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September 5, 2016

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1656-P
P.O. Box 8013
Baltimore, MD 21244-8013

Subject: CMS-1656-P Medicare Program; Revisions to the Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs for CY 2017; Electronic Health Record (EHR) Incentive Programs

Dear Mr. Slavitt,

On behalf of the American Association of Neurological Surgeons (AANS) and Congress of Neurological Surgeons (CNS), representing over 4,000 neurosurgeons in the United States, we appreciate the opportunity to comment on the above-referenced Notice of Proposed Rulemaking (NPRM).

Electronic Health Record (EHR) Incentive Program

Although unrelated to the Hospital Outpatient Prospective Payment (OPPS) and Ambulatory Surgical Center (ASC) payment systems, CMS uses this rule as an opportunity to propose changes to the Medicare Electronic Health Record (EHR) Incentive Program.

90-Day EHR Reporting Period in 2016

For 2016, CMS proposes to allow all eligible professionals (EPs) and eligible hospitals, including returning participants, to use a 90-day reporting period rather than report over the entire year. The AANS and CNS appreciate this proposal since it would provide EPs with more flexibility to acclimate to recently modified EHR Incentive Program measures. However, we are concerned that this proposal would not be finalized until November 2016, when it will be too late for EPs to take advantage of the 90-day reporting period. Therefore, we urge CMS to implement this policy as soon as possible. If that is not feasible due to the requirements of rulemaking, CMS adopt a hardship exemption that accommodates this change should physicians be unable to meet the 90-day reporting requirement as a result of the delays in finalizing a shorter reporting period.

New Participants in 2017

After the publication of the 2015 EHR Incentive Programs Final Rule, CMS determined that, due to cost and time limitation concerns related specifically to 2015 Edition Certified EHR Technology (CEHRT) updates in the EHR Incentive Program Registration and Attestation System, it is not technically feasible

for EPs and eligible hospitals that have not successfully demonstrated meaningful use in a prior year (i.e., new participants) to attest to the Stage 3 objectives and measures in 2017. Due to this technical barrier, CMS proposes that EPs and eligible hospitals that have not successfully demonstrated meaningful use in a prior year only would be required to attest to Modified Stage 2 measures by October 1, 2017. Returning EPs and eligible hospitals would report to different systems in 2017 and, therefore, would not be affected by this proposal. The AANS and CNS support this proposed accommodation, particularly in light of the revised measures and thresholds for Stage 3, which we continue to believe are overly challenging and unrealistic.

Significant Hardship Exception for New Participants Transitioning to MIPS in 2017

CMS proposes to offer a one-time significant hardship exception from the 2018 payment adjustment for individual clinicians who, as of 2017, have not yet successfully participated in the EHR Incentive Program, but plan to report on measures specified for the new Advancing Care Information performance category under the Merit-Based Incentive Payment System (MIPS) in 2017. This hardship exception would account for the confusing overlap with 2017 being the proposed performance period for the first MIPS payment adjustment in 2019, but also the last year in which new participants to the current EHR Incentive Program may attest to meaningful use (i.e., for a 90-day reporting period in 2017) to avoid a payment adjustment in 2018. The AANS and CNS support this proposal, but request that CMS adopt a hardship exception application process that is as simple and readily available as possible for EPs impacted by this policy since they will be expected to take action for both the EHR Incentive Program and MIPS.

Proposed Additional Hospital Value-Based Purchasing (VBP) Program Policies

Removal of the HCAHPS Pain Management Dimension from the Hospital VBP Program

CMS proposes to remove the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Pain Management Dimension from the Hospital Value-Based Purchasing (VBP) Program beginning with the FY 2018 program year due to concerns about the opioid epidemic. The questions that comprise this dimension are:

- During this hospital stay, did you need medicine for pain?
- During this hospital stay, how often was your pain well controlled?
- During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?

The AANS and CNS support efforts to measure aspects of pain management and ensure high-quality of care on this topic. However, we also concur with the agency's rationale for removing these measures from the Hospital VBP Program since they focus on pain control rather than communication, which could lead to perverse incentives to inappropriately prescribe pain medications, particularly in a program where payment is tied to measure performance.

Proposed Deletions from the Inpatient Only List

The AANS and CNS believe that the decision for the site of service in cases where a procedure may typically be performed safely in multiple settings should remain with the operating surgeon in consultation with the patient. As such, we support the CMS proposal to remove the following four spine procedures from the Inpatient Only List:

- CPT Code 22840 *Posterior non-segmental instrumentation (e.g., Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)*

- CPT Code 22842 *Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)*
- CPT Code 22845 *Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)*
- CPT Code 22858 *Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (List separately in addition to code for primary procedure)*

Proposed Additions to ASC Procedures List

In addition to our support for the for Inpatient Only list deletions, we agree with CMS' support to add the following codes to the ASC Covered Surgical Procedures list. Again, we believe that the operating surgeon should have the option to perform the procedures in an ACS for the appropriate patients. This does not imply that all patients, or even most, would be suitable candidates for the ASC; however, some may be.

- CPT Code 20936 *Autograft for spine surgery only (includes harvesting the graft); local (e.g., ribs, spinous process, or laminar fragments) obtained from the same incision (List separately in addition to code for primary procedure)*
- CPT Code 20937 *Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (List separately in addition to code for primary procedure)*
- CPT Code 20938 *Autograft for spine surgery only (includes harvesting the graft); structural, biocortical or tricortical (through separate skin fascial incision)*
- CPT Code 22552 *Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical C2, each additional interspace (List separately in addition to code for separate procedure)*
- CPT Code 22840 *Posterior non-segmental instrumentation (e.g., Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)*
- CPT Code 22842 *Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)*
- CPT Code 22845 *Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)*
- CPT Code 22851 *Application of intervertebral biomechanical device(s) (e.g., synthetic cage(s), methylmethacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure)*

Stereotactic Radiosurgery

The AANS and CNS support fair, adequate and stable reimbursement for stereotactic radiosurgery (SRS). We continue to be cautiously optimistic that CMS is getting the data it needs to identify costs for this important treatment modality correctly. We support the agency's efforts to maintain a clinically

appropriate and technology neutral definition of bundled services within comprehensive APC 5627. CMS should continue its evaluation of the costs of treatment planning services by separately paying for these services in 2017 and building a reliable data set to bundle services appropriately. We urge CMS to provide its analysis of the data used to reintegrate the costs of CT localization, MRI and clinical treatment planning services into C-APC 5627 in future rulemaking so that affected parties can provide informed feedback to the agency before implementation of any changes in reimbursement.

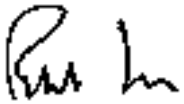
Complexity Adjustment for Deep Brain Stimulation

We are concerned about the proposal by CMS to eliminate the complexity adjustment for bilateral placement of single-array deep brain stimulation devices when placing or replacing deep brain stimulator (DBS) generators. In CY 2015, CMS made the decision to make the payment for placement of bilateral single array generators the same as a single dual channel array device. The payment was set at $26,728. This was due to a "complexity adjustment" modification. In the CY2017 NPRM, CMS proposes to eliminate the complexity adjustment, which would decrease the payment to $17,534 — resulting in 34.4 percent reduced payment. We believe that the decision is based on flawed data and appears to be based on one outlier hospital cost report. Supporters of this important technology are concerned that there were many additional hospital related cost reports for the same procedure that were not included in the data used to set the CY2017 payment. The proposed substantial payment reduction presents an abrupt and serious handicap to medical centers striving to sustain a deep brain stimulation program. DBS provides a vital treatment option — often the only effective treatment option — for patients with Parkinson's disease and other movement disorders. The AANS and CNS support appropriate compensation for these critical technologies so neurosurgeons can offer them to their patients.

CONCLUSION

The AANS and CNS appreciate the opportunity to provide feedback on these provisions. If you have any additional questions or need additional information, please feel free to contact us.

Sincerely,



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