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President
NATHAN R. SELDEN, MD, PHD
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August 31, 2015

Andy Slavitt, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1633-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1633-P Medicare Program; Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems for CY 2016; Proposed Rule

Dear Mr. Slavitt:

On behalf of 4,000 practicing neurosurgeons in the United States, the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS) appreciate the opportunity to comment on the payment provisions of the above referenced Centers for Medicare and Medicaid Services' (CMS) 2016 Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment Systems for 2016. AANS and CNS believe that the decision for 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 offer the following comments.

Proposed Changes to the Inpatient Only List

AANS and CNS support the CMS proposal to remove the following four spine procedures from the Inpatient Only List:

- CPT Code 20936, *Autograft for spine surgery only (includes harvesting the graft); local (eg, ribs, spinous process, or laminar fragments) obtained from the same incision;*
- CPT Code 20937 *Autograft for spine surgery only (includes harvesting the graft); morselized through separate skin or fascial incision)*
- CPT Code 20938 *Autograft for spine surgery only (includes harvesting the graft); structural, bicortical or tricortical (through separate skin or fascial incision)*
- CPT Code 22552 *Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophyctomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace;*

ASC Procedures List

In addition to our support for the for Inpatient Only list deletions, we would recommend that CMS add these codes, CPT Codes 20936, 20937, 20938, 22552, 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 appropriate candidates for the ASC, however, some may be. In addition, CMS should consider adding the following to the ASC list.

- CPT Code 22840: Posterior non-segmental instrumentation (eg, 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 (eg, 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) (eg, synthetic cage(s), methylmethacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure)

Instrumentation and bone graft are key components of many procedures whose codes have been added to the ASC Covered Surgical Procedures list in recent years, including CPT Codes 22551, 22552, 22554, 22612, 22614, 63020, 63030, 63042, 63045, 63047, and 63050. However, because many instrumentation and graft codes are not currently included on the list of ASC covered surgical procedures, the provision of the arthrodesis, laminotomy, laminectomy, and decompression procedures codes approved in the ASC setting is limited.

Short Inpatient Hospital Stays

We appreciate the willingness of CMS to listen to stakeholders on the issue of short inpatient hospital stays. The proposal to allow for inpatient stays of less than “two midnights,” on a case-by-case-basis, is less onerous. However, we continue to believe the “two midnights rule,” even as revised, is burdensome, confusing, and unnecessary. We urge CMS to explore other policy options for addressing inappropriate short inpatient hospital stays.

Stereotactic Radiosurgery

AANS and CNS support fair, adequate, and stable reimbursement for stereotactic radiosurgery. We are cautiously optimistic about the CMS proposals for 2016. We support the use of HCPCS modifier J1 when billing for services related to single session SRS to allow CMS to clearly identify which services are included in the bundled payment and reported correctly. This will provide the data needed to correctly identify costs.

Conclusion

We appreciate the opportunity to comment on the 2016 Medicare Hospital OPPS and ASC Proposed Rule. As always, we recognize the hard work and expertise of the many individuals involved in Medicare policy.

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

Sincerely,



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



Nathan R. Selden, MD, PhD, President
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