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August 31, 2009

Charlene Frizzera, Acting Administrator  
Centers for Medicare & Medicaid Services  
7500 Security Blvd.  
Baltimore, MD 21244-1850

RE: CMS-1413-P

Dear Acting Administrator Frizzera:

The North American Spine Society (NASS) is a multispecialty medical organization dedicated to fostering the highest quality, evidence-based, ethical spine care by promoting education, research and advocacy. NASS is comprised of more than 5,500 physician and non-physician members from several disciplines, including orthopedic surgery, neurosurgery, physiatry, pain management, neurology, radiology, anesthesiology, research, physical therapy and other spine care professionals.

### **SGR**

NASS would like to thank CMS for removing physician-administered drugs from physician services when calculating the conversion factor update under the SGR. Along with other medical specialty societies, NASS has been requesting this change for years and appreciates that it has been proposed for implementation. NASS would urge CMS to enact this provision in the final rule. However, NASS is concerned that this change will not go into effect until 2011, resulting in a projected 21.5% reduction in the 2010 conversion factor. A payment reduction of this magnitude will negatively impact spine specialists' ability to provide care to Medicare beneficiaries. It is imperative that Congress act to prevent this cut in the conversion factor from going into effect.

### **Consultations**

NASS is concerned with the proposal to stop payment for all inpatient and office/outpatient consultation codes in 2010. NASS understands and supports CMS' efforts to ensure that CPT codes are used appropriately. However, NASS does not believe that deleting the consultation codes is the best means to achieve proper coding. In the proposed rule, CMS indicates that consultations should be billed with the office, inpatient, and nursing facility visit codes. Consultations in the inpatient and outpatient settings are distinctive from initial office, hospital and nursing facility visits. Additionally, the existing visit codes do not include reporting to the referring body, a key component of a consultation. NASS requests that CMS work with the

CPT Editorial Panel to modify the consultation code descriptors to ensure appropriate utilization rather than ceasing payment for these codes.

NASS does appreciate that the proposal would be budget-neutral if implemented and would allow both the admitting physician and the specialist physician to bill initial hospital and nursing facility visit codes. However, NASS believes that consultative services are unique and should be paid separately from visit codes. Therefore, **NASS requests that CMS retain the consultation codes and review billing guidelines to ensure appropriate utilization.**

### **AMA PPI Survey**

**NASS strongly supports CMS' proposal to implement the updated practice expense data that the AMA collected through the Physician Practice Information (PPI) survey.** Utilization of these data is critical to ensure that Medicare payments to physicians and other healthcare providers are based on accurate, updated data. Seventy medical and other healthcare provider groups participated in the survey and contributed financially to collecting data. The PPI survey instrument was scientific and statistically valid and all participating groups were provided numerous opportunities to provide input on the instrument. Furthermore, the AMA provided regular updates on the response rates for all groups, providing ample opportunity for communication and outreach to increase survey participation. Once the surveys were completed, the AMA worked with the Lewin Group to ensure that all data met CMS' criteria and were analyzed consistently across the board. Data that did not meet the criteria, were outliers, or were statistically unacceptable were excluded from the results. The survey results were independently corroborated and the Lewin Group recommended that CMS utilize the data. CMS showed its confidence in the data by choosing to propose full implementation in 2010.

Fully implementing the PPI data at this time will correct practice expense payment distortions caused by the utilization of independent supplemental survey data from a small number of specialties and healthcare providers. As 2010 is the final year of transition to the new practice expense payment methodology, it is the appropriate time to utilize correct PE inputs so that payments are calculated in the most accurate and fair manner possible. Finally, implementing the PPI data will meet calls from MedPAC and the GAO to utilize updated and accurate practice costs for all specialties. **NASS urges CMS to fully implement the PPI data in the 2010 final rule in order that all Medicare provider payments are based on the most current and reliable inputs available.**

For the first time, spine surgery-specific data were collected independently from that of orthopedic surgery and neurosurgery. The new practice expense per hour for spine surgery is \$190. This is 40% greater than the average cost for neurosurgery (\$190/hr vs. \$135/hr) and 17% greater than the cost for general orthopedic surgery (\$190/hr vs. \$162/hr).

There are several unique factors that increase the costs of practice for spine surgeons compared with general orthopedists and neurosurgeons. Firstly, spine surgeons treat a large number of chronic pain patients with complex diagnoses and treatments, requiring more administrative and staff time, and therefore resource use is higher. Secondly, spine surgeons treat more workers' compensation patients, which necessitates a higher number and intensity staffing due

to the amount and complexity of document review and insurance authorizations required. Finally, spine surgeons also treat a significant number of legal/motor vehicle accident patients, again requiring a higher degree of administrative personnel and time to complete the required disability and legal forms.

The spine surgery data were obtained from a sample of 33 orthopedic spinal surgeons. Neurosurgery does not designate sub-specialties within the field and neurological spine surgery was not included in the survey. Currently orthopedic spine surgery does not have a separate Medicare specialty designation and there is no existing mechanism to easily incorporate the new data for orthopedic spine surgery into the new practice expense calculations.

However, the North American Spine Society has considered several options for utilizing the new practice expense data for orthopedic spine surgeons:

1. The most accurate method for incorporation would be a direct substitution of the orthopedic spine surgery practice expense data for that of the general orthopedic surgery data for 142 codes identified as spine surgery codes (see attached list). This approach would allocate any resultant changes in PE reimbursement due to the higher PE costs most directly to the proper procedures and most directly to the affected physicians. NASS and the AAOS considered this alternative and the AAOS has decided not to support this approach
2. A second option for incorporation would be to blend the orthopedic spine surgery data into the general orthopedic data. This would retain the added spine surgery costs within the field of orthopedics, but would spread any potential added reimbursement over the entire spectrum of general orthopedic physicians. This approach would be easier to implement than the creation of a new Medicare specialty for spinal surgery. A blend could be based upon either the number of PPI survey respondents (66 general orthopedic surgeons and 33 orthopedic spinal surgeons) or upon the relative RVU contribution of spinal surgery and general orthopedic surgery to the Medicare fee schedule. The latter is more complex to calculate, but a better and more accurate representation of overall general orthopedic surgery practice expense
3. A third option, the one that NASS supports and recommends that CMS implement, is the substitution of a blend of the orthopedic spinal surgery and general orthopedic surgery practice expense data for the current general orthopedic surgery data for 142 spine surgery codes. This option more closely reflects the actual practice expense incurred by orthopedic spinal surgeons than the current approach of using the general orthopedic data. It allocates any resultant change in reimbursement most directly to those physicians incurring the expense. Finally it retains the ability for CMS to frequency weight the PE component for each procedure according to the percentage performed by each specialty. For example, procedures performed more often by neurosurgeons can continue to have a higher weight of the neurosurgical practice expense.

We estimate that at least 90% of spinal surgery is performed by orthopedic surgeons who subspecialize and devote the vast majority of their time and resources to spinal care. If CMS accepts this option, they could substitute a 90/10 blend of the orthopedic spine surgery/general orthopedic data for the 142 procedures. We recommend, however, a more conservative two thirds/one third blend of the spinal surgery/general orthopedic data as an interim value until additional survey data can be collected to clarify this number.

**NASS requests that CMS utilize the new practice expense data for orthopedic spine surgery as they finalize details for the 2010 Medicare physician fee schedule.** We believe that each of the three options described above would improve the accuracy of practice expense reimbursement for spine surgeons within the Resource Based Relative Value System. We believe that option three is the best and most reasonable approach and recommend that CMS adoption this choice.

#### **AMA RUC Review of Potentially Misvalued Codes**

NASS is very concerned with CMS' proposed methodology to reduce the RUC-approved values for services identified through the Five-Year Review Identification Workgroup's site of service anomaly screen. All of these codes were reviewed twice through the RUC process, by the Five-Year Review Identification Workgroup and by the full RUC. The RUC carefully considered both historical and new data for the codes and followed the standard valuation process. The CMS-proposed methodology diverges from this process and ignores the resources used in providing the services included in Table 8 of the proposed rule. Section 1848 of the Social Security Act requires that Medicare physician payments be based on uniform RVUs determined by the relative resources used in furnishing a service.

Using the proposed methodology, CMS has published a proposed work RVU of 1.29 for code 62350 *Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy*, although it was valued by the RUC at 6.00 RVUs. NASS does not understand how a service requiring one hour of physician intra-service and follow-up visit time could receive such a low payment rate as it does not encompass the resources required to provide the service. Reducing the RVUs so substantially for this code will create a rank order anomaly within the family of codes as well as within the entire fee schedule.

NASS also has concerns that the proposal methodology is based upon using intensity factors to offset physician work, which is inconsistent with all previous CMS methodologies. Furthermore, CMS has questioned the validity of this method in the past, including in the 2007 final rule, in which CMS stated "We are not yet convinced about the validity of IWPUT analysis when applied to such cognitive services, particularly if such an analysis were to be used to negate the findings of acceptable surveys." Therefore, NASS is unclear why CMS is using this tool with no additional evidence supporting its validity.

NASS is also concerned with the methodology as it results in negative values for five codes. As indicated above, the proposed methodology results in a significant decrease in RVUs for code 62350. When applied to Physician payments are based on a relative value scale. When CMS' proposed methodology is applied to the other codes in the family (62355, 62360, 62361, 62362 and 62365), the result is negative work RVUs. This indicates that the methodology is inherently flawed as it says that physicians should receive no payment for these services and should, in fact, pay CMS or their patients. Additionally, the proposed methodology assumes that relativity does not apply to these codes. Again, this is concerning as the entire fee schedule is based on relativity. Stating that relativity does not apply to select codes will distort the entire system.

**NASS supports the RUC-recommended values for the codes in Table 8 as they are based on accepted methodologies and urges CMS to implement these values rather than implementing the proposed methodology.**

#### **Establishing Appropriate Relative Values for Physician Fee Schedule Services**

NASS supports the AMA's Relative Value Update Committee (RUC) and its efforts to improve the accuracy of the RVUs for physician fee schedule services. Therefore, **NASS does not support MedPAC's recommendation to establish an independent group of experts to review RUC recommendations.** As the proposed rule notes, the RUC has completed numerous steps, including completion of the latest Five-Year Review and extensive revision of the methodology used to calculate practice expense RVUs, which have resulted in greater accuracy in physician payments. The RUC and its 120 component medical specialty and healthcare professional societies are committed to continually refining the RUC process to insure the most accurate and equitable system possible.

MedPAC recommended that an oversight group be composed of people who are not affected by Medicare's payment rates, including experts in medical economics and technology diffusion and physicians employed by managed care organizations academic medical centers. While NASS understands the desire to have unbiased parties involved, it is concerning that those without expertise and experience in the valuation of medical procedures could play a key role in the process. The valuation process has the ability to impact access to care across the country and the potential effects of any changes to this process must be considered carefully.

Additionally, the current RUC process already has oversight built into it. The members of the RUC function autonomously of their specialties when voting on RVUs. Once accepted by the RUC, all RVU recommendations are reviewed by CMS prior to publication the physician fee schedule proposed rule. The proposed rule itself functions as an oversight measure in that any interested party is able to submit comments on the proposed values. Furthermore, CMS currently has a Refinement Panel process to appeal RUC decisions. At this time, the Refinement Panel process is underdeveloped and non-transparent. NASS recommends that the existing process be improved rather than developing an additional, duplicative oversight body.

Finally, MedPAC noted that their recommendation would "increase demands on CMS and [we] urge the Congress to provide the agency with the financial resources and administrative

flexibility to undertake them.” NASS does not believe that allocating financial resources to independent oversight of the RUC would be a prudent use of limited financial resources at this time.

**NASS recommends that CMS request the RUC to develop and imlement a detailed timetable to review and update the thousands of Harvard valued procedure codes.** This review should be completed within 2 years.

## **PQRI**

### **2. Section 131: Physician Payment, Efficiency, and Quality Improvements - Physician Quality Reporting Initiative (PQRI);**

#### **2b. Incentive Payments for the 2010 PQRI**

NASS applauds the extension of incentive payments for the 2010 PQRI to group practices as well as individuals, providing practicing professionals with additional options for receipt of incentive payments that best meet their or their groups’ needs.

#### **2d. Proposed 2010 PQRI Reporting Mechanisms for Individual Eligible Professionals**

NASS supports the addition of EHR-based reporting in addition to that of claims-based and registry-based reporting. Claims-based reporting, although practical, was never the optimum method for data collection for all the reasons cited in the proposed rule. However, since the claims-based method has been made available to participants in PQRI and is the sole method that is universally available, and that implementation of ARRA HIT standards and physician implementation of EHRs will take time, NASS recommends that claims-based reporting continue to be made available for at least the next two years.

##### **2.d.3 Requirements for Individual Eligible Professionals Who Choose the EHR-based Reporting Mechanism**

The proposed rule indicates that CMS does not propose any option to report measures groups through EHR-based reporting on services furnished during 2010, due to the fact that EHR-based reporting to CMS will be new to PQRI in 2010. As the back pain measures may only be reported as a measures group, this would limit the ability of spine care providers to report on the measures most relevant to them by eliminating one reporting mechanism.

##### **2.d.4 Qualifications for Registries**

CMS proposes to post the final 2010 PQRI registry requirements, including the exact date by which registries that wish to qualify for 2010 must submit a self-nomination letter and instructions for submitting the self-nomination letter, on the PQRI section of the CMS Web site by November 15, 2009. CMS anticipates that new registries that wish to self-nominate for 2010 will be required to do so by January 31, 2010. If providers are expected to begin reporting January 1, 2010, the list of eligible registries must be made

available to them prior to the start of the reporting period and with enough time to elect to report either individually or via registry (at least one month).

## **2e. Proposed Criteria for Satisfactory Reporting of Individual Quality Measures for Individual Eligible Professionals**

NASS agrees that an eligible professional should be required to report data on at least one individual measure on a minimum number of Medicare Part B FFS patients seen during the reporting period and feel that the minimum thresholds are reasonable. This minimum patient sample size requirement would enhance the scientific validity of the data and prevent “gaming” of the system by selecting minimal numbers of patients to report on.

## **2f. Proposed Criteria for Satisfactory Reporting Measures Groups for Individual Eligible Professionals**

We support the proposal to remove the requirement to report on patients seen consecutively by date of service, due to the fact that this requirement is difficult for professionals to apply accurately. This change will simplify and clarify the reporting process for professionals.

### **2.h.2 Other Considerations for Measures Proposed for Inclusion in the 2010 PQRI**

- In regard to the following:  
*“We do not believe there needs to be any special restrictions on the type or make up of the organizations carrying out this basic development of physician measures, such as restricting the initial development to physician-controlled organizations. Any such restriction would unduly limit the basic development of quality measures and the scope and utility of measures that may be considered for endorsement as voluntary consensus standards.”*

While NASS does not believe that measure development should necessarily be restricted to physician-controlled organizations, it is imperative that any measure development process include relevant physician input due to their expertise in the subject areas and the fact that physicians will be assessed by these measures.

- NASS supports removal from the 2010 measures list any 2009 PQRI measures that were part of the 2007 and/or 2008 PQRI in which the 2007 and 2008 PQRI analytics indicate a lack of significant reporting and usage. Continued review and revision of the measures list will help to refine the process and validity of the program and reduce undue burden on participants, increasing meaningful participation.

## **k. Public Reporting of PQRI Data**

While group practices will have the opportunity to know their performance rates in advance of submission to CMS and public reporting, it is crucial that individual

participants also have an opportunity to verify their results in advance of public reporting. Even though only the individual participant name will be publicized as having successfully completed the requirements for a PQRI year, past experience with PQRI has demonstrated that even whether the requirements have been successfully met has been in question in the past and participants should be able to verify/review their data before public reporting takes place—even if that only entails publishing a name as successfully completing a program year.

### **General**

NASS agrees that the proposed standards for registries and EHRs should apply to both the PQRI and e-prescribing incentive in simplifying the submission process for vendors and participants. NASS also believes the costs of compliance to physicians for reporting to PQRI, as estimated, are too low.

It is unclear whether NQF or consensus organization endorsement/adoption is required for all suggested measures for 2010 or 2011 or whether the Secretary can suggest measures of his own accord when measures do not already exist with this endorsement. This section requires clarification.

NASS would like to thank you for the opportunity to comment on this proposed rule. If you have any questions or need additional information, contact Allison Waxler, Senior Manager of Health Policy and Practice at 630-230-3683 or [awaxler@spine.org](mailto:awaxler@spine.org).

Sincerely,



Charles Branch, MD  
President



Charles Mick, MD  
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