September 1, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

RE: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017
[CMS-1654-P]

Dear Acting Administrator Slavitt:

The American Academy of Neurology (AAN) is the premier national medical specialty society representing more than 30,000 neurologists and clinical neuroscience professionals and 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 such as Alzheimer’s disease, stroke, epilepsy, Parkinson’s disease, migraine, multiple sclerosis (MS), and brain injury.

The AAN appreciates the opportunity to offer comments to the Centers for Medicare & Medicaid Services (CMS) regarding the proposed rule entitled Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017 [CMS-1654-P].

This letter includes the AAN’s recommendations, comments, and questions regarding the following provisions of the proposed rule:

- Improving Payment Accuracy for Primary Care, Care Management, and Patient-Centered Services
- Collecting Data on Resources Used in Furnishing Global Services
- Medicare Telehealth Services
- Appropriate Use Criteria for Advance Diagnostic Imaging Services
- Accountable Care Organizations
- Reports of Payments or Other Transfers of Value to Covered Recipients
I. Improving Payment Accuracy for Primary Care, Care Management, and Patient-Centered Services

The AAN shares CMS’ recognition that the most valuable and cost-effective health resource is physician time with patients, which CMS describes in the proposed rule as “primary care, care management and coordination, and cognitive services.” CMS should provide incentives for every provider, in every specialty, to spend more time with patients because examining and talking with people sets the foundation for all preventative, diagnostic, and therapeutic care. Primary or principal care is more difficult for reasons including:

- The typical Medicare patient is now increasingly complex. The population is older, and physicians diagnose and treat recently-recognized disorders and risk factors. Neurologists are treating more disorders and more drug interactions for each patient visit.
- Many patients who would have been hospitalized in past years are now treated in care-intensive outpatient programs.
- Near-universal use of electronic health records (EHRs) has improved some aspects of patient care, but it imposes on the provider substantially longer work and higher practice expense. It is difficult to implement EHR technology, especially for small and solo practices that do not have ready access to technical expertise.

Because providers spend more time and resources to effectively manage the typical patient, we support GPPP1, GPPP2, and GPPP3. Although few neurologists will use these codes, they set an important precedent to recognize interdisciplinary care that requires significant non-face-to-face work. We anticipate that similar code series may be developed in the future to describe complex management in other specialties including neurology. We also support CMS’ code proposal to use the language approved at CPT that carefully defined the roles of multiple professionals.

The AAN also supports GPPP6, GPPP7, 99358, and 99359. Payment for these codes will appropriately recognize the increasing non-face-to-face work needed to treat complex patients. The proposed thresholds for time are sufficiently high to ensure program integrity. Both the CPT descriptor and the proposed rule would require providers to spend at least 60 minutes of non-face-to-face work before they can bill using 99358, and lower time increments would not be paid.

CPT approved these codes for prolonged service on a single date, and the proposed rule appears to adopt that convention. However, a physician may interact with a complex patient on several occasions during a given month. For example, if a patient has breakthrough of typical seizures with adverse effects of medication, the neurologist may have weekly interactions including phone conversations with the patient and family, ordering and reviewing lab tests, and changing prescriptions. Careful non-face-to-face attention may save office visits for patients with poor mobility, and may prevent visits to the emergency room or hospital admissions. In this case the total non-face-to-face time may be under 60 minutes for each day, but may be much more than 60 minutes when the time is summed for an entire month.

To further encourage the efficient physician management of patients, we recommend that CMS state that codes 99358 and 99359 may be used to bill for total physician time with a
single patient over the course of a calendar month, rather than during a single day. This is similar to current CMS convention, and similar to the proposed rule for chronic care management services (CCM), codes 99487, 99489, and 99490. For these codes the total non-face-to-face service time is summed over a month. We will also recommend to the RUC/CPT Emerging Issues Workgroup that CPT consider revising the code definition similarly.

By approving payment for codes 99358 and 99359, CMS will take another step toward recognizing the medically necessary work for patients with multiple chronic disorders. One physician may bill for 99358 and 99359, and during the same month another physician may bill for chronic care management. For example, a neurologist may care for a patient with late Parkinson’s disease who also has associated symptoms including periods of “freezing” during the day, dementia, hallucinations, orthostatic hypotension, and falls. Between office visits, the neurologist interacts frequently with the patient, family, home medical caregivers, and other physicians to adjust medications, adapt diet for swallowing dysfunction, and improve safety in the home. During the same month the primary care provider may be performing chronic care management services while monitoring antihypertensive medications and other coexisting disorders including diabetes, renal function, and chronic pain. Both providers will collaborate on decisions regarding long-term care and end-of-life planning.

We recommend that documentation of these services not be burdensome, but should be in line with current CMS policy. We further recommend that CMS may adopt the same documentation requirements as the 1997 guidelines for documentation of face-to-face E/M services that consist predominantly of counseling or coordination of care. CMS stated: “If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter (face-to-face or floor time, as appropriate) should be documented and the record should describe the counseling and/or activities to coordinate care.”

Medicare has published similar guidelines for documentation of prolonged face-to-face visits 99354-99359: “Documentation, however, is required to be in the medical record about the duration and content of the medically necessary evaluation and management service and prolonged services that you bill.”

Our experience is that physicians often spend more time than recognized within the E/M post-service periods, yet less than a full hour. The AAN anticipates that CMS and CPT may refine the time thresholds in coming years, as we learn about the use and limitations of these codes.

Regarding GPPP6, the AAN appreciates that CMS adopted the CPT language, which will improve the consistency of physician coding when the CPT code becomes active. We

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welcome CMS’ willingness to approve a G-code for 2017 to appropriately recognize the extra physician work and expense of evaluating patients with cognitive impairment. We request that CMS adopt the RUC recommended value of 3.44, which is higher than 3.30 proposed through this rule. If CMS chooses a lower payment, we request the agency explain its specific rationale for rejecting the RUC valuation method.

The GPPP7 code recognizes that physicians, including neurologists, occasionally perform additional work and take on added expenses when required for a beneficiary that also needs CCM services. For GPPP7, and CPT codes 99358 and 99359, the AAN agrees that CMS should allow separate billing for each of these services. CMS should reiterate that physician time must be counted only once, and CMS can specifically provide a table of time thresholds with examples of how to bill for multiple services, as CPT has done for billing prolonged services.3 We will propose at the RUC/CPT Emerging Issues Workgroup, that CPT and CMS adopt the same language and time thresholds.

Additionally, the AAN agrees that the proposals to reduce administrative burden and improve payment accuracy will allow the activities associated with CPT codes 99487 and 99489 to be appropriately provided to more patients who greatly need these services. We also recommend eliminating copayments for care coordination services. Feedback from practicing physicians suggests that copayments are a major reason that patients are refusing care coordination, which is cost effective for the patient as well as for CMS.

The AAN supports code GPPP7, another code to recognize valuable non-face-to-face services. CMS has requested comment on how to delineate distinctions among GPPP7, 99358, and 99359. The AAN believes that CMS should prepare examples of how these codes might be used in specific clinical situations. Providers will benefit from a table that distinguishes pre- and post-service work; additional work on the same day; and additional work during the entire month. The table should illustrate which services should be counted toward E/M, CCM, GPPP7, 99358 and 99359, using specific clinical examples. CMS also proposes an initiating visit only for new patients or patients not seen within one year. We agree that one year is an appropriate interval, but the interval should be reviewed as providers gain more experience with the new coding proposals.

Furthermore, we are pleased that CMS recognizes that a beneficiary with a mobility-related disability requires more physician and clinical staff time, often needing skilled assistance throughout an E/M visit. Furthermore, an E/M visit for a patient with a mobility-related disability commonly requires specialized equipment. Current practice expense inputs for E/M do not accurately reflect these necessary additional resources.

Neurologists have a relatively high number of patients with mobility-related disorders, and as a specialty disproportionately subsidize these services. Therefore, we support CMS’ proposed code GDDD1. The proposed code GDDD1 requires that a physician’s office must have specific assistive devices. We note, however, that many patients with mobility-related disabilities require extra services, even for a low-level office visit, and even if specific

assistive devices are not used. As an example, a neurologist may begin an examination by observing a person with multiple sclerosis ambulate into the room. Whether or not the patient uses an assistive device, the office E/M visit requires additional time and resources, simply because the patient walks slowly and unsteadily, and there is a risk of falling.

We propose GDDD2 as a lower-level, lower payment add-on code for E/M services to patients with mobility-related disabilities when specific assistive devices are not required, but when extra time and resources are needed for E/M services. An example includes Parkinson’s disease patients. While they may not require a specific assistive device, they would require additional time and resources because of the bradykinesia and gait slowing.

The AAN suggests that GDDD1 and GDDD2 should be billable with any office-based, face-to-face service. We will propose, through the RUC/CPT Emerging Issues Workgroup, that CPT consider similar service codes. Whatever codes CMS adopts in the final rule, the AAN requests further clarification on the documentation requirements and limitations on who may report the code.

CMS recognizes there are other populations for which payment adjustment may be appropriate. In the proposed rule, CMS notes that some physician practices furnish services to particular populations for which the relative resource costs are similarly systemically undervalued. The AAN recommends that CMS also establish a code to recognize the extra time and resources needed for patients with an established diagnosis of dementia: to schedule and remind patients and families of visits, to get historical information from family and caregivers, and to comply with the often burdensome additional documentation requirements for those in assisted living or nursing homes.

As we have stated in previous comment letters, current E/M codes were developed over 30 years ago. They do not adequately describe the range of work in current E/M visits. Visit intensity is now higher, and in some cases much higher, than it was 30 years ago for patients requiring chronic care coordination. Often these patients have more severe illnesses and a higher number of active medical diagnoses. Many are undergoing multiple treatments that interact, and they need coordination of services from multiple providers. Some who would have been admitted for care in prior years are now managed as outpatients and documentation for all these activities is time-consuming.

This results in many patients requiring medical decision making that is more complex than recognized for level 5 E/M; the decision making sometimes is much more complex. For patients needing chronic care management, physicians provide even more pre- and post-service work and incur higher practice expenses to provide the much needed services.

Each year, neurologic disorders affect an estimated 50 million Americans and cost hundreds of billions of dollars in medical expenses and lost productivity. It takes significant time and skill to provide ongoing cognitive care to manage complex chronic conditions for people with neurologic diseases like Alzheimer’s disease and other neurodegenerative diseases, genetic brain diseases, diseases affecting muscle and nerve, Parkinson’s disease, and stroke. Often, these diseases represent the highest-need, highest-cost Medicare beneficiaries.
Therefore, the fair valuation of E/M services is the most important Medicare fee-for-service issue for neurologists and our patients. About 20 percent of neurologists perform no procedures. For about two-thirds of neurologists, E/M constitutes more than 60 percent of billed services. Careful and complex medical decision making can reduce unnecessary testing and treatment, control medical expense, and improve the patient experience. Correct E/M reimbursement is also key to fairly recognize neurologist work in ACOs and under alternative payment models (APMs).\(^4\)\(^5\)

This is also why we have previously called upon CMS initiatives to improve the evidence base of work intensity and time duration for medical services as they evolve. A University of Cincinnati group, sponsored by the AAN and other medical specialty societies, has explored the use of validated alternative methodologies to the RUC methodology (NASA Task Load Index, Subjective Work Assessment Technique, Dundee Stress State Questionnaire) and performed immediately after a patient encounter.\(^6\)\(^7\)\(^8\)

These peer-reviewed publications establish that methods used to measure work intensity in non-medical fields are valid for measuring physician work intensity. In these studies, surgeons and non-procedural physicians reported similar work intensity for surgery and office visits when asked immediately after performing a surgical procedure and finishing clinic. We encourage CMS to use current industrial engineering methods to measure the complexity, intensity, and time demands of medical work.\(^9\)

The AAN requests that CMS perform more comprehensive research on the relative intensity of E/M, surgical services, medical procedures, and imaging, for the purpose of assigning correct relative valuation. The AAN also requests that CMS perform new evaluations of the resource inputs for E/M services, particularly to correctly value the impact of electronic medical records on E/M workflow and practice expense.

II. Collecting Data on Resources Used in Furnishing Global Services

The AAN applauds CMS’ efforts to gather data on physician time and effort spent for codes with 10- and 90-day global services. The methods outlined by CMS are likely to give the


\(^7\) Id. at 108-113.


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agency the necessary data to appropriately value global period services. **We agree with CMS’ stated goal to measure, not just estimate, the number and complexity of visits during the global period.**

CMS proposes eight new G-codes to collect three characteristics of services during the global period, including place of service, complexity of patient, and service time. We suggest that it is equally important to identify the service provider as:

- the physician who coded for the global service or another separately billing provider within the same tax identification number practice; or
- the global physician’s non-provider clinical staff; or
- house staff under attending physician supervision; or
- a provider from other tax identification numbers or other specialties who can bill Medicare for their services during the global period.

We also believe that CMS cannot reliably collect time and intensity data separately, given current gaps in understanding of these services. CMS needs to determine which activities are to be included in service times, and CMS needs to adopt modern industrial engineering techniques to measure both time and intensity of physician activities. Until then, it will be difficult for providers to get accurate time data, or for CMS to evaluate the data. Providers might reasonably measure the times for face-to-face visits, but they have no expertise in doing so.

In addition, they cannot be expected to reliably measure times to obtain prior authorization, schedule facility access and coordinate schedules for multiple providers for complex procedures, respond to pharmacy and durable medical equipment queries, complete forms for workers leaving and returning to work, and react to other family and social concerns. On the other hand, physicians are competent to code and document E/M services to CMS standards, since almost all provide a high percentage of stand-alone E/M services in addition to any global period services. Reports of E/M service equivalents, together with code 99024, are most likely to give reproducible estimates of both time and intensity for global period services. CMS should validate the reported level of services by auditing the documentation for a representative sample of these same services.

CMS proposes a survey of a representative sample of practitioners about the activities and resources for global period services, and a more in-depth study, including direct observation. We also suggest that CMS track the number of visits to nonsurgical specialists during the global period. Global period visits by hospital or ICU-based physicians, or by office-based primary care providers, may affect the intensity of the surgical postoperative care. CMS needs the results of these in-depth studies before developing a new evidence base to define and code global period services.

**The AAN advocates that CMS require reporting of global period services to include:**

1. Provider type, one of four as described above; and
2. Site of service; and
3. E/M code, together with code 99024.
We agree with CMS’ proposal to require reporting of all global period postoperative visits, since any sampling method would be subject to incalculable bias. For example, surgeons providing a high number of postoperative visits might have a higher incentive to report them than surgeons who do fewer visits; but, if reporting were discretionary, they might feel too busy to report those visits. Any voluntary mechanism would likely increase reporting particularly among surgeons who are knowledgeable of payment policy and recognize the inherent self-interest of reporting. Any sampling method imposed by regulation is not likely to adequately represent the many existing variations in patient care. However, if CMS determines instead to investigate a sampling of global period services, we recommend that CMS require reporting from all providers of high volume, high cost procedures.

We further agree that the agency should implement the data collection process on January 1, 2017. We believe that rapid implementation of the data collection process is required by MACRA. Data collected should be open for public review and audit. Data-based valuation of surgical services will benefit all specialties and promote fairness across the Fee Schedule.

The AAN believes that the resource-based payment methodology is best to fairly value the physician’s time, work intensity, and practice expense in most clinical circumstances. CMS needs to adjust payments for services with a global period as procedures change over time, and as care is delivered within new staffing models.

III. Medicare Telehealth Services

The AAN is pleased to see the introduction of GTT1 and GTT2 for critical care consultations via telehealth. We applaud CMS for supporting innovations in health care technology like telehealth that will improve specialty care. Neurologists treat patients with complex, chronic conditions. However, these patients do not always have access to the important specialized care that a neurologist provides. Capacity-building technologies will increase access for patients and improve a neurologist’s ability to provide timely and appropriate care. Telehealth services will also be increasingly important for neurology patients. Many of these patients have limited mobility and are often living in rural areas with limited access to specialty and subspecialty neurologic care.

Additionally, AAN members are especially concerned with maintaining a strong neurology workforce. We believe GTT1 and GTT2 will increase the use of telemedicine implementation. This technology will positively impact patient care and help to reduce physician shortages in areas of specialty care. Neurologists continue to lead the way in telemedicine implementation and these codes are helpful to further the proliferation of innovative patient-centered care.

CMS is justifiably concerned that inappropriate billing may occur as physicians learn to use these new codes in conjunction with existing E/M, CCM, and TCM codes. We agree that physician and staff time must be counted only once; but, we are also concerned that physician and staff time should be counted, whether it occurs on the day of service, or at any time during the month of service. We propose that CMS provide explicit guidance on how to tabulate physician and staff time on the day of service and during a calendar month for the proposed codes, as well as for existing E/M, CCM, and TCM services. CMS should also
provide highly specific examples of how to bill for multiple services, as CPT has done for billing prolonged services.

The AAN also recommends that the intensity of critical care telehealth services should be similar to the intensity of critical care face-to-face work. In each case, the clinical problem and medical decision making are the same. The intensity of face-to-face services may be increased by factors related to the patient or family, but the intensity of telehealth services may be increased by the relative limitations on the quality of available data. The AAN requests that CMS recognize the practice expenses for telehealth, including rent, communications equipment, electronic health records, and professional liability insurance.

Malpractice is a serious concern for neurologists. All medical practices, whether they are telemedicine based or face-to-face, require a physician with a malpractice policy and some level of overhead to allow the practice to function. Telemedicine does not remove these costs, and there should be some accounting for them. Neurologists are also aware that providing the same service in person can, in some cases, be less risky than performing it over a camera. By working with patient populations in a telemedicine setting, neurologists are at no less risk of being sued. The risk may actually increase, for example, if the technology fails in the middle of a consult. In that case, a neurologist may need to work with less information which increases the risk of error and unexpected harm. CMS should recognize and more fully appreciate the additional risk neurologists are willing to undergo to help communities that lack neurologic services but will benefit from telehealth consultations.

The AAN recommends that telehealth for critical care should not be limited geographically. Neurologic critical care is valuable for stroke patients in rural, suburban, and urban areas alike, who benefit from emergency expert consultations about potential use of thrombolytic therapy. Most community healthcare is provided in the absence of a staff neurologist, but emergency neurologic opinion should be available 24 hours a day, seven days a week.

In addition, governing academies and accreditation bodies require timely responsiveness for these hospitals to maintain their accreditation. Telemedicine is the best solution to meet those requirements, and it should not matter where that facility is located. Telemedicine connects the appropriate provider to the correct patient in the shortest amount of time possible, and in critical medical problems, that benefit should know no geographic limitations.

IV. Appropriate Use Criteria for Advance Diagnostic Imaging Services

The AAN has previously written in support of CMS’ decision to implement Appropriate Use Criteria (AUC) for advanced diagnostic imaging services. The AAN recommends that if CMS implements AUC, it be done through the requirement of a clinical decision support mechanism (CDSM) that is fully integrated within the Certification Commission for Healthcare Information Technology criteria for electronic health records. Additionally, appropriate use could be better codified. There should be a table of appropriate ICD-10 codes that are associated with the CPT, similar to a medical coverage policy.

We appreciate the opportunity for regular vetting of AUC by specialists. This allows neurologists to identify areas of concern and provide clarification better than the ACR
scorecard approach. We also agree with the emphasis that is placed on workflow and the need to not further burden healthcare providers. The AAN does worry, however, that the timeline may be too short for vendors to implement and for healthcare providers to implement into their current workflow. We do not believe vendors are already working on this as standards are still continuing to evolve. CMS should consider pushing back the mandated timeline to allow 18 months for implementation.

This is especially important if a physician’s EHR is not yet compatible or automated, creating the need to use a third party with yet more training to fully implement and understand a new user interface. This proposal may also increase the cost of EHR systems. Despite near universal use of EHRs, it is difficult to implement CDSM, especially for small and solo practices that do not have ready access to technical expertise and must rely on the EHR company to do this for them. Furthermore, we would also like to see seamless integration of CDSM tied to a vendor’s certification standards. This would ensure that vendors are designing their systems to comply with new regulatory standards and have seamless integration into their systems.

Additionally, the method used to create the initial list of priorities is reasonable, but places more emphasis on neurology than other specialties. As the use of AUC evolves, and there becomes more data from prior authorizations that will be mandated when there are outliers, information and expertise from the AAN should be used to refine the target list. This focus could then shift more to those areas of suspected abuse or confusion about the value of imaging, rather than concentrating on the volume of MRIs ordered for standard neurologic conditions. We believe it will benefit the AUC committee to value guideline experts, such as the AAN’s experts on imaging services. Groups like the NQF cannot be the only resources for approving changes to the AUC.

We agree that the ordering physician must have access to the AUC and references when using the CDSM. We question whether there will be a mechanism for recording the reason for disagreement, rather than a simple checkbox to indicate agreement, disagreement, or not applicable. This would help evolve the AUC over the years.

The AAN also wishes to express an interest in working with CMS, especially if there is a way for the CDSM feedback to be incorporated into our Axon QCDR. Because Axon is approved by CMS, there may be a way to explore tying AUC compliance reporting into Axon’s real-time dashboard.

V. Accountable Care Organizations

The AAN supports CMS’ proposed quality reporting changes. It is imperative that neurology practices have the opportunity to report their own measures, especially using our Axon QCDR to report if the ACO does not report measures that are pertinent to neurology. Furthermore, although we support improving the validation of reporting, it is not clear the CMS proposal as currently stated would reduce burdens on physicians and we caution CMS to consider the impact this will have on an already stressed physician workforce.
The beneficiary assignment proposal addresses some of the AAN’s concerns regarding the attribution process. As a fundamental policy, the AAN continues to advocate that neurologists should be held responsible only for the costs that are within their direct control. They should not be held responsible for costs related to illnesses and for care outside of this specific scope.

Previously, we asked CMS to allow Medicare beneficiaries the opportunity to specify their principal physician and modify that designation when their health needs change. Therefore, we are pleased to see this proposal’s intention to allow a patient the ability to voluntarily assign a neurologist as their “main doctor”. This is important to neurologists because they may provide a patient ongoing services on an occasional basis at the request of a primary care provider; but, the neurologist may become the primary or principal physician during a period of acute or chronic illness, as during the first months after a stroke, or during a progressive illness such as ALS.

Furthermore, CMS states it may use terminology based on focus group testing and/or other feedback from beneficiary representatives. We implore CMS to include the AAN in these discussions, especially as they relate to cognitive care. It also remains our policy that the beneficiary assignment process should avoid the use or reference to “primary care services.” Physicians who see patients face-to-face bill Medicare under new or established patient E/M visit codes. There is no code in the Fee Schedule for “primary care services.” Primary care physicians and cognitive specialists like neurologists bill identical codes and either may coordinate care for individual patients.

VI. Reports of Payments or Other Transfers of Value to Covered Recipients

The IRS requires that a report of income be sent both to the income’s recipient and to the IRS. The AAN questions whether CMS’ Open Payments policy could offer a similar structure. When a report is sent to CMS, a copy would be sent to the physician in question. In this way, there is knowledge up front that such a company or hospital has reported a transfer of value, and an early opportunity to question the basis for the report. This would be one step toward making the reporting system more accurate. It also provides an easier way for a physician to trace the source of a report.

Furthermore, the funds transferred in a teaching hospital do not always accrue to the named physician. A school or department may take and impound these funds, using them for another purpose, even though the funds were originally intended for a specific physician. Simply put, the physician may never see these funds. We believe there should be a provision that transfers of value attributed to a physician be those that were actually received by that physician and made available for that physician’s discretionary use.

Still, many neurologists note that the reported amounts on Open Payments differ from what their institutions received. In many cases, neurologists were only made aware of this by looking themselves up in the Open Payments database. Therefore, we believe it would be useful if the database could be refined in terms of the costs it publishes for public review. It may be misleading to the public that a researcher appears to have received funds which are not allocated toward physician compensation, a distinction not reflected in the current data.
We also ask CMS to redesign Open Payments’ dispute process icon. Users who view a physician see a flag, as if to infer a warning, next to “Total Disputed Payments” and “Total Undisputed Payments”. At best this is unclear and at worst it implies the dispute process is somehow inherently problematic. This is not the case. The dispute process is an important tool to ensure the integrity of the data and to protect physicians from misinformation. CMS should release data from its focus group testing that indicates consumers understand the meaning of a dispute process and do not misinterpret how it is currently visually represented on Open Payments.

VII. Conclusion

We greatly appreciate this opportunity to share the views of the AAN regarding the proposals and issues raised by CMS in this rule. If you have any questions regarding our letter, please contact Daniel Spirn, Regulatory Counsel for the AAN, at dspirn@aan.com or (202) 525-2018.

Sincerely,

Terrence L. Cascino, MD, FAAN
President, American Academy of Neurology