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Partnership for Quality Measurement
Submitted electronically via p4qm.org/2025-MSR-Cycle-Proposed-Measure-Comments

Subject: Proposed Measures for the 2025 Measure Set Review (MSR) Cycle

Dear Members of the 2025 PQM MSR Recommendation Group:

On behalf of the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), representing more than 4,000 neurosurgeons in the United States, we appreciate the opportunity to comment on which quality measures should be prioritized for review during the 2025 Measure Set Review (MSR) cycle, which considers measures for continued use in select Centers for Medicare & Medicaid Services (CMS) quality programs.

Our comments below focus on the following measures:

- MIPS 459: Back Pain After Lumbar Surgery
- MIPS 461: Leg Pain After Lumbar Surgery
- MIPS 471: Functional Status After Lumbar Surgery

MIPS 459: Back Pain After Lumbar Surgery

Under this measure, for patients 18 years of age or older who had a lumbar discectomy/laminectomy or fusion procedure, back pain is rated by the patients as less than or equal to 3.0 OR an improvement of 5.0 points or greater on the Visual Analog Scale (VAS) Pain scale or a numeric pain scale at three months (6 to 20 weeks) postoperatively for discectomy/laminectomy or at one year (9 to 15 months) postoperatively for lumbar fusion patients. Rates are stratified by procedure type; lumbar discectomy/laminectomy or fusion procedure.

The AANS and CNS continue to oppose the use of this measure in the Merit-Based Incentive Payment System (MIPS). We believe this measure is poorly written since it assumes back pain is the primary indication for surgery. If a surgeon is doing a decompression procedure (lumbar discectomy or laminectomy) for a patient who has leg pain, but no back pain, an improvement of 3.0 points may be difficult and the surgeon would perform poorly on this measure. Put another way, a lumbar spine operation may still be high-quality from a technical and clinical standpoint, even if the patient's back pain remains constant. We believe the flawed construction of this measure has contributed to its lack of use under the program and CMS' inability to accrue enough data to calculate a benchmark year after year.

As such, we believe that the PQM should prioritize MIPS 459 for review under the MSR process and recommend removing it from the program.

MIPS 461: Leg Pain After Lumbar Surgery

Under this measure, for patients 18 years of age or older who had a lumbar discectomy/laminectomy or fusion procedure, leg pain is rated by the patient as less than or equal to 3.0 OR an improvement of 5.0

points or greater on the VAS Pain scale or a numeric pain scale at three months (6 to 20 weeks) for discectomy/laminectomy or at one year (9 to 15 months) postoperatively for lumbar fusion patients. Rates are stratified by procedure type; lumbar discectomy/laminectomy or fusion procedure.

The AANS and CNS believe this measure is poorly written since it assumes leg pain is the primary indication for surgery. Similar to our argument against the use of MIPS 459, but in reverse, back pain could be the overriding symptom in a patient that receives a fusion procedure, in which case, an improvement of 3.0 points related to leg pain may be difficult to achieve. We believe the flawed construction of this measure has contributed to its lack of use under the program and CMS' inability to accrue enough data to calculate a benchmark year after year.

As such, we urge the PQM to prioritize MIPS 461 for review under the MSR process and recommend removing it from the program.

MIPS 471: Functional Status After Lumbar Surgery

Under this measure, for patients age 18 and older who had a lumbar discectomy/laminectomy or fusion procedure, functional status is rated by the patient as less than or equal to 22 OR an improvement of 30 points or greater on the Oswestry Disability Index (ODI version 2.1a) at three months (6 to 20 weeks) postoperatively for discectomy/laminectomy or at one year (9 to 15 months) postoperatively for lumbar fusion patients. Rates are stratified by procedure type; lumbar discectomy/laminectomy or fusion procedure.

The AANS and CNS believe that MIPS 471 is an important measure that should remain in MIPS, at least until more clinicians have had an opportunity to report on it. At the same time, we are concerned that few, if any, clinicians report on this measure due to the fact that the only acceptable functional assessment tool that can be used to satisfy it is the Oswestry Disability Index (ODI). The AANS and the CNS urge CMS to work with the measure developer to incorporate other, more appropriate functional outcome tools, such as PROMIS® (Patient-Reported Outcomes Measurement Information System), into MIPS 471. Most other measures in MIPS offer clinicians a choice of tools and do not pigeon hole clinicians into using one specific tool. For example, despite our opposition to MIPS 461 and 471, these two measures rely on "either a postoperative Visual Analog Scale (VAS) Pain **or** Numeric pain score," providing clinicians with the flexibility to choose the most appropriate pain scale tool for their patient population. Similarly, the specifications for MIPS 358: Patient-Centered Surgical Risk Assessment and Communication state that "risk calculators based on multi-institutional, validated clinical data are acceptable for this measure." The measure specifications go on to cite the American College of Surgeons' NSQIP risk calculator as an example, but notes that other risk calculators are available and acceptable for this measure, including but not limited to the risk calculator from the Society of Thoracic Surgeons.

If the MSR process affords the opportunity to suggest changes that would strengthen a measure, then we believe that the PQM should prioritize review of MIPS 471. We believe that by expanding the choice of functional status tools available under this measure, more clinicians would be willing to report it and CMS would accrue enough data to calculate a benchmark. However, if the MSR process is solely concerned with whether or not to retire a measure from a program, then we do not believe that the PQM should prioritize this measure for review and that CMS should instead work with the measure developer to expand the measure's list of acceptable functional assessment tools.

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The AANS and the CNS appreciate the opportunity to provide feedback on measures under consideration through the MSR. If you have any questions or would like to discuss these issues further, please contact Rachel Groman, Vice President of Clinical Affairs and Quality Improvement at Hart Health Strategies, at rgroman@hhs.com. Thank you.

Sincerely,

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