calculation that is clear to stakeholders and can be independently verified by the RUC and others.

Phase-in of Significant RVU Reductions

The AANS and CNS support the requirement that significant reductions should be phased-in over a two-year period to allow physicians to plan for, and adjust to, these changes. However, we urge CMS to reconsider its proposal to adopt a 19 percent reduction as the maximum one-year reduction and to phase-in any remaining reduction in the second year of the phase-in period. Instead, we urge CMS to adopt a 50 percent phase-in approach, whereby one-half of the reduction would be applied in each of the two years. While the possibility exists that this would create rank order anomalies within new families of codes, these anomalies would only be true for the transitional year. Furthermore, any rank order anomaly could not be used as part of the RUC process for valuing other codes and it is unlikely this would exist for many codes in the MPFS. This approach will be much cleaner and more understandable to those paid under MPFS.

Private Contracting/Opt-out

The AANS and CNS are long-time proponents of private contracting for Medicare patients and support the ability of physicians to opt-out of the program without the requirement to file an affidavit every two years to remain in an opt-out status. We are pleased that Congress has acted to simplify this process and we support CMS' revising regulations to implement the law.

CONCLUSION

The AANS and CNS appreciate the opportunity to comment on the payment provisions of the proposed 2016 Medicare Physician Fee Schedule Proposed Rule. As always, we recognize the hard work and expertise of the many individuals involved in Medicare policy and look forward to working with the CMS to improve the accuracy of the fee schedule.

If you have any questions or need additional information, please contact us.

Sincerely,



H. Hunt Batjer, MD, President
American Association of Neurological Surgeons



Nathan R. Selden, MD, PhD, President
Congress of Neurological Surgeons

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