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American Association of Oral and Maxillofacial Surgeons

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February 7, 2023

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: Division of Outpatient Care, Acting Director, David Rice
Baltimore MD 21244

RE: Pre-Proposed Rule CPL Recommendations for CY 2024

Dear Sir/Madam:

The American Association of Oral and Maxillofacial Surgeons (AAOMS) appreciates the opportunity to nominate procedures for addition to CMS's Ambulatory Surgery Center Covered Procedure List (ASC CPL) in advance of the CY 2024, Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Proposed Rule.

AAOMS represents more than 9,000 oral and maxillofacial surgeons in the United States. AAOMS supports CMS's overarching commitment to patient safety but wishes to emphasize that evolving technology and treatment modalities have allowed for increasingly complex procedures to be performed safely and efficiently across a wide range of care settings, including ambulatory surgery centers. The AAOMS Committee on Healthcare Policy, Coding and Reimbursement convened a special panel of surgeons with extensive experience performing orthognathic surgery to evaluate whether certain oral and maxillofacial surgical procedures meet the criteria for addition to the ASC CPL. The specialty panel reviewed each oral and maxillofacial surgical procedure payable in the outpatient setting for CY 2023, assessing the merit of the exclusion from payment in the ASC through both a retrospective case log review and a comprehensive search of current scientific literature and perioperative protocols for orthognathic surgery procedures. Through this process, the panel identified and reached an expert consensus on the recommendation of four codes to the ASC CPL for CY 2024.

We hope to be able to work with CMS in the reconsideration of facility coverage for select procedures we believe not only meet the longstanding patient safety criteria but represent a mechanism for increasing access to care in a safe and cost-effective way. AAOMS strongly encourages the following procedures be added to the ambulatory surgery center coverage list:

- **21193 Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft**
- **21194 Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)**
- **21195 Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation**
- **21196 Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation**

Due to the high vascularity of the maxillofacial and maxillomandibular regions, blood loss is of primary concern to the OMS when treatment planning and furnishing orthognathic surgical procedures. However, the AAOMS specialty panel concluded that patients undergoing the above listed reconstructive procedures of the mandible experience minimal blood loss, with an average blood loss of 100cc or 100mL. This is consistent with Lee et al. that found the mean intraoperative blood loss for a typical single-jaw orthognathic case, specifically either a sagittal split ramus osteotomy (SSRO) or intraoral vertical ramus osteotomy (IVRO) ranges from 55 to 167mL and 82 to 104mL, respectively¹. Chen et al. reported an average interoperative blood loss of 105.9mL in patients undergoing bilateral vertical ramus osteotomy². It is an exceedingly rare instance, if ever, that a patient would need to remain hospitalized due to excessive blood loss. Indeed, although Moenning et al. reported a slightly increased average blood loss of 176.6mL, in a study of 171 patients undergoing SSRO none required perioperative blood transfusion³.

The implementation of advanced clinical protocols in conjunction with orthognathic surgery, particularly the four procedures being recommended for coverage in the ASC have been shown to improve patient outcomes by shortening length of stay, facilitating postoperative pain control and decreasing the incidence of postsurgical complications including nausea and vomiting⁴. For example, the Enhanced Recovery After Surgery (ERAS) protocol has been adopted across multiple specialties and represents a systematic, multimodal approach to improving patient outcomes⁵. Integrating perioperative ERAS protocols for areas of the head, neck, face and jaws include considerations such as presurgical hydration, glycemic control, patient mobilization and preemptive pain management. A retrospective study by Ferrara et al.⁵ found the implementation of ERAS protocols led to a decrease in overall length of stay, allowing for safe and effective same-day discharge for patients undergoing extensive bimaxillary or two-jaw orthognathic surgery. The authors also cited a decrease in blood loss, as well as opioid use based on implementation of the perioperative ERAS regiment⁵. A retrospective cohort study by Stratton et al.⁴ including both single-jaw and double-jaw orthognathic surgeries found that a standardized ERAS protocol was effective in reducing postoperative nausea and vomiting as well as opioid consumption in the postsurgical period.

Other factors have contributed to the mitigation of hemorrhage risk associated with certain orthognathic surgical procedures, particularly those described by codes 21193, 21194, 21195 and 21196. For instance, technique advancement has predominantly happened by way of efficiencies from virtual surgical planning (VSP). This process allows surgeons to anticipate issues intraoperatively, for example predicting bony interferences or the position of the inferior alveolar nerve. VSP may also be used to provide custom plates for rigid internal fixation and osteotomy cutting guides. This translates to less surgical time and a decrease in intraoperative blood loss.

It should be noted that each of the procedures being recommended for addition to the ASC CPL are “core” procedures which oral and maxillofacial surgeons are trained to perform during their residency program at accredited institutions. Further, none of the other patient safety criteria for exclusion from the ASC setting apply to the four mandibular procedures herein discussed. As such, AAOMS recommends that these procedures be added to the ASC CPL. The attached bibliography and cited references throughout support the premise that advancements in perioperative patient management and treatment protocols can be utilized to effectively improve patient outcomes and divert complex surgical procedures from more resource-intensive sites of service to the ambulatory setting.

It is also critical to consider the clinical population of patients who undergo these services. Oral and maxillofacial surgeons are primary surgical providers of patient services associated with the above listed codes. As such, we know relying exclusively on Medicare claims site-of-service data to define procedure location skews the outcomes because the vast majority of these services are provided for patients who are not covered by Medicare, thus not part of the Medicare claims database. The flaw in this methodology is supported by the extremely low frequency of many of these procedures in the Medicare population. The 9,000 fellows and members of AAOMS primarily perform these procedures in younger, non-disabled patients, who are not representative of the typical Medicare or Medicaid population.

As a specialty society, we recognize that the CMS classification of ASC procedures dictates the pattern of coverage in the ASC industry, both for federally funded programs and commercial carriers. The effect of coverage limitations on site of service for certain procedures inherently limits the ability of specialty societies to produce substantiating data from commercial and/or private payers that would more accurately represent the patients appropriately receiving these services in places other than an inpatient setting or, in some cases, hospital outpatient departments.

We respectfully request CMS to take a leadership position on this issue as place-of-service restrictions driven by such coverage policies have the potential to severely limit reasonable access to care and increase costs to the system without improving the quality of care provided.

It is the firm belief of AAOMS that the practitioner should not be restricted from utilizing an ASC when a patient’s medical condition, age, or anesthetic requirement is best served by

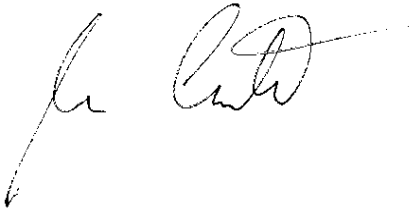
performing the procedure in an ambulatory setting. Furthermore, AAOMS believes that, especially after reviewing the CMS frequency data for these procedures, the exclusion of these codes would not translate into significant cost savings for the program. We also believe that the continued exclusion of these codes from the list of covered services could work to increase costs by shifting those services which could be safely performed in the ASC to the more costly hospital setting.

Thank you for your consideration of these comments. Please contact Patricia Serpico, Director, Health Policy, Quality & Reimbursement with any questions at 800-822-6637, ext. 4394 or pserpico@aaoms.org.

Sincerely,

A handwritten signature in black ink that reads "Paul J. Schwartz, DMD". The signature is written in a cursive, flowing style.

Paul J. Schwartz, DMD
AAOMS President

A handwritten signature in black ink that reads "Joshua E. Everts, DDS, MD, FACS". The signature is written in a cursive, flowing style.

Joshua E. Everts, DDS, MD, FACS
Chair, AAOMS Committee on Healthcare Policy, Coding & Reimbursement

CC: Scott Talaga Scott.Talaga@cms.hhs.gov
Mitali Dayal Mitali.Dayal2@cms.hhs.gov

References

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- 4 Stratton, M., Waite, P.D., Powell, K.K., Scopel, M.M. and Kukreja, P. (2021). Benefits of the enhanced recovery after surgery pathway for orthognathic surgery. *International Journal of Oral & Maxillofacial Surgery*,51(2). 214-218. <https://doi.org/10.1016/j.ijom.2021.04.008>
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