August 31, 2015

SUBMITTED ELECTRONICALLY

Andrew M. Slavitt
Administrator
Centers for Medicare & Medicaid Services
Attn: CMS–1633–P
Box 8013
7500 Security Blvd.
Baltimore, MD 21244-1850

RE: Medicare Program; Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems for CY 2016; Proposed Rule

Dear Administrator Slavitt:

The North American Spine Society (NASS) appreciates the opportunity to comment on the 2016 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems Proposed Rule. 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 8,000 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.

**Proposed Comprehensive APCs**

While NASS appreciates efforts to restructure and consolidate ambulatory payment classifications (APCs) to improve clinical and resource homogeneity and to reduce resource overlap, we are concerned that such a significant change is being proposed without input from the affected specialties. Restructuring nine APC clinical families is an extensive undertaking and should be done only after appropriate study and involvement from the specialties. Specifically, the proposal to consolidate the current 24 orthopedic APCs into 9 less granular APCs would have significant consequences as it affects 649 ASC codes. The potential impact of this change should be assessed prior to implementation. Therefore, NASS urges CMS to not finalize the proposed development of comprehensive APCs for 2016 and work with the appropriate specialties to realign the APCs based on clinically appropriate criteria.

**Proposed Changes to the Inpatient Only List**

NASS appreciates and agrees with the proposal to remove codes 20936: Autograft for spine surgery only (includes harvesting the graft); local (eg, ribs, spinous process, or laminar fragments) obtained from
same incision; 20937: Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision); 20938: Autograft for spine surgery only (includes harvesting the graft); structural bicortical or tricortical (through separate skin or fascial incision); and 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 from the inpatient-only list for 2016 and urges that the proposal be finalized. All of these procedures are commonly and safely performed in the outpatient setting.

**Proposed Update to the Lists of ASC Covered Surgical Procedures and Covered Ancillary Services**

NASS commends CMS for proposing to add codes 0171T: Insertion of posterior spinous process distraction device (including necessary removal of bone or ligament for insertion and imaging guidance), lumbar; single level and 0172T: Insertion of posterior spinous process distraction device (including necessary removal of bone or ligament for insertion and imaging guidance), lumbar; each additional level to the list of ASC Covered Surgical Procedures as they are performed safely and appropriately in the ASC setting.

NASS requests that CMS revisit its decision to continue to exclude codes 20936, 20937, 20938, 22552 from the ASC Covered Surgical Procedures list based on concerns about risk to beneficiary safety or requirement of an overnight stay. While these codes have been removed from the inpatient only list, keeping them off of the ASC Covered Surgical Procedures list limits their performance in the outpatient setting. Additionally, NASS requests that the following codes be added to the ASC Covered Surgical Procedures list as well as they can safely be performed in the ASC setting and would not require an overnight stay for the majority of the Medicare population.

- 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);
- 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);
- 22845: Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure);
- 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 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 severely and inappropriately limited. Therefore, NASS requests that CMS add the related instrumentation and graft codes to the covered procedures list.

**Short Inpatient Hospital Stays**

NASS continues to be concerned about the detrimental impact of the two-midnight rule as it minimizes the role of physician judgment, increases the number of medically unnecessary inpatient hospital stays of more than one day, and inappropriately shifts inpatient and outpatient stays. Additionally, the rule is
administratively burdensome in requiring additional, medically unnecessary documentation of inpatient admissions. Since the rule’s implementation in August 2013, enforcement has been delayed due to a high number of concerns, including those addressed above. Therefore, NASS requests that CMS permanently repeal the two-midnight rule and explore other policy options for addressing inappropriate short inpatient hospital stays.

NASS appreciates the opportunity to comment on this proposed rule. If you have any questions or need additional information, contact Allison Waxler, Director of Regulatory Affairs at 630-230-3683 or awaxler@spine.org.

Sincerely,

Heidi Prather, DO
President