AMERICAN ACADEMY OF NEUROLOGY®

201 Chicago Avenue
Minneapolis, Minnesota 55415

Tel: (612) 928-6100
Fax: (612) 454-2744

AAN.com

January 28, 2020

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: Medicare Program; CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations Final Rule; and Coding and Payment for Evaluation and Management, Observation and Provision of Self-Administered Esketamine Interim Final Rule [CMS-1715-F]

Dear Administrator Verma:

The American Academy of Neurology (AAN) is the world's largest neurology specialty society representing more than 36,000 neurologists and clinical neuroscience professionals. The AAN is dedicated to promoting the highest quality patient-centered neurologic care. A neurologist is a physician with specialized training in diagnosing, treating, and managing disorders of the brain and nervous system. These disorders affect one in six people and include conditions such as multiple sclerosis (MS), Alzheimer's disease, Parkinson's disease, stroke, migraine, epilepsy, traumatic brain injury, ALS, and spinal muscular atrophy.

The AAN applauds the Centers for Medicare and Medicaid Services (CMS) for finalizing its proposal related to coding and reimbursement for evaluation and management (E/M) services. The AAN remains highly supportive of the new coding and reimbursement structure and supports CMS' decision to implement the new policies on January 1, 2021. The AAN urges CMS to implement the new structure as finalized and without any additional delay. In support of this goal, the AAN offers the following comments related to the GPC1X add-on code and CMS' decision to exclude office visits bundled into the global surgery package from the increase applied to outpatient E/M services.

GPC1X Add-On Code

CMS finalized a descriptor for the GPC1X add-on code stating: "Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex chronic condition."[1] The AAN supports payment for the finalized GPC1X add-on code, as it accounts for the complexity of non-procedural specialized medical care. The AAN was pleased to see in the previous rulemaking cycle that CMS recognized that neurologic patients generally present with complex diseases. We applaud CMS' intent to recognize and reward physicians who provide E/M services to complex patients, regardless of specialty, with the finalization of the GPC1X add-on code. The AAN concurs with CMS' rationale that there are different per-visit resource costs associated with non-procedural specialized medical care and the AAN is grateful that this code is not restricted by specialty or to primary care practitioners. As such, the AAN supports the finalized code to account for "additional resource costs inherent in furnishing some kinds of office/outpatient E/M visits."[2] The AAN agrees with CMS that there are additional resource costs associated with visits related to a patient's single serious, or complex chronic condition that are not included in the value of the standalone E/M code. The AAN believes the resources needed for these visits are higher due to increases in the probability of morbidity and mortality and a greater need for collaboration between providers.

The AAN supports the finalized value of 0.33 RVUs for GPC1X. There are few precedents in the Physician Fee Schedule (PFS) for valuing work intensity and the AAN believes that CMS' crosswalk is rational. The finalized value and time for the GPC1X are reasonable values for the added per-visit complexity and time associated with "ongoing care related to patient's single, serious, or complex chronic condition(s)."[3] The AAN concurs with CMS that this work is "qualitatively different from the work accounted for in the revalued office/outpatient E/M visits."[4]

Valuation of Global Packages and Valuation of E/M Services

The AAN supports the decision to exclude office visits bundled into the global surgery package from the increase applied to outpatient E/M services. The AAN believes it would be inappropriate for CMS to revalue global surgery packages while they are currently examining data related to global surgery valuations. The AAN appreciates that CMS appears to share this concern, noting "it is unclear whether it would be appropriate to use a building-block approach to increase the valuation for global surgical packages in a way that could disrupt potentially more accurate estimates of total work for procedures with global periods from magnitude estimation."[5] Furthermore, the AAN agrees with CMS that a premature revaluation could "result in inappropriate shifts in relativity under the PFS, and the

[1] 84 Fed. Reg. at 62855
[2] 84 Fed. Reg. at 62854
[3] 84 Fed. Reg. at 62855
[4] 84 Fed. Reg. at 62856
[5] 84 Fed. Reg. at 62858

associated budget neutrality adjustment could result in potentially inappropriate adjustments to payment rates for services without global periods, such as separately-billed E/M visits."[6]

The AAN concurs with CMS that "there are now important, unresolved questions regarding how post-operative visits included in global surgery codes should be valued relative to stand-alone E/M visit analogues."[7] The AAN appreciates that CMS noted the key distinction that while post-operative visits may be similar to stand-alone E/M services, they are not the same. The medical-decision-making for the typical post-procedure outpatient visit is less complex than the typical stand-alone E/M. The post-procedure visit usually is concerned with a well-defined problem; and, by definition, the provider has taken a medical history and examined the patient a short time before the visit in the global period. Practice expense may differ for post-procedure visits, some of which require supplies such as suture removal kits and dressings. The resources required for postprocedural visits in the global period differ from resources needed for the typical office visit and we agree with CMS that these visits should be valued independently of typical office E/M visits. This approach is supported by MedPAC, which recommended "a budget-neutral payment adjustment for ambulatory E&M services – excluding the ambulatory E&M services currently considered when valuing global packages."[8]

The AAN appreciates that CMS is carefully considering the findings from RAND related to the disparity between expected and observed post-operative visits. We note that RAND, the Office of the Inspector General, and other reports support the conclusion that CMS is now paying for many postprocedural visits that do not actually occur. The AAN concurs with CMS that "If the number of E/M services for global codes is not appropriate, adopting the AMA RUC-recommended values for E/M services in global surgery codes would exacerbate rather than ameliorate any potential relativity issues."[9] Any investigation of the global billing periods will have limitations, but the AAN is not aware of any independent data that support the number of postprocedural visits indicated in RUC surveys and in current CMS global periods. The AAN is in agreement with CMS that the current body of evidence "suggests that the values for E/M services typically furnished in global surgery periods are overstated in the current valuations for global surgery codes."[10]

Additionally, it is important to note that the AAN believes that CMS has the authority to exercise discretion in valuing global surgical packages separately under section 523(a) of MACRA which states: "Nothing in clause (i) shall be construed to prevent the Secretary from revaluing misvalued codes for specific surgical services or assigning values to new or revised codes for surgical services."[11] Under the statute, CMS is not required to arbitrarily revalue the global packages in conjunction with the revaluation of stand-alone E/M services. It is the AAN's view that CMS' current course of action is entirely appropriate because under section 523(c) of MACRA, the Secretary of Health and Human Services is directed to "use the information reported under subparagraph (B)(i) as appropriate and other available

[6] Id.
[7] Id.
[8] Rebalancing Medicare's Physician Fee Schedule toward Ambulatory Evaluation and Management Services. June 2018. www.medpac.gov/docs/default-source/reports/jun18_ch3_medpacreport_sec.pdf?sfvrsn=0. p. 79.
[9] Id.
[10] Id.
[11] Medicare Access and CHIP Reauthorization Act of 2015

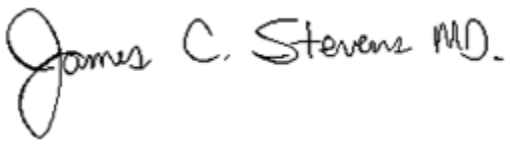
data for the purpose of improving the accuracy of valuation of surgical services under the physician fee schedule under this section."[12] As the Secretary has been directed to use information collected by RAND and other sources to improve the accuracy of valuation of surgical services, the AAN believes it would be inappropriate to revalue surgical services without accounting for the available body of evidence, while data collection and analysis is still ongoing, and while the agency is aware that such a revaluation would be likely to exacerbate inaccuracies in the valuations of these services.

It is of the utmost importance that the valuation of the global packages accurately reflects the work being done and that the values are supported by data. The AAN recommends that CMS continue to work to collect and analyze all relevant data.

Conclusion

The AAN greatly appreciates the opportunity to offer comments on provisions of the final rule related to E/M services. The AAN strongly urges CMS to consider our comments and fully implement the finalized E/M coding structure and valuations on January 1, 2021. If CMS were to consider making any changes to the finalized E/M structure or values, including any changes to the GPC1X add-on code or to the valuations of the global surgery packages, the AAN urges CMS to consult with relevant specialty groups, including the AAN, to better understand any potential negative consequences of a change, prior to releasing a proposal. Please contact Matt Kerschner, the AAN's Government Relations Manager at mkerschner@aan.com or Daniel Spirn, the AAN's Senior Regulatory Counsel at dspirn@aan.com, with any questions or requests for additional information.

Sincerely,



James C. Stevens, MD, FAAN
President, American Academy of Neurology

[12] Id.