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October 20, 2022

Ms. Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
ATTN: CMS-1771-F
P.O. Box 8013 Baltimore, MD 21244-1850

Submitted electronically via https://www.mearis.cms.gov

SUBJECT: Fiscal Year (FY) 2023 Medicare Hospital Inpatient Prospective Payment System (IPPS) Final Rule (CMS-1771-F). Additional Comments on MR-DRGs 025—027 for Laser Interstitial Thermal Therapy (LITT) procedures

Dear Administrator Brooks-LaSure:

On behalf of the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), we appreciate the opportunity to comment on the MS-DRG assignments for Laser Interstitial Thermal Therapy (LITT) procedures.

We are pleased that in the FY 2023 IPPS final rule, the agency confirmed its plans to reassign new ICD-10 PCS codes for LITT of the brain to MS-DRGs 025-027. We strongly supported this action. This change acknowledges that the use of LITT in the brain is aligned in terms of cost and clinical concerns with the other neurosurgical procedures grouped to MS-DRGs 025-027.

As we stated in our comments on the proposed rule submitted on June 14, we disagree that there is a need for CMS to re-evaluate the assignment of other neurosurgical procedures within the craniotomy MS-DRGs 023-027 in future proposed regulations. The procedures in these MS-DRGs have been well established from a clinical similarity perspective, and the procedures' costs have been stable. **We disagree that the reassignment of LITT procedures back to the craniotomy MS-DRGs for FY 2023 should trigger the realignment of other procedures currently assigned to the craniotomy MS-DRGs**. The surgical approach, percutaneous via a smaller opening vs. open, does not equate to less resource use and lower cost.

Although CMS has identified a limited number of cases reporting LITT procedures for other anatomic sites and invited further comment regarding the use of and experience with LITT for other anatomic sites, we do not believe that LITT has been performed outside of the brain and in some limited cases the spine. We suspect that the few claims CMS has identified in the FY2021 IPPS dataset for LITT outside of the brain and spine were likely miscoded.

Should CMS move forward and consider further refinement of the MS-DRGs 023-027, we urge the agency to continue to recognize the clinical similarity of the LITT procedures to the craniotomy procedures. Open vs. percutaneous surgical access should not be the single determinant of reclassifying procedures. In fact, we do not believe that the correct assignment of the brain LITT procedures back to MS-DRG 025-027, which represent a minimal subset of the total procedures within the craniotomy MS-DRGs, should trigger any further refinement of other procedures assigned to the craniotomy MS-DRGs 023-027 in future proposed regulations.

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Brain LITT procedures and surgical resection craniotomy, as noted above, are similar in total resource use and potential for complications. Both procedures involve the risk of intracranial bleeding, infection, and brain swelling, whether the opening is created via a drill into the skull percutaneously or through a larger incision in the skull for a craniotomy. While costs may vary by revenue center/department (i.e., supply costs for LITT procedures are typically higher than craniotomy procedures and craniotomy procedures typically involve more prolonged ICU stays), the total average costs are comparable.

In addition, CMS has asked whether the brain LITT procedures should be separated based on diagnosis (epilepsy or malignant neoplasm). We do not support separating LITT procedures based on the diagnosis code. In surgical MS-DRGs, the ICD-10 procedure code generally drives the grouper logic, not the patient's primary diagnosis. This should also apply to LITT. LITT cases assigned to MS-DRGs 025-027 are surgical interventions to treat brain tumors or lesions causing epilepsy. Differences in the disease-causing tumors or lesions do not affect the resource use for performing the procedure or the post-operative care for the patient. The LITT procedure requires the same steps, time, and clinical resources when performed for brain cancer and epilepsy. It is worth noting that two category I CPT codes were recently created by the CPT Editorial Panel. While developing the CPT Code Change Application for these new codes, submitted by the AANS and the CNS, we thoroughly evaluated this topic and determined that separate codes based on diagnosis were unnecessary. We believe the same to be true for the assignment of MS-DRGs.

In summary, we thank CMS for returning the LITT procedures to MS-DRGs 025-027. However, we do not believe that the assignment of the LITT procedures should trigger a more comprehensive refinement of craniotomy MS-DRGs, and we do not support grouping the brain LITT procedures based on the diagnosis code.

We appreciate the opportunity to reinforce our comments on this issue. Thank you.

Sincerely,

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