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August 31, 2022

Ms. Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
ATTN: CMS-1751-P
P.O. Box 8013 Baltimore, MD 21244-1850

Submitted electronically via www.regulations.gov

Subject: CMS-1770-P Medicare Program; CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-Payment Medical Review Requirements.

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

CODING AND REIMBURSEMENT ISSUES

Conversion Factor

The AANS and the CNS are concerned about the overall decrease in the Calendar Year (CY) 2023 conversion factor. We urge CMS to take all possible actions to provide a positive update to the Medicare conversion factor in 2023.

Global Surgical Codes

The AANS and the CNS note the request from CMS for input on global surgical codes for possible future rulemaking. CMS should immediately increase the 10- and 90-day global codes to reflect the proportionate increase in value of the new evaluation and management (E/M) codes. Additionally, the agency should utilize the American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) to address any potentially misvalued global surgery codes.

Medicare Economic Index

The AANS and the CNS urge CMS to delay any change in the Medicare Economic Index (MEI) until the AMA's practice cost data collection work is completed. Furthermore, CMS should not consider using

other cost data sources for calculating the MEI until the AMA project is finished and the data has been reviewed.

Evaluation and Management Codes

- **E/M Increases in the Global Surgery Codes**. Again, the AANS and the CNS continue to urge CMS to apply the RUC-recommended changes to the E/M component of the 10- and 90-day global surgery codes to maintain the relativity of the fee schedule and to comply with the Medicare law's prohibition on specialty payment differentials.

- **Split/Shared Visits**. The proposed rule defines split (or shared) E/M visits as visits provided in a facility setting by a physician and a non-physician provider in the same group and delays for one year, the requirement that the practitioner who provides the substantive portion of the visit would bill for the visit. The AANS and the CNS are pleased with the delay and urge CMS to eliminate the proposal.

Practice Expense (PE) RVUs

- **CMS Changes to Direct PE Inputs for Neurosurgery Codes.** CMS proposes removing 125 minutes of equipment time for an exam light for spine CPT codes 63020 and 63030. However, we believe the exam light is needed to check for possible seroma and to examine and take out stitches. We urge CMS not to remove the exam light expense from these code values.

- **Pre-Service Clinical Labor Time for Surgical Procedures**. The AANS and the CNS agree with the RUC that last year, for major surgical procedures with 000 and 10-day global periods — such as the Interstitial Thermal Therapy (LITT) procedures (CPT codes 61736 and 61737) — CMS inappropriately reduced the PE pre-service clinical labor time from 60 to 30 minutes. We support the new RUC clinical labor time packages recognizing major in-facility procedures' pre-service clinical labor time.

CMS Valuation of Specific Codes

- **CMS Should Accept RUC-Recommended Values**. The AANS and the CNS recommend that CMS accept RUC-passed values, which are based on valid, clinically relevant information that preserves relativity.

- **Arthrodesis Decompression (CPT codes 22630, 22632, 22633, 22634, 63052 and 63053)**. The AANS and the CNS urge CMS to accept the RUC-recommended values for these codes.

- **Lumbar Laminotomy with Decompression (CPT codes 63020, 63030, and 63035)**. The AANS and the CNS urge CMS to accept the RUC-recommended values for these codes.

- **Spine Allograft Code (CPT code 23091)**. The AANS and the CNS agree with the agency's decision not to designate CPT code 23091 as misvalued.

Telehealth — Neurostimulator Pulse Generator/Transmitter

- **Analysis of cranial nerve neurostimulation (CPT codes 95976 and 95977)**. The AANS and the CNS agree with CMS' proposal not to add these codes to the Medicare Telehealth Services List

because the full scope of service elements described by these codes cannot currently be furnished via two-way, audio-video communication technology.

- **General brain nerve neurostimulation (CPT codes 95970, 95983, 95984)**. The AANS and the CNS disagree with the CMS proposal to limit these codes to the Medicare Telehealth Services List on a Category 3 basis. Given safeguards in the devices, we believe these procedures should be added to the telehealth list permanently to allow them to be performed remotely, even after the PHE.

QUALITY ISSUES

- The AANS and the CNS urge CMS to maintain measures that lack a benchmark to ensure a diverse inventory of measures that reflect specialty care.

- For the agency's proposed changes to the Back Pain After Lumbar Fusion and Leg Pain After Lumbar Fusion quality measures, the AANS and the CNS strongly oppose lumping fusions in with discectomies/decompressions since this would not reflect the indications and expectations for surgery.

- The AANS and the CNS strongly urge CMS to encourage Congress to make technical updates to the Medicare Access and CHIP Reauthorization Act (MACRA) to (1) extend the incentive payments for qualifying participants (QPs) in Advanced APMs, and (2) maintain the current QP threshold levels.

DETAILED COMMENTS

CODING AND REIMBURSEMENT ISSUES

Conversion Factor

The AANS and the CNS are concerned about the overall decrease in the CY 2023 conversion factor. At a time when physicians face continued challenges from the COVID-19 pandemic and steep inflation, a cut in the conversion factor is particularly distressing. **The AANS and the CNS urge CMS to take all possible actions to provide a positive update to the Medicare conversion factor in 2023**.

Global Surgical Codes

The AANS and the CNS are concerned with the agency's failure to resolve outstanding global surgery code values issues. We are particularly frustrated that CMS has refused to adjust the 10- and 90-day global surgery codes to reflect recent increases in the E/M codes.

For nearly a decade, the AMA and the surgical community have engaged in a good-faith dialogue with CMS, yet issues related to the global surgery codes remain unresolved. While we believe there is little more to say on this subject — given the extensive comments and input that CMS has received — we join the surgical community in reiterating our willingness to work with the agency to ensure that the global surgery codes are appropriately valued. To this end, we offer the following comments and recommendations in response to the agency's request for strategies for improving global surgical package valuation in preparation for future rulemaking.

- **Global Surgical Codes and Changes in the Health Care Landscape.** CMS has asked if changes in the health care practice environment, including the recent COVID-19 Public Health Emergency

(PHE) and advances in medical technology, have impacted the relevance of the global packages. Neurosurgeons have continued to care for their patients during the global period, which has not changed during the PHE or otherwise. Modifiers account for situations where the operating surgeon does not provide post-operative care — though this rarely occurs in neurosurgical practice, as the care of the neurosurgical patient extends far beyond the operating room. For some procedures, such as the new LITT procedures valued last year, we have recommended a 000-day global period because the procedure is used for both epilepsy and brain procedures, for which the post-operative care may vary. On a limited basis, surgical specialty societies and CMS can assess similar procedures, for which 000 makes sense. However, there are several issues to address in that case, including the pre-service clinical staff time.

- **Impact of Recent Coding and Valuation Changes for E/M Services on Global Packages.** The AANS and the CNS continue to strongly object to the failure of CMS to incorporate the adjusted values for the revised office/outpatient E/M codes into the global surgical codes. By setting aside the explicit recommendations from the RUC and failing to incorporate the recommended work and time values for the revised office visit E/M codes for CY 2021 into adjustments to the 10- and 90-day global codes, CMS improperly failed to implement new E/M values in an arbitrary fashion that specifically undervalued the work of providers these procedures.

- **Necessary Additional Care of the Surgical Patient Furnished in Global Services.** In addition to visit services, there are many other post-operative care services included in 10- and 90-day global packages, such as:

  + Dressing changes;
  + Local incision care;
  + Removal of operative packs;
  + Removal of cutaneous sutures, staples, lines, wires, tubes, drains, casts and splints;
  + Insertion, irrigation and removal of urinary catheters;
  + Routine peripheral intravenous lines; and
  + Changes and removal of tracheostomy tubes.

  These essential services must be considered when the global service work is reviewed, as merely stripping out visits and permitting them to be reported separately does not account for the work of many procedures reported in the global packages. Furthermore, post-operative work also includes non-facing services such as conversations with patients over the phone, by email or via telehealth to answer patient questions regarding wound healing, pain management and other medication-related issues.

- **Flaws in the RAND methodology.** We have not changed our views on the flaws of the original RAND reports. The AANS and the CNS thoroughly reviewed the three RAND reports when they were first released. We support the RUC comments regarding the flaws in the RAND reports. To the extent there may be specific outlier global surgical procedures that the RUC has not recently reviewed, CMS can follow well-established precedent by identifying those codes as potentially misvalued and allow the RUC to conduct a thorough review without a sweeping, useless and burdensome disruption to surgeons and their patients. Otherwise, no further action on this project is warranted. Below we have repeated some of our comments on each RAND report.

  + **RAND Report 1, Claims-Based Reporting of Post-Operative Visits for Procedures with 10- or 90-Day Global Periods**. Since July 1, 2017, Medicare practitioners in nine states have been required to report on their post-operative visits during the global period of specified procedures

using CPT code 99024 (post-operative follow-up visit). The AANS and the CNS agree with the RUC that this dataset cannot reasonably be used to forecast any overall trends, given the limited and likely intermittent participation of eligible physicians as well as the current difficulty the agency and RAND researchers have implied in matching up procedures to CPT code 99024. Only 46 percent of expected practitioners to participate submitted tracking code 99024 through June 2018. Fifty-four percent of physicians eligible for this data collection project were either unaware of the requirement to participate or unable to participate for another reason. Also, only 17 percent of eligible physicians were classified as "robust reporters," indicating that a majority of those that did participate did so intermittently or did not begin until partway through the reporting period. If most eligible providers did not participate in a CPT code, which was the case for many codes, the median count of post-operative visits would be zero, irrespective of what study participants reported; thus, the mean number of visits would be greatly understated.

Furthermore, the dataset that includes only practices with 10 or more practitioners is potentially not representative as most physicians are in practices that have fewer than 10 providers. The AMA 2018 Physician Practice Benchmark Survey indicated that 54 percent of physicians are in practices with fewer than 10 physicians. Also, for surgical specialties, 64 percent of physicians are in practices with fewer than 10 physicians. We are especially concerned about this issue with practicing neurosurgeons, who often practice in groups smaller than 10.

The AANS and the CNS strongly disagree with the RAND conclusion that only 39 percent of 90-day global visits and 4 percent of 10-day global visits were performed**.** There are many flaws in the computation to arrive at these figures. First, 54 percent of physicians in the nine states who were eligible to participate did not do so. RAND inappropriately assumes that each of these physicians did not provide any office visits in any surgery's global period. RAND also did not distinguish between post-operative visits performed in the hospital setting and those in the office. This is problematic for many neurosurgeons, whose patients can spend several days in the hospital. For physicians who use a separate electronic health record system in the office than the hospital where they perform surgery, there may be challenges in capturing and submitting claims for post-operative in-hospital visits.

RAND also acknowledged the difficulty in matching 99024 visits to their associated procedures. The researchers chose to limit the potential confounder of multiple procedures performed during the same global period by focusing their analysis on so-called "clean" procedures — that is, procedures with no overlap with any other procedures during the global period. This, however, led to a significant reduction of available so-called "clean" procedures, which represented only about 60 percent of the available 90-day global procedures. However, for procedures in the category of "Nervous System: Spine and Spinal Cord," this represented less than 40 percent of the available procedures.

The information gathered cannot be extrapolated to all 10- and 90-day surgical global services. **Therefore, the AANS and the CNS recommend that CMS not implement any changes in the global surgical services based on the RAND sample of physicians reporting CPT code 99024 and abandon further such data collection altogether.**

+ **RAND Report 2: Survey-Based Reporting of Post-Operative Visits for Select Procedures with 10- or 90-Day Global Periods**. CMS contracted with RAND to conduct a survey to collect additional data on post-operative services, including the level of post-operative services. RAND launched a survey pilot in the fall of 2017 with a sample size of 557 practitioners and received only a single complete response. Following this setback, CMS and RAND decided to significantly narrow the scope of their survey initiative to only three high-volume services: cataract surgery

(only CPT code 66984), hip arthroplasty (only CPT code 27130) and complex wound repair (CPT codes 13100, 13101, 13120, 13121, 13131, 13132, 13151, and 13152).

Beyond the obvious limitations of the survey instrument examining less than one thousand physicians who perform three procedures, RAND's main conclusion in the second report is flawed. They assert that the average visits were somewhat shorter than anticipated for cataract surgery (16.4 minutes vs. 19.4 minutes) and hip arthroplasty (22.9 minutes vs. 29.6 minutes) and longer for complex wound repair (21.8 minutes vs. 16 minutes). However, RAND misinterpreted the findings of their survey data as they compared only the survey physician time "on the day of the visit" to the CMS physician time file, where the pre-service and post-service time of E/M services are not specific to the date of the encounter. The researchers also inappropriately excluded nurse practitioner (NP) and physician assistant (PA) time from their visit time comparison analysis. Additionally, in 2019, time is not the only factor relevant in selecting a code level.

RAND categorized NP/PA survey data as "staff time" and incorrectly observed that "…such staff time would be considered as part of PE in the RUC process and not contribute to the physician time component nor to the level of the visit." While this is the case for work performed by clinical staff, this is never the case for qualified health care professionals who can separately report Medicare services. The researchers did not account for Medicare rules on "incident to" and split/shared E/M services. When an NP or PA assists with an office visit, both the physician and NP/PA work are used to select the visit level if the requirements for "incident to" are met, and the patient is an established patient.

Most importantly, the new E/M office visit framework allows a physician to report a 99212 if 10 minutes are spent on the date of the encounter. Most surgical post-operative office visits are attributed as 99212 in the global surgical period in determining physician work, physician time and practice expense. The RAND survey instrument had significant methodological flaws, but the new coding structure developed by the RUC renders this RAND report moot.

+ **Rand Report 3: Using Claims-Based Estimates of Post-Operative Visits to Revalue Procedures with 10- and 90-Day Global Periods**. This third study used the reverse building block methodology to estimate the change in Medicare payment based on RAND's summary data from the first study. The analysis included in this study is extremely flawed and disingenuous. The researchers completely disregarded the "robust reporters" concept highlighted in the first study. They did not attempt to filter out the 54 percent of eligible providers that did not participate in the data collection initiative. When 54 percent of eligible providers were assumed never to perform post-operative visits simply because they were unaware or unable to participate in the data collection project, the median number of visits for many surgical global codes would be zero, irrespective of what participating physicians reported. Also, as no specialty achieved a 100 percent participation rate, all codes included in the study would have been undercounted to some extent.

For neurosurgery, specifically, the numbers extrapolated by RAND based on their claims data bear no resemblance to actual clinical practice. For example, two of the 15 neurosurgical codes captured by the RAND analysis — CPT codes 61312 and 61510 — represent craniotomy codes, one for the evacuation of a hemorrhage and the other for the resection of an intracranial tumor. Both of the patient populations represented by these procedures are medically complex. They are typically seen multiple times — both in the hospital (often in intensive care unit setting) and in the clinic in the global period. However, according to the RAND analysis, the most common (mode) number of post-operative visits for these two procedures was zero, meaning that RAND

concluded that neurosurgeons never see patients who have undergone these procedures in the post-operative period. Obviously, this is grossly inaccurate and highlights the lack of utility in the RAND data. Therefore, it is unreasonable to draw conclusions from this flawed data or make any significant changes in the payment of the global codes based on these findings.

The AANS and the CNS concur with the AMA and RUC, which object to the "reverse building block methodology" to systematically reduce work RVUs for services. We contend that the reverse building block methodology, or any other purely formulaic approach, should never be used as the primary methodology to value services. It is inappropriate as magnitude estimation has been used to establish work RVUs for services since the first Medicare physician payment schedule was published in 1992. This methodology, for example, ignores the care coordination work performed during the global surgical period, as evidenced by the flawed RAND survey of hip arthroplasty analysis.

Implementation of the methodology outlined in this RAND report would result in unreasonable reductions in total Medicare payment for many surgical specialties, putting at risk access to care for Medicare beneficiaries (e.g., payment reductions of 18.4% for cardiac surgery, 18.1% for surgical oncology, and 13.5% for neurosurgery). Such steep reductions are unwarranted, particularly if based on the flawed RAND methodology.

In summary, the results from the RAND studies should not be used to justify distorting the relativity of office visits within the RBRVS.

- **Strategies for a Revaluation Process for Global Services**. The AANS and the CNS believe the RUC Relative Value Workgroup (RAW) process to identify misvalued codes is the fairest, most accurate and appropriate way to address visits in the post-operative period. **For the reasons we have stated above, the RAND reports are flawed and a wholesale effort to review all the 10- and 90-day global period codes is unnecessary. Furthermore, CMS must increase the global codes to account for the proportionate increases included in the stand-alone E/M office visit codes**. Again, we point out the overwhelming support by RUC members and others for CMS to take this action and urge CMS to finalize a policy that adopts this recommendation for the 2023 Medicare physician fee schedule. Finally, **CMS should follow well-established precedent by identifying global codes it believes are potentially misvalued and allowing the RUC to conduct a thorough review to determine whether any changes in value are necessary**.

Medicare Economic Index

The AANS and the CNS have reviewed the discussion in the proposed rule on the agency's considerations for updating the MEI. **We urge CMS to delay any change in the MEI until the AMA's practice cost data collection work is completed. Furthermore, CMS should not consider using other cost data sources for calculating the MEI until the AMA project is finished and the data has been reviewed**.

From the inception of the MEI in 1975 — when payments reflected the usual, customary and reasonable charge payment methodology — through 1993 — the year after implementation of the Resource Based Relative Value Scale (RBRVS) — the physician work component was 60 percent, and the practice expense component, including professional liability insurance (PLI) costs, was 40 percent. These initial weights were derived from data obtained from the AMA. In the nearly 50 years since the initial MEI was established, data collected by the AMA has served as the consistent source of information about physician earnings and practice costs. In 1993, the MEI components were updated using AMA data and then apportioned to 54.2 percent physician work, 41 percent practice expense and 4.8 percent PLI. The

current allocation is 50.9 percent physician work, 44.8 percent practice expense and 4.3 percent PLI. The CMS proposal would drastically shift this allocation to weigh practice costs more than physician work — 47.3 percent physician work, 51.3 percent practice expense and 1.4 percent PLI — using non-AMA data. This proposal is particularly outrageous for specialties like neurosurgery with significant PLI premiums. Indeed, the current allocation of PLI costs already undervalues neurosurgery PLI costs, which typically account for more than the current 4.3 percent weighting. A reduction to 1.4% would exacerbate an already inequitable situation.

CMS proposes to update the MEI weights using 2017 data from the United States Census Bureau's Service Annual Survey (SAS), a data source that was never intended to update the MEI. As the AMA has pointed out, the proposed shift in payment weights from physician work to practice expense principally favors diagnostic testing facilities (+13%), portable x-ray suppliers (+13%), independent laboratories (+10%) and radiation therapy centers (+6%) to the detriment of cardiothoracic surgery (-8%), neurosurgery (-8%), emergency medicine (-8%) and anesthesiology (-5%). Modest increases occur for specialties that provide services in the office with costly disposable supplies embedded into physician payment. Primary care would also face decreases — family medicine (-1%), geriatrics (-2%), internal medicine (-2%) and pediatrics (-2%). Such significant decreases in payment from physician work would be devastating, especially when coupled with a steep decrease in the Medicare conversion factor, the continued impact of the COVID-19 pandemic and, certainly in the case of neurosurgery, a reduction in the valuation of key procedures.

In addition, the AMA has pointed out that geographic redistribution would also occur, as CMS proposes to modify the weights of the expense categories (employee compensation, office rent, purchased services and equipment/supplies/other) within the practice expense Geographic Practice Cost Index (GPCI). A significant reduction in the weight of office rent from 10.2 to 5.9 percent would lead to cuts in payments to urban localities and increases in payments in rural areas and states with a single GPCI. The agency's impact analysis should also be expanded to consider how significant decreases in PLI payments may negatively impact geographical regions with relatively high PLI premiums.

The MEI changes that CMS proposes are almost entirely related to the category weights primarily derived from the Census Bureau's 2017 SAS for the "Offices of Physicians" industry, which, as we have pointed out above, was not designed with the purpose of updating the MEI. Therefore, CMS must use data from other sources to fill in the gaps, a wasted effort that could be saved by waiting for the AMA data to be complete. Again, we strongly recommend that the agency study the AMA's comments and join them in pointing out below the flaws in using Census Bureau data, to wit:

- Seven percent of the revenue for "Offices of Physicians" on the 2017 SAS was from non-patient care sources (e.g., grants and investment income). Any expenses associated with these sources cannot be excluded.

- The SAS for "Offices of Physicians" collects payroll and benefits for all staff combined, but the MEI has separate cost categories for physician and non-physician compensation. Non-physician compensation is further broken out in the MEI by staff type. CMS is proposing to use the Bureau of Labor Statistics (BLS) 2017 Occupational Employment and Wage Statistics (OEWS) data to estimate the share of SAS personnel costs that apply to physicians (including qualified health care professionals (QHPs)) and non-physicians. Based on the 2017 OEWS, CMS states that 63.2 percent of employee compensation for "Offices of Physicians" is for physicians and QHPs. CMS appears to have misclassified registered nurse salaries in this estimate.

  Additionally, the OEWS only covers employees, so it is missing compensation for a large segment of the physician population (practice owners). To compensate, CMS is proposing to

estimate total compensation for practice owners as a share of practice net income from the 2017 SAS (the difference between total revenue and total expense, which amounted to $44.9 billion out of $490.9 billion in revenue for 2017). The share of net income proposed is the estimated percent of patient care physicians that are owners (46.5%), averaged from the 2016 and 2018 AMA Physician Practice Benchmark Surveys, resulting in an estimated $20.9 billion in compensation for owners. CMS's estimate of $20.9 billion in compensation for owners represents just 10 percent of total compensation for all physicians and QHPs ($203.8 billion), which is far out of line with any reasonable estimate since nearly half of physicians in the United States are owners.

- CMS used BLS data to split out the US Census SAS data using the North American Industry Classification System (NAICS) 6211 "Offices of Physicians" category. However, only 64 percent of employed physicians are in this category in both the U.S. Census SAS and BLS OEWS datasets. This analysis excludes 36 percent of physicians employed in other health care settings, such as hospitals. For example, the NAICS 6221 "General Medical and Surgical Hospitals" category was not included in the agency's analysis, and this category includes 158,880 employed physicians according to the 2017 BLS OEWS data. Hospital-based physicians have a higher proportion of physician earnings and PLI costs relative to other practice costs, as many of these costs are the responsibility of the hospital or other facility. The CMS proposal greatly underrepresents the cost share of physician work and PLI relative to practice expense due to this inappropriate exclusion.

- In the current MEI, CMS excludes expenses for separately billable supplies and drugs. The 2017 SAS for "Offices of Physicians" has a single category for medical supplies without any breakout for the separately billable component. To estimate separately billable supply and drug expenses, CMS proposes to age forward AMA-PPI results for these expenses and then compare the estimated total to medical supplies expense from the SAS (finding that 80% of medical supplies expense is for separately billable medical supplies or drugs). There are two problems with the CMS proposed approach:

    1) The measures used to age expenses forward are not entirely appropriate (using growth in Medicare Part B drug spending when an all-payer measure would be better and using measures of inflation — CPI and PPI from BLS — to age spending); and
    2) Totals estimated from two entirely different surveys are being compared when those surveys may have different populations and methods (for example, the wording of the questions and direction on what to include in the category could be entirely different).

- The dramatic decrease in the weight for PLI cost seems unrealistic and is particularly concerning to neurosurgery. In 2021, the Medicare physician fee schedule allowed charges totaled $91 billion. If PLI payment only represented 1.4 percent of this payment, total Medicare spending on its share of these premiums and self-insured actuarial costs would be $1.274 billion. With more than one million physicians and other health care professionals billing Medicare, this would compute to Medicare paying an average of $1,275 per individual. Assuming Medicare represents approximately 25 percent of physician payment, an understated $5,100 in PLI premium cost results. This contradicts the volume weighted PLI premium costs of $21,700 computed by CMS elsewhere in the proposed rule. A 4-5 percent PLI weight appears more appropriate than the proposed 1.4 percent — although this still likely understates the allocation of PLI expenses for high-risk specialties like neurosurgery.

We urge CMS to collaborate with the AMA in its physician practice expense data collection effort to ensure consistency and reliability in physician payment. Updating the MEI weights should be postponed until new AMA survey data are available.

Practice Expense RVUs

- **CMS Changes to Direct PE Inputs for Neurosurgery Codes**. CMS proposes removing 125 minutes of equipment time for an exam light for spine CPT codes 63020 and 63030. However, we believe the exam light is needed to check for possible seroma and to examine and take out stitches. The standard overhead lighting in an exam room is insufficient to examine these patients' wounds, and an exam light is required to check for infection and wound healing. **We urge CMS not to remove 125 minutes of equipment time for exam light for these procedures.**

- **Clinical Staff Pre-Time for Major Surgical Procedures**. In the CY 2022 Medicare Physician Fee Schedule (MPFS) Final Rule, CMS reduced the RUC-recommended pre-service clinical staff time for CPT codes 61736 and 61737 for LITT from 60 minutes to 30 minutes because these are 000-day global codes. We continue to disagree with CMS' action on this. As a compromise and accommodation to CMS, the RUC recently developed a pre-service clinical staff time package for major surgical procedures that are 000 or 10-day global periods yet require greater time than the standard 000 and 10-day clinical staff time packages. **The AANS and the CNS agree with the RUC that clinical labor time for major surgical procedures with 000 and 10-day global periods should be reviewed on a case-by-case basis**. Although the post-service clinical labor time varies based on the global period, the pre-service time remains the same, regardless of the global period. Again, we believe the RUC can address these issues on a case-by-case basis. However, we concur that the RUC-recommended "comprehensive" category reasonably follows "extensive use" and helps to more appropriately account for the comprehensive care required for the patients involved in major surgical procedures. In addition to procedures such as LITT, which were proposed as new codes with 000-day global periods, the new pre-service package would also encompass the global conversions from 90-day to 000 or 10-day global periods, such as the recently valued hernia codes developed by the American College of Surgeons last year. **We urge CMS to accept the new RUC additional pre-service clinical staff time package**, Comprehensive Use of Clinical Staff," as an option for those procedures in the facility setting that are assigned 000 or 10-day global periods yet require pre-service clinical staff time commensurate with a 90-day procedure. In addition, **we ask that CMS restore the pre-service clinical staff time for LITT CPT codes 61736 and 61737 using the new RUC packag**e.

CMS Valuation of Specific Codes

The AANS and the CNS are concerned with the increased incidence of CMS reducing RUC-recommended values. **We agree with the RUC that any suggested approach that uses "reverse building block methodology" to systematically reduce work RVUs (wRVUs) for services is flawed**. Reverse building block methodology, or any other purely formulaic approach, should not be used as the primary methodology to value services. Magnitude estimation has been used to establish wRVUs for services since the implementation of the first MPFS in 1992.

Below are detailed comments on eight spine codes for which CMS has reduced the RUC-passed wRVUs.

We appreciate the agency's willingness to discuss these eight codes at an August 25, 2022, virtual meeting with physicians and staff from the AANS, CNS, North American Spine Society, American Academy of Orthopaedic Surgeons and the International Society for the Advancement of Spine Surgery. During the call, CMS staff asked why the ZZZ global period ("add-on") CPT codes 63052/53 in the arthrodesis decompression set of codes had lower time but a higher value than the ZZZ global period ("add-on") CPT code 63035 in the laminotomy decompression set of codes. We appreciate this question as it goes to the heart of the importance of understanding that work valuation includes both time and

intensity/complexity. The two add-on codes are part of separate and distinct procedures. CPT codes 63052/53 describe the work of decompression after the work of the base CPT codes 22630/33 is completed. CPT codes 63052/53 are intense, high-risk work. After the less intense surgical exposure work has already been performed as part of the base code, the physician work of CPT codes 63052/53 involves the high intensity, dangerous aspects of neural element and spinal cord decompression. CPT code 63035 describes an additional level for a lumbar or cervical laminotomy. Although this procedure does take more time than the decompression procedure, some of the time in CPT code 63035 is of lower intensity. A discectomy is less complex than an interbody fusion. **We believe the RUC-recommended values and times for these codes are accurate, and we appreciate the opportunity to clarify the issue**.

- **Arthrodesis Decompression (CPT codes 22630, 22632, 22633, 22634, 63052, and 63053)**

Code	Long Descriptor	CMS Proposed wRVU	RUC Recommended wRVU
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar	20.42	22.09
22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)	5.22	5.22
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; lumbar	24.83	26.80
22634	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; each additional interspace and segment (List separately in addition to code for primary procedure)	7.30	7.96
63052	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [e.g., spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)	4.25	5.70
63053	each additional segment (List separately in addition to code for primary procedure)	3.78	5.00

Following a long history with CMS on the arthrodesis decompression issue, which resulted in two new codes — CPT Codes 63052 and 63053 — in January 2021, the AANS and the CNS, along with other spine societies, surveyed these new codes. The RUC submitted interim values for these codes and asked the organizations to resurvey them, along with CPT Codes 22630, 22632, 22633 and 22634. **The AANS and the CNS support the RUC-passed values and urge CMS to accept the values based on the rationale below:**

+ **CPT Code 22630.** CMS proposes a wRVU of 20.42 for CPT code 22630, rather than the RUC-recommended wRVU of 22.09, based on reverse building block methodology to account for the surveyed reductions in physician time. CMS states that it would be inappropriate to maintain the current wRVU given the decrease in intra-service time, absent an obvious or explicitly stated rationale for why the relative intensity has increased. The RUC thoroughly considered the reduction of intra-service time of 30 minutes for 22630 and crosswalk code alternatives; none of the crosswalk code options were deemed clinically comparable or sufficiently matched to the difficulty of the procedure. The change in time for CPT code 22630, since it was valued in 1995, was attributed to changes in technology that reduced operator time but increased the intensity of the service provided within that time. Routine use of fluoroscopy to obtain intraoperative films may decrease the time required for the procedure, but the surgeon is using that data in real-time to determine the positioning and safety of hardware placement. Using high-speed electric drills eliminates the routine need to change out air pressure tanks required for pneumatic drills, but the differences in torque and handling change the “feel” of a procedure involving a high-speed drill close to the spinal nerves. Pneumatic drills were routinely used in 1995; electric drills were unavailable when CPT code 22630 was initially valued.

  Hence, the decrease in intraoperative time is due to a reduction in time devoted to low-risk and less intense portions of the procedure (e.g., waiting on a radiology technician to obtain an intraoperative cross-table lateral film; waiting for X-ray films to be developed after a flat plate film was taken and waiting for air tanks to be changed out for a pneumatic drill). However, the decrease in intra-service time is matched by a related increase in the intensity of the procedure itself. The lower intensity aspects of the procedure have been eliminated, leaving the high-risk elements unchanged. As the RUC noted, while the procedure may be more efficient, it is not safer or less difficult. The risks of the procedure — the possibility of neurological injury — and technical demands of the procedure are now provided in less time with greater intensity. Therefore, the current value should be maintained.

  By proposing to base the wRVU of CPT code 22630 on the reverse building block methodology, CMS disregards the input from 111 neurosurgeons, orthopaedic spine surgeons and the RUC. **The AANS and the CNS agree with the RUC that any suggested approach that uses “reverse building block methodology” to systematically reduce wRVUs for services is flawed**. **Reverse building block methodology, or any other purely formulaic approach, should not be used as the primary methodology to value services**. It is inappropriate as magnitude estimation has been used to establish wRVUs for services since the publication of the first MPFS in 1992. This includes 10- and 90-day global codes, which include post-operative office visits.

  Reductions in intraoperative time from the current values to the survey values can be attributed to improvements in the intraoperative workflow and the surgical technique regarding low-risk aspects of the procedure. These low-risk aspects of the procedure do not entail work around neural elements and the spinal cord. They do not change the procedure's inherent high intensity and complexity, which has not decreased. The RUC also noted that the total recommended time of 479 minutes is nearly identical to the current total time from the original review in 1995. The

post-operative visits have decreased by one, but the level of the visits has changed, practically resulting in a net change of zero in overall physician time despite the decrease of one visit.

Finally, to justify the current wRVU of 22.09, the RUC compared the survey code to the top key reference service CPT code 22533 (Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar) — with wRVUs of 24.79, 180 minutes intra-service time and 549 minutes total time — and CPT code 22612 (Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)) with wRVUs of 23.53, 150 minutes intra-service time and 482 minutes total time. The RUC noted that the majority of respondents indicated that the overall intensity/complexity of code 22630 is somewhat or much more relative to the key reference codes.

The AANS and the CNS join the RUC in disagreeing with the agency's use of reverse building block methodology for valuing services and strongly recommend that CMS maintain the wRVU of 22.09, which falls below the survey 25th percentile. Again, the AANS and the CNS urge CMS to accept a wRVU of 22.09 for CPT code 22630.

+ **CPT Code 22633.** For CPT code 22633, CMS disagrees with the RUC-recommended wRVU of 26.80 and proposes a wRVU of 24.83 based on the reverse building block methodology. CMS believes its proposed wRVU is more accurate than the RUC-recommended wRVU because there was no explicitly stated rationale in the RUC's recommendations for the change in intensity of intra-service time, and there was a 20-minute decrease in intra-service time for CPT code 22633.

Similar to the discussion regarding CPT code 22630, reductions in intraoperative time from the current values to the survey values are due to improvements in intraoperative workflow and techniques regarding aspects of the procedure that do not involve work around neural elements and the spinal cord and do not change the inherent high risk of this procedure. The complexity and intensity of the procedure have not changed; instead, it is now "packed into" a shorter intraservice time.

For CPT code 22633, the RUC determined that changes in intra-service and total time for the procedure warranted a direct wRVU crosswalk to Multi-specialty Points of Comparison (MPC) CPT code 55866 (Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed) — with wRVUs of 26.80, 180 minutes intra-service and 442 minutes total time — which fell below the survey 25th percentile and has identical intra-service time that appropriately accounts for the entire physician work involved in this service. The RUC used a crosswalk due to the changes in visits that caused a decrease in total time, primarily due to a change in inpatient care. Previously, there were two level-3 hospital visits and one level-2 hospital visit. This has been decreased to two level-2 and one level-1 inpatient visit along with a discharge day visit causing a substantial decrease in total time for the procedure, more significant than the decrease in intra-service time; thus, a crosswalk was selected, rather than recommending maintaining current value.

The RUC values services using magnitude estimation, not reverse building block methodology, and justified the crosswalk value of 26.80 wRVUs by comparing the survey code to the top key reference service code 22612 (Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed) — with wRVUs of 23.53, 150 minutes intra-service time and 482 minutes total time — and a second key reference code 22857 (Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace

(other than for decompression), single interspace, lumbar) — with wRVUs of 27.13, 180 minutes intra-service time and 550 minutes total time.

The AANS and the CNS join the RUC in objecting to reverse building block methodology and agree that CPT code 22633 should be valued based on a direct wRVU crosswalk to CPT code 55866, which falls below the survey 25th percentile. The AANS and the CNS urge CMS to accept a wRVU of 26.80 for CPT code 22633.

+ **CPT Code 22634.** For CPT code 22634, CMS proposes a wRVU of 7.30 rather than the RUC-recommended wRVU of 7.96, based on a comparison to its base code, CPT code 22633. The proposal is derived by dividing the proposed parent code's wRVU by its current wRVU and multiplying it by the current wRVU for add-on CPT code 22634. The current value for CPT code 22634 is also based on a calculation in 2011 that estimated the new add-on code was 70 percent of the survey 25th percentile wRVU. CMS proposes a new and flawed approach to determine the wRVU and claims it accounts for the decrease in intra-service time. Meanwhile, the RUC recommends reducing the wRVU to account for the decrease in median intra-service time and recommends 65 minutes of intra-service time, as supported by the survey.

  By proposing to establish the wRVU for CPT code 22634 using an equation based on its base code, CMS disregards the input of 111 neurosurgeons, orthopaedic spine surgeons and the RUC. As we have stated above and in numerous previous comments, we object to any purely formulaic approach as the primary methodology to value services. This differs from the RUC methodology, using survey data to determine the RVU and then comparing it with key reference codes based on similar intra-service time and total time. Clinical expertise from physicians familiar with the procedure is essential to determine the most accurate valuation.

  The survey code is well bracketed by comparator CPT code 34820 (Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)) — with wRVUs of 7.00, 60 minutes intra-service and total time — and CPT code 33746 (Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catheterization for congenital cardiac anomalies, and target zone angioplasty, when performed (e.g., atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); each additional intracardiac shunt location (List separately in addition to code for primary procedure)) — with wRVUs of 8.00, 60 minutes intra-service and total time. CMS notes that its proposed value is bracketed by similar comparison codes (CPT codes 34820 and 34833), calling to question the use of a formula rather than the robust survey data.

  Using magnitude estimation, the AANS and the CNS concur with the RUC that CPT code 22634 should be valued at the 25th percentile wRVU, less than the current value, and supported by the survey. The AANS and the CNS urge CMS to accept a wRVU of 7.96 for CPT code 22634.

+ **CPT Code 63052.** CMS disagrees with the RUC's wRVU recommendation of 5.70 for CPT code 63052, which accounts for an increase in intra-service time from the most recent survey. Instead, CMS proposes maintaining a wRVU of 4.25 as finalized in the CY 2022 MPFS final rule. CMS based its value on a crosswalk to CPT code 22853 (Insertion of interbody biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to intervertebral disc space in conjunction with interbody

arthrodesis, each interspace (List separately in addition to code for primary procedure)) — with wRVUs of 4.25 and 45 minutes intra-service time — and proposes to maintain this value because the intra-service times now match.

CPT code 22853 is not a valid crosswalk code because it does not entail the work of decompressing neural elements and removing compression around the spinal cord. Further, CPT code 22853 should not be used as a crosswalk due to multiple process issues concerning its valuation. The RUC-recommended value for CPT code 22853 of 4.88 wRVUs was less than the 5.25 wRVUs recommended by the physician survey. A crosswalk was used to define the value of 22853, comparing the code to 57267 (Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (List separately in addition to code for primary procedure)) — with wRVUs of 4.88, 45 minutes total time. CMS ignored the extensive RUC rationale and instead imposed a value for CPT code 22853 of 4.25 wRVUs. By using CPT code 22853 to value CPT code 63052, a code surveyed twice recently with consistent values, CMS uses an invalid method to propose a work value for CPT code 63052.

We note that the intra-service time increased by five minutes to a total of 45 minutes and that the time included in this add-on service is essentially all high-risk. The lower intensity surgical exposure activities have already been completed with the base code, so the physician work of 63052 involves only the high intensity, dangerous aspects of neural element and spinal cord decompression.

CMS states that commenters on the CY 2022 MPFS proposed rule supported the brackets for CPT code 63052. The agency reiterates the RUC's comments which compared CPT code 63052 to the key reference service code 22552 (Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy, and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for primary procedure)) — with wRVUs of 6.50 and 45 minutes intra-service time — and noted that the reference code has slightly higher intensity as anticipated for a surgical procedure and in comparison, with a lumbar procedure. CMS also restates the RUC comparison of CPT code 63052 to MPC code 34812 (Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)) — with wRVUs of 4.13 and 40 minutes intra-service time — which notes that the MPC code involves open femoral artery exposure by groin incision and closure of the wound, typically for separately reported delivery of an endovascular prosthesis for an asymptomatic infrarenal abdominal aortic aneurysm. In comparison, exposure and closure for the survey code are performed as part of the primary arthrodesis code. The intra-service time includes higher intensity bony and soft tissue resection (typically pathologic and not normal in nature) and decompression of neural elements in immediate high-risk proximity of the pathologic anatomy. Therefore, although both codes require the same time, the physician work and intensity of CPT code 63052 is greater than CPT code 34812. These bracket codes are still supported and appropriate to justify a wRVU of 5.70.

CMS states that "it is best for entire code families to be surveyed at the same time." However, its proposal to maintain the value it set for CPT code 63052 in the 2022 final rule disregards the recent survey of the entire code family from April 2021. Survey results from 111 neurosurgeons, orthopaedic spine surgeons and the RUC determined that the survey 25th percentile wRVU of 5.70 appropriately accounts for the physician work involved in this add-on service. Suggesting a crosswalk value to a code valued by crosswalk is like saying two "wrongs" magically make a "right" and completely ignores a survey of 111 practicing spine surgeons and the efforts of the

RUC to establish appropriate relativity. **The AANS and the CNS urge CMS to accept a wRVU of 5.70 for CPT code 63052.**

+ **CPT Code 63053.** In the CY 2022 MPFS final rule, CMS assigned a value of 3.19 for CPT code 63053 based on an intra-service time ratio and now proposes to modify the wRVU to 3.78 based on a revised intra-service time ratio between CPT codes 63052 and 63053 ((40 minutes/45 minutes) * 4.25 = 3.78). **We disagree with CMS calculating intra-service time ratios to account for changes in time**. This approach ignores magnitude estimation and is inconsistent with RBRVS principles. CMS is not using a valid method to propose a wRVU for CPT code 63053 by offering a value based on an intraoperative time ratio. The second survey of CPT code 63053 included more respondents who routinely performed this procedure. The RUC acknowledged that the survey times for CPT code 63053 accurately reflected the work.

CMS disregards the input of 141 neurosurgeons, orthopaedic spine surgeons and the RUC by proposing to base the wRVU of code 63053 on an intra-service time ratio. **We agree with the RUC-recommended wRVU of 5.00 for CPT code 63053, which supports the survey 25th percentile**. The new survey from April 2021, which included all six codes in the family, elicited an intra-service time of 40 minutes, which is only five minutes less than the work related to CPT code 63052 and is believed to be a more accurate reflection of the difference in work between laminectomy/facetectomy/foraminotomy with decompression of the first segment and an additional segment.

As rationale for a wRVU of 5.00, the RUC compared CPT code 63053 to several comparator codes with the same intra-service time. The RUC compared the survey code to top key reference service CPT code 22614 (Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)) — with wRVUs of 6.43, 40 minutes intra-service and total time — and noted that while the codes have identical intra-service time, the reference code is more intense and is appropriately valued higher than the survey code using magnitude estimation. The RUC compared the survey code to MPC CPT code 34812 (Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)) — with wRVUs of 4.13, 40 minutes intra-service and total time — and noted that the MPC CPT code involves open femoral artery exposure by groin incision and closure of the wound, typically for separately reported delivery of an endovascular prosthesis for an asymptomatic infrarenal abdominal aortic aneurysm (AAA). In comparison, exposure and closure for the survey code are performed as part of the primary arthrodesis code. The intra-service time for CPT code 63053 includes bony and soft tissue resection (typically pathologic and not normal in nature) and decompression of neural elements in immediate high-risk proximity of the pathologic anatomy. Therefore, the physician's work and intensity of CPT code 63053 are appropriately greater than CPT code 34812.

The AANS and the CNS recommend that CMS embrace the input from practicing physicians when valid surveys are conducted, rigorous analysis by the specialty society committees is performed and review of magnitude estimation and cross-specialty comparison has been thoroughly debated by the RUC. The AANS and the CNS urge CMS to accept a wRVU of 5.00 for CPT code 63053.

- **Lumbar Laminotomy with Decompression (CPT codes 63020, 63030, and 63035)**

Code	Long Descriptor	CMS Proposed RVU	RUC Recommended RVU
63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical	14.91	15.95
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar	12.00	13.18
63035	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar	3.86	4.00

In October 2018, CPT code 63030 was identified by the RUC as having a site of service anomaly when compared to Medicare utilization data. The Medicare data from 2014 through 2017 indicated that CPT code 63030 was performed less than 50 percent of the time in the inpatient setting yet included inpatient hospital evaluation and management (E/M) services within its global period. CPT codes 63020, 63030 and 63035 were surveyed. CMS disagreed with the RUC-recommended wRVUs for all three codes because CMS believes the recommendations do not account for the observed changes in time, and CPT code 63630 did not appropriately apply the CMS 23-hour stay policy.

+ **CPT Code 63020.** CMS disagreed with the RUC wRVU recommendation of 15.95 for CPT code 63020. CMS references a time ratio calculation and proposes a direct crosswalk to CPT code 27057 (Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (e.g., gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle) with debridement of nonviable muscle, unilateral) — with wRVUs of 14.91. The RUC recommended the survey 25th percentile wRVU using magnitude estimation from a valid survey of physicians who perform this service. The RUC-recommended wRVU appropriately accounts for the decrease in intra-service time and therefore did not need to be decreased further. In addition, the RUC considered the key reference service CPT code 63047 as strong support for the 25th percentile as it both closely matches the 63020 procedure and has almost identical pre-, intra- and post-service times and visits. The RUC urges CMS to use valid survey data to establish wRVUs when possible, instead of a calculation to arrive at a value and then searching for a code with that value to support the calculation. CPT code 27057 is a rarely performed procedure (<30) for a significantly different patient that is inappropriate as a comparison and inappropriately discounts the time, work and intensity required to perform CPT code 63020.

  The AANS and the CNS disagree with directly crosswalking the wRVU from CPT code 27057 to 63020. CPT code 63020 requires the removal of bone, along with dissection around nerve roots and the spinal cord, whereas CPT code 27057 only requires the soft tissue work of a fasciotomy. The work described by CPT code 27057 does not entail the same intensity of work required by CPT code 63020, does not include a significant risk of paralysis, and does not require routine use of fluoroscopy and image guidance to perform the procedure. Positioning for CPT

code 63020 requires using the Mayfield headrest and is more complex than a routine prone positioning for CPT code 27057. CPT code 27057 includes gluteal muscle debridement, which is tedious and time-consuming but not as complex as work involving the resection of bone and retraction of spinal nerves. **The AANS and the CNS urge CMS to accept a wRVU of 15.95 for CPT code 63020.**

+ **CPT Code 63030.** CMS disagreed with the RUC-recommended wRVU of 13.18 for CPT code 63030 because they contend that the CMS 23-hour stay policy was incorrectly calculated. For CPT code 63030, CMS states, "the wRVUs for services that are typically performed in the outpatient setting and require a hospital stay of less than 24 hours may in some cases involve multiple overnight stays while the patient is still considered to be an outpatient for purposes of Medicare payment. Because such services are typically furnished in the outpatient setting, they should not be valued to include inpatient post-operative E/M visits."

  However, in this same proposed rule, CMS has accepted the revised E/M services codes that combined inpatient and observation (outpatient) services because they represent identical physician work. Therefore, it is inconsistent for CMS to state in one part of the rule that CPT code 99231 cannot be included in the valuation of a global code and in another part of the same rule that CPT code 99231 represents physician work for both inpatient and observation (outpatient) (e.g., CPT code 99231, Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded).

  When the RUC considered CPT code 63030, it was noted that the physician service times stayed the same. The only adjustment was the change in post-operative visits — one less facility visit and a higher level of office visit. The survey actually indicated that the total physician work was much higher than the current value based on magnitude estimation compared with similar services, with a survey median wRVU of 15.46 and the 25th percentile wRVU of 15.31. Therefore, the RUC recommended maintaining the wRVU of 13.18, accounting for the change in the post-operative facility and office visits and maintaining the correct rank order with the cervical laminotomy service, CPT code 63020, and key reference CPT code 63047. In addition, and more importantly, the RUC believes that the recommended wRVU of 13.18 already takes into consideration the CMS policy reduction of wRVUs related to the post-operative visits in that the actual starting wRVU is the survey median, and the proposed RUC wRVU is below the 25th percentile — many wRVUs less than the wRVUs that would be subtracted per the CMS policy. Reducing CPT code 63030 to 12.00 wRVUs without considering the relation to CPT code 63020 causes a disproportionate difference between the values of these services.

  CMS indicates that their proposed wRVU is higher than using total time ratio math (based on changes to time per the 23-hour policy) and higher than using reverse building block (which is contrary to the valuation of the code based on magnitude estimation). CMS also notes their value is bracketed by CPT codes 28725 (Arthrodesis; subtalar) — with wRVUs of 11.22 — and 58720 (Salpingooophorectomy, complete or partial, unilateral or bilateral (separate procedure)) — with wRVUs of 12.16. However, the RUC wRVU recommendation of 13.18 is bracketed by codes 53500 (Urethrolysis, transvaginal, secondary, open, including cystourethroscopy (e.g., postsurgical obstruction, scarring)) — with wRVUs of 13.00 — and 33203 (Insertion of epicardial electrode(s); endoscopic approach (e.g., thoracoscopy, pericardioscopy)) — with wRVUs of 13.97. As with code 63020, CMS proposed to use math and discounted work (i.e., time instead of visit wRVUs and half visits) instead of magnitude estimation. **The AANS and the CNS urge CMS to accept a wRVU of 13.18 for CPT code 63030.**

+ **CPT Code 63035.** For CPT code 63035, CMS proposes a wRVU of 3.86 based on a reverse building block methodology to account for the 11-minute increase in intra-service time. The proposed value is between the surveyed 25th percentile value of 3.50 and the RUC recommended survey median wRVU of 4.00. CMS references CPT code 50706 (Balloon dilation, ureteral stricture, including imaging guidance (e.g., ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure) — with wRVUs of 3.80 — and CPT code 63621 (Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional spinal lesion (List separately in addition to code for primary procedure)) — with wRVUs of 4.00 — to support the proposed value. However, there are 34 RUC-reviewed ZZZ add-on codes with 60 minutes of intra-service time, and even the 25th percentile wRVU for these codes is 4.44 or more than the RUC recommendation of 4.00. Of the 34 codes, only five codes are less than 4.00 wRVUs, and these are office-based or radiology department services. CPT code 63035 represents an additional level of a major surgical procedure that is more intense and complex than these five codes.

  CPT code 63035 was a Harvard-valued code with time and work value generated from the base code 63030, which has since been resurveyed twice. The Harvard survey did not include all of the surgical specialties that now perform this service, with only 17 responses from neurosurgeons. Therefore, the previous intra-service time should not be used to arrive at a calculated value

  The RUC is concerned that CMS did not address the compelling evidence provided and proposed a wRVU using math instead of magnitude estimation, which has been the basis for the Medicare fee schedule since its implementation.

  The RUC recommended the survey median of 4.00 wRVUs based on the survey time of 60 minutes from the neurosurgeons and orthopaedic spine surgeons who perform this service, which appropriately accounts for the correct time and uses magnitude estimation when compared with 34 RUC-reviewed ZZZ add-on codes with 60 minutes. The AANS and the CNS urge CMS to accept a wRVU of 4.00 for CPT code 63035.

Potentially Mis-valued Code

CMS received a request to designate CPT code 23091 (Allograft, structural, for spine surgery only (Listed separately in addition to code for primary procedure)) as potentially misvalued. CMS has disagreed with the rationale provided by the requester and is proposing not to designate the procedure as misvalued. **The AANS and the CNS agree with the agency's proposal not to designate this code as misvalued.**

Telehealth — Neurostimulator Pulse Generator/Transmitter (CPT codes 95976, 95977, 95970, 95983, 95984)

CMS considered the following codes for possible telehealth status:

- **Analysis of cranial nerve neurostimulation (CPT codes 95976 and 95977)**. CMS is not proposing to add these codes to the Medicare Telehealth Services List because the full scope of service elements described by these codes cannot currently be furnished via two-way, audio-video communication technology. **The AANS and the CNS agree with CMS that this is inappropriate for CPT codes 95976 and 95977 as there is no currently available technology to perform these services (simple and complex programming of implanted cranial nerve neurostimulator pulse**

generators/transmitters) via telehealth. If such technology becomes available in the future and proves safe and appropriate, the AANS and the CNS would support reconsidering this request.

- **General brain nerve neurostimulation (CPT codes 95970, 95983, 95984)**. CMS proposes to add these codes to the Medicare Telehealth Services List on a Category 3 basis and has asked for comment on concerns regarding patient safety and whether the services are appropriate for inclusion outside the circumstances of the PHE. **The AANS and the CNS disagree with the agency's proposal to not promote CPT codes 95970, 95983, and 95984 to category 1 or 2, instead leaving them in category 3.** CMS justifies this proposal with several unfounded reservations about these services when performed via telehealth. These CPT codes describe the electronic analysis (CPT code 95970) of implanted brain neurostimulator pulse generators/transmitters, as well as the first 15 minutes (CPT code 95983) and each additional 15 minutes (CPT code 95984) of brain neurostimulator programming. CMS expresses concern about whether the connection between the implanted device and the analysis/calibration equipment (the neurostimulator programmer) can be done remotely. However, systems have been used successfully for over a year and a half, allowing for a stable, secure 2-way telehealth connection for brain stimulator pulse generator programming. These systems route through a secure HIPAA-compliant server and allow the managing physician to remotely control all essential functions of the patient device while providing real-time audio and video for patient assessment and feedback.

  Moreover, CMS is concerned about patient safety if the programming is incorrect, or another problem occurs. These are valid concerns that have been addressed in the development and deployment of existing remote brain neurostimulator programming systems. These systems ensure that the patient controller has a "safe" program (set of stimulation parameters). If there is an interruption in the remote connection, the device automatically reverts to this "safe" program so that the patient is not left with a potentially problematic set of programming parameters. **The AANS and the CNS believe that the successful track record of these remote programming systems performing brain stimulator programming both safely and reliably merits the inclusion of CPT codes 95970, 95983, and 95984 in category 1 or 2 of the Medicare Telehealth Services List.**

QUALITY ISSUES

Merit-Based Incentive Payment System (MIPS)

- **Quality Category.** CMS proposes removing numerous measures from MIPS currently included in the Neurosurgical Specialty Set. Our comments on these proposals are detailed below:

  + **#260: Rate of Carotid Endarterectomy (CEA) for Asymptomatic Patients**. CMS proposes to remove this measure because its limited patient population and limited adoption have not allowed for the creation of performance benchmarks. The AANS and the CNS are concerned about eliminating specialty-specific measures since MIPS reporting and scoring policies have historically disincentivized clinicians from reporting more granular measures. Starting in 2023, CMS proposes to further disincentivize specialty-specific measures by assigning measures that lack a benchmark zero rather than 3 points. While we appreciate that last year, CMS adopted a 5-point floor for "new" measures during their first two years in the program, this policy does nothing to address the numerous measures that have been in the program for many years but continue to lack a benchmark and are at risk for removal. With minimal incentive to report on measures that lack a benchmark, these measures have never even had the opportunity to gain traction. **We strongly urge CMS to maintain measures that lack a benchmark to ensure a diverse inventory of measures that reflect specialty care. CMS should maintain these measures until it has had time to implement, test, and expand the new MIPS Value**

Pathways (MVP). MVPs, as well as the subgroup participation policy associated with this pathway, present an important opportunity for clinicians to focus on more specialty-specific measures, and CMS must maintain an adequate inventory of measures for use in MVPs.

+ **#460: Back Pain After Lumbar Fusion / #473: Leg Pain After Lumbar Fusion**. CMS believes measure #460 is duplicative to measure #459: Back Pain After Lumbar Discectomy/ Laminectomy. CMS proposes substantive changes to measure #459 that would encompass the eligible patient population and clinical quality action represented within measure #460.

  CMS believes measure #473 is duplicative to measure #461: Leg Pain After Lumbar Discectomy /Laminectomy. It proposes substantive changes to measure #461, encompassing the eligible patient population and quality action represented within measure #473.

  For both proposals, the AANS and the CNS strongly oppose lumping fusions in with discectomies/decompressions since this would not reflect the indications and expectations for surgery. Although both groups may see improvements in back pain and/or leg pain, the discectomy patients are more likely to have leg pain as an indication for surgery, and the fusion patients are more likely to have back pain as an indication for surgery. Therefore, combining them will only serve to further muddy the waters on the assessment of outcomes. For example, with a 50/50 distribution of such cases, if all the discectomy patients had leg pain relief and all the fusion patients had back pain relief, the measure would indicate no overall improvement as a result of combining these two cohorts under a single measure.

- **Other Quality Topics.** We refer CMS to the comment letter submitted by the Alliance of Specialty Medicine, which reflects our feedback on other proposed quality policies, including MVPs, the MIPS performance threshold, data completeness thresholds for the quality category, the proposed Screening for Social Drivers of Health, and public reporting of utilization data. We also refer CMS to the comment letter submitted by the Physician Clinical Registry Coalition, which reflects our views regarding qualified clinical data registry policies.

Qualifying Participants (QPs) in Advanced APMs

RFI on Quality Payment Program Incentives beginning in Performance Year 2023. Under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, starting with the 2023 performance year/2025 payment year, QPs will no longer qualify for a 5 percent APM incentive payment. Instead, clinicians who are QPs in 2023 will receive a 0 percent update in 2025. Starting with the 2024 performance period and 2026 payment year, QPs will be eligible for a higher base conversion factor update (0.75 percent vs. 0.25 percent for non-QPs, including those participating in MIPS). MACRA also prescribes specific payment and patient thresholds that clinicians must meet to become a QP. Specifically, for performance years beginning with 2023, the Medicare Option QP Thresholds will increase to 75 percent (from 50 percent) for the payment amount method and 50 percent (from 35 percent) for the patient count method.

The AANS and the CNS are very concerned about the negative impact these shifting policies will have on specialty eligibility for the QP track and the movement of specialists towards APMs, in general. As we have discussed with CMS in the past, there have been very few opportunities for specialists to participate meaningfully in Advanced APMs and to qualify as QPs since most existing models are primary care or population-focused and provide no actionable role for specialists. **The AANS and the CNS strongly urge CMS to encourage Congress to make technical updates to MACRA to 1) extend the incentive payments for QPs in Advanced APMs, and 2) maintain the current QP threshold levels.** Physicians are already facing staggering Medicare payment reductions compared to other Medicare providers. Even if CMS were to provide opportunities for specialists to participate in more meaningful payment and

delivery models, they would still need the APM incentive payment to offset the financial risk and additional administrative costs associated with implementing those models.

CONCLUSION

The AANS and the CNS appreciate the opportunity to provide feedback on these coding, payment and quality provisions in the CY 2023 MPFS proposed rule. We are particularly concerned about the agency's failure to incorporate the increased E/M office visit work into the 10- and 90-day global surgical codes, the failure to adopt the RUC-recommended values and the potential significant reductions to neurosurgery that could result from the rebasing/revision the MEI. Furthermore, now is not the time for any cuts to the health care system, so we urge CMS to take all necessary steps to prevent any Medicare payment reductions.

Thank you for considering our comments. We appreciate the expertise, hard work and dedication of CMS leaders and staff. We look forward to collaborating on these and other policy matters to ensure timely patient access to quality care.

Sincerely,

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