



April 23, 2024

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Deputy Administrator and Director, Center for Medicare  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

**Subject: Medicare Device Payment Policy for Add-on Codes**

Dear Dr. Seshamani,

On behalf of the American Association of Neurological Surgeons (AANS), American Association of Orthopaedic Surgeons, Congress of Neurological Surgeons (CNS), AANS/CNS Joint Section on Disorders of the Spine and Peripheral Nerves, International Society for the Advancement of Spine Surgery, Lumbar Spine Research Society, North American Spine Society, Scoliosis Research Society and Society for Minimally Invasive Spine Surgery, representing practicing neurosurgeons and orthopaedic spine surgeons in the United States and the patients they serve, we are writing to urge the Centers for Medicare & Medicaid Services (CMS) to take action to ensure access to care for certain spine procedures performed in hospital outpatient departments (HOPDs) and ambulatory surgery centers (ASCs). Specifically, we recommend that CMS modify its current HOPD and ASC payment policy to better account for procedure combinations involving add-on codes using implanted devices.

**Background**

Generally, add-on services are not separately payable under Medicare's outpatient prospective payment system (OPPS) and ASC payment system. Instead, the payment is always packaged into the payment for the primary procedure. However, CMS established an OPPS complexity adjustment policy in the 2014 final rule. More recently, in 2023, CMS implemented a new policy to recognize the additional costs and complexity involved with performing certain combinations of primary services and add-on procedures in the ASC setting. Under the ASC policy, CMS provides ASCs with adjusted payments for certain procedure code combinations that meet Medicare's criteria for a complexity adjustment when performed in the HOPD.

## **Current Limitations**

We appreciate that the CMS policy is intended to recognize the additional costs to ASCs associated with complex procedures involving expensive add-on procedures. However, this policy fails to recognize situations where an add-on procedure includes a higher-cost implant when the primary procedure does not. Under current policy, an ASC complexity adjustment C code could have combined procedure device costs well over the 30% device-intensive procedure threshold because an add-on code has costly device costs, but the combined procedure would not be eligible for device-intensive status if the primary code did not involve an implant or if the device costs of the primary procedure were lower than 30% of procedure costs.

This situation is particularly relevant to spinal surgery since add-on codes can include significant device costs. For instance, the AMA considered an add-on code for the procedure currently represented by *C9757 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and excision of herniated intervertebral disc, and repair of annular defect with implantation of bone anchored annular closure device, including annular defect measurement, alignment and sizing assessment, and image guidance; 1 interspace, lumbar*. Under CMS policy, if an add-on code was created for the implantation of bone anchored annular closure device and this add-on code was reported with *CPT 63030, low back disk surgery* — which is not device intensive — the complexity adjusted pair would be given a new C code to facilitate patient access in the ASC, yet would be barred from device-intensive status, regardless of the significant device implant costs associated with the former C9757 procedure. Without device-intensive status, the OPPS and ASC payment level will be insufficient to recognize the substantial device implant costs described by the add-on code for this combined costly procedure, and patients would lose access to this procedure in the convenient, cost-effective ASC setting. In this scenario, C9757 exactly describes the procedure combination. If an add-on code is created, a near-term solution would be maintaining access to the current C code.

## **Request**

**We urge CMS to modify its device-intensive policy and complexity adjustment policy for cases where the primary code in a complexity adjustment C code is not device-intensive, but the add-on code has device costs that meet the criteria for device-intensive status.** In such cases, CMS should compare the device costs for the combined primary and add-on procedure to the total costs for the complexity adjustment C code. In cases where the combined device costs exceed the 30% device-intensive procedure threshold, the complexity adjustment C code should be granted device-intensive status.

Furthermore, recognizing that device cost information for add-on codes may be underreported in the hospital claims data, CMS should accept invoice data to establish offset amounts for [new] add-on codes. We also recommend that CMS accept invoice data for existing add-on HCPCS codes established by CMS or C codes that transition to add-on CPT codes established by the AMA.

If CMS does not revise its ASC complexity adjustment policy more broadly, CMS should take other steps to retain access to the C9757 procedure to the extent that new CPT coding is adopted, such as through continued use of the existing C code for Medicare purposes, with corresponding review/correction of the device offset for this device-intensive procedure.

Thank you for considering our request. In the meantime, please let us know if you have any questions or need additional information.

Sincerely,

American Association of Neurological Surgeons  
American Association of Orthopaedic Surgeons  
Congress of Neurological Surgeons  
AANS/CNS Section on Disorders of the Spine and Peripheral Nerves  
International Society for the Advancement of Spine Surgery  
Lumbar Spine Research Society  
North American Spine Society  
Scoliosis Research Society  
Society for Minimally Invasive Spine Surgery

cc: Ing-Jye Cheng, Acting Deputy Director, Center for Medicare  
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David Rice, Director, Division of Outpatient Care

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