Autumn ■ 2012

Spine Section Newsletter

AANS/CNS Joint Section on Disorders of the Spine and Peripheral Nerves

American Association of Neurological Surgeons

and the American Association of Neurosurgeons

Education and Innovation

Welcome

Welcome to the Newsletter of the Spine and Peripheral Nerve Joint Section of the American Association of Neurological Surgeons and Congress of Neurological Surgeons.

Charles Sansur and I will try to put together a semi-quarterly update on issues relevant to spine surgeons.

In this issue, we present a brief update on RUC activity, concentrating on code surveys that are pending for the fall, and on the Rapid Response Team ran by Joe Cheng. To illustrate what this tirelessly working group of volunteers is doing, we are linking to 2 separate letters prepared by the team.

The content from these letters can be used in your appeals to insurance companies or used for talking points when you are doing peer reviews for denials of coverage, if desired.

In the next issue, I hope to have a review of what spine surgeons need to do now to avoid reimbursement cuts applied by the upcoming transition of PQRS measures from a carrot to a stick. Previously, reporting PQRS measures was voluntary, and led to small bonuses in Medicare reimbursement. Now, surgeons face imposition of CMS reimbursement decreases to practices that do not demonstrate compliance with PQRS measures.

If all of this sounds like alphabet soup, consider taking one of the sponsored coding courses linked to on the back page of the Newsletter!

We are open to suggestions of other content and would be happy to review and publish member content, please feel free to contact us. We would like this to be your newsletter, but we need member direction to accomplish that goal!

Thanks again and let us know what else we can do!

John Ratliff, MD jratliff@stanford.edu
Charles Sansur, MD csansur@gmail.com

Rapid Response Team Members

- **Joseph Cheng, MD** *(Chair)*
- **Charles Sansur** *(Vice Chair)*
- **Peter Angevine**
- **Kurt Eichholz**
- **Kai-Ming Fu**
- **Kojo Hamilton**
- **Dan Hoh**
- **Michael Kaiser**
- **Praveen Mummaneni**
- **David Okonkwo**
- **John Ratliff**
- **Mike Steinmetz**
- **Karin Swartz**
- **Lou Tumialan**

Spine Section's Rapid Response Committee Continues to Address Multiple Insurer Policy Issues

Insurance companies and other payers for health care often change protocols over what services will be covered under a given insurance policy. These policies have the potential to impact patient care, by denying coverage for some treatment options. By denying coverage, physician choice of what may be best for their patients is limited.

Joseph Cheng developed the Rapid Response Team to answer these concerns and to provide a working group to respond to insurance industry policy. The foundation of the team was reviewed by Kurt Eichholz in a previous edition of the Section newsletter: http://www.spinesection.org/files/pdfs/newsletters/spinenews1011.pdf

By noting that a given procedure is "experimental" an insurance company deems that it is investigational as well, and therefore not medically necessary. This obviates the need for the insurer to cover the procedure for their covered members.

■ *Continued on page 2*

■ *Continued from page 1*

Committee Addresses Multiple Insurer Policy Issues

Here are some topics that the Rapid Response Team has recently participated in. Two letters prepared by the team are included in the newsletter, with links to the full content of the letters for your review. Many thanks to Cathy Hill, for assistance in preparing this summary of Rapid Response Team activity!

AHRQ Requests Comments on Key Questions in Proposed Research

A number of members of the Rapid Response Team recently contributed to answering a set of Key Questions posed by the Agency for Healthcare Research and Quality, reviewing research options on the topic of spinal fusion for degenerative disease.

The draft question list is available at: http://effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?search=&topicid=410&pageaction=displaytopic

This effort is extremely important, since it may direct where funding for future studies may be targeted. The comments also sought to direct funding away from avenues that may not improve patient care.

The entirety of the letter is linked to at: http://spinesection.org/files/pdfs/Rapid Response/AHRQ Spine Fusion CER 2.21.12.pdf.

BCBS of Michigan Minimally Invasive Lumbar Interbody Fusion

BCBS of Michigan developed a policy review noting that lateral interbody fusion techniques were experimental and investigational. The Rapid Reponse Team developed a reply, linked to at: http://spinesection.org/files/pdfs/Rapid Response/AANS-CNS Comments Michigan BCBS Spine Fusion 5 1 12.pdf.

Washington State Health Care Authority BMP Review

On March 16, 2012, the Washington State Health Care Authority held a meeting to discuss and vote on coverage for use of bone morphogenetic proteins in spine surgery. John Ratliff, MD, made a presentation based on comments submitted by AANS and CNS in response a Technology Assessment on the use of BMP in spine fusion. The Spine Section Rapid Response Team prepared the comments, which answered questions considered key by the group in their assessment of coverage and policy. Brian Hoh, MD, Charley Sansur, MD, Kojo Hamilton, MD, Karin Swartz, MD, Lou Tumialan, MD, Pete Angevine, MD, Kai-Ming Fu, MD, Kurt Eichholz, MD and others contributed. Trent Tredway, MD, also attended the meeting.

The panel voted not to cover any uses of BMP-7, which has a humanitarian exemption and is rarely used. The panel voted to accept the use of BMP-2 for the FDA on-label uses in the lumbar spine and for lumbar spine surgery for patients who are at high risk not to fuse.

Minnesota Blue Cross/Blue Shield BMP Policy

AANS and CNS joined the Scoliosis Research Society in a letter to Blue Cross/Blue Shield of Minnesota regarding its policy regarding BMP. Our letter focused on process related issues, including a lack of transparent process development and of a clear rationale for the policy. We were concerned that the payer is essentially limiting the surgical tools that surgeons are using to take care of their patients and threatening to refuse payment for physician and hospital charges affiliated with a spine surgery if BMP is used.

WellPoint Requests for AANS/CNS Input

The Rapid Response Team is also the primary source for responses to WellPoint requests for comments on a variety of issues. One of the recent responses required work with our colleagues in radiation oncology, primarily Jason Sheehan, MD. WellPoint asked for input on a draft policy that includes specific criteria for when stereotactic radiosurgery or stereotactic body radiotherapy (SBRT) is medically necessary.

Oregon Coverage for Lumbar Fusion

The Oregon Healthcare Authority (HCA) has begun conducting coverage reviews similar to those in Washington State. Oregon's Healthcare Evidence Review Commission (HERC) has three subcommittees. The Healthcare Technology Assessment Subcommittee (HTAS) has oversight for the development of healthcare assessments and coverage guidance development. On April 23, 2012, the HTAS met to discuss a draft coverage guidance for artificial discs, vertebroplasty, kyphoplasty, sacroplasty and discography. The HTAS considers several sources for technical assessment including AHRQ and the Washington State Health Technology Assessment.

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Read this entire letter at:
http://spinesection.org/files/pdfs/Rapid Response/AHRQ Spine Fusion CER 2.21.12.pdf

February 21, 2012

Scientific Resource Center, Oregon EPC
Mail code: BICC
3181 S.W. Sam Jackson Park Road
Portland, Oregon 97239-3098

RE: Key Questions -- Spinal Fusion for Painful Lumbar Degenerative Disc or Joint Disease

To whom it concerns:

On behalf of the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), we would like to thank the Agency for Healthcare Research and Quality (AHRQ) for the opportunity to comment on the Key Questions regarding proposed research on the topic of "***Spinal Fusion for Painful Lumbar Degenerative Disc or Joint Disease***". We appreciate the efforts of AHRQ's Effective Health Care Program, and the research summaries regarding the benefits and risks of different treatment options for health conditions based on comparative effectiveness reviews. We also understand that these research summaries are not clinical recommendations or guidelines, but are nevertheless frequently utilized as such with respect to healthcare policy development.

For the formulation of each of these Key Questions, AHRQ has requested a description of the included studies including patient indications, methods of diagnosis, inclusion and exclusion criteria, treatments, and surgical techniques and devices used. The AANS and CNS, along with other medical societies, have developed clinical guidelines on this topic and do not feel that another systematic review of these questions will yie
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Read this entire letter at:
http://spinesection.org/files/pdfs/Rapid Response/AANS-CNS Comments Michigan BCBS Spine Fusion 5 1 12.pdf

May 1, 2012

Thomas L. Simmer, MD
Chief Medical Officer
Blue Cross and Blue Shield of Michigan
600 Lafayette Blvd.
Detroit, MI 48226-2927

Subject: BCBSM Policy on Minimally Invasive Lumbar Interbody Fusion

Dear Dr. Simmer:

On behalf of the American Association of Neurological Surgeons (AANS), the Congress of Neurological Surgeons (CNS), and our AANS/CNS Joint Section on Disorders of the Spine and Peripheral Nerves, we would like to thank Blue Cross-Blue Shield of Michigan for the opportunity to comment on the BCBSM medical policy BCBSM Minimally Invasive Lumbar Interbody Fusion. We appreciate the efforts of your team in developing a review of the published literature reporting on the use of minimally invasive procedures for lumbar interbody fusion such as lateral interbody fusion (e.g., extreme lateral lumbar interbody fusion or XLIF, direct lateral lumbar interbody fusion or DLIF), but ***disagree*** that such interventions are considered experimental and investigational, and not medically necessary.

We believe that minimally invasive lateral interbody fusion (e.g., XLIF, DLIF) with direct visualization is a medically necessary option in appropriate patients with medical indications as determined by their treating physician. There is a distinction between percutaneous procedures, in which the surgeon is unable to directly visualize the anatomy being operated on with the naked eye, with minimally invasive (MIS) procedures, which are open procedures using specialized retractors, such as muscle-dilating retractor systems, to allow direct visualization of the spinal structures. Open, or direct visualization, lateral interbody fusion procedures are reported with the appropriate CPT code: 22558, Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar

Lateral lumbar interbody

Date: March 6 to March 9, 2013. **Where:** Phoenix, Arizona

29th Annual Meeting

of the AANS/CNS Section on Disorders of the Spine and Peripheral Nerves

Maximum Impact: Surgeons as Key Advocates in Patient Care

Abstracts

The abstract center for the meeting is open and located here: http://spine13.cns.org/

Submission deadline is September 13, 2012, at 11:59 PM CST!

Abstract Guidelines:

All abstracts must be submitted through the AANS/CNS Section on Disorders of the Spine and Peripheral Nerves online Abstract Submission Center. Abstracts may not exceed 300 words and must include four areas:

- **Introduction** - Should clearly state the problem and purpose of the study
- **Methods** - Should provide a description of what was actually done
- **Results** - Should contain the findings of the study
- **Conclusions** - Should be based upon the findings and relate to the stated purpose of the study and existing knowledge

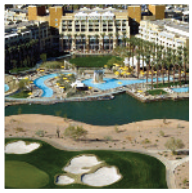
JW Marriott Desert Ridge

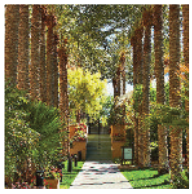
Phoenix, Arizona

The JW Marriott Desert Ridge offers luxury accommodations and amenities your whole family is sure to enjoy, from fine dining to a host of recreation opportunities. This 316-acre luxury resort features a unique architectural design incorporating the elements of nature: fire, water, earth and sky.

Amenities:

- Deluxe guest rooms, overlooking wildflower gardens, swimming pools, lakes, waterways and golf course or mountain views.
- Four fine-dining restaurants, two cafes, a lounge and a spa bistro.
- Four acres of turquoise pools and shimmering waterways.
- WildFire Golf Club featuring two on-site 18-hole golf courses.
- Off-site activities including Horseback riding, hot- air ballooning, off-road desert tours and great shopping.
- Stunning, two-story spa oasis, featuring signature treatments that combine ancient rituals with cutting- edge techniques.





Phoenix, Arizona

Coding Courses

If all this coding stuff seems Greek to you, consider taking one of the coding courses sponsored by the AANS. Managing Coding & Reimbursement Challenges in Neurosurgery 2012 is designed to keep surgeons and their staff members up to date on the latest changes in CPT coding and the latest insights in reimbursement.

The courses are taught by a crack team of neurosurgeons managed by Joseph Cheng, Course Director, and John Ratliff, Course Co-Director, along with professional coding consultants from Karen Zupko and Associates.

The goals of the course are:

- Apply correct CPT coding concepts to key neurosurgical services
- Discuss application of new and revised neurosurgical CPT codes in reporting services.
- Discuss ways you can streamline processes to reduce overhead in your practice.

Details and a schedule of courses are available at www.aans.org.

Random Case & Question

A 39 y/o female presents with low back pain and right greater than left bilateral lower extremity pain. Symptoms were much worse after a recent pregnancy. Pre-op images show a grade III spondylolisthesis with severe bilateral foraminal stenosis (***Fig 1, sag CT recon midline image***).

Fig 1, sag CT recon midline image

Fig 2, sag CT recon midline image

Fig 3, sag MRI image

After failing conservative therapy, she is treated with an anterior and posterior reconstruction with reduction of her deformity (***Fig 2, sag CT recon midline image***). Lateral sagittal CT images and axial CT images confirm good bony foraminal decompression. She is intact immediately post-op.

Post op day #1 she develops bilateral LE foot drops, with weak dorsiflexion, inversion, and eversion. An MRI shows no hematoma, the degree of foraminal decompression is impossible to judge on MRI due to hardware artifact (***Fig 3, sag MRI image***).

What do you do? Observe it? Explore the foraminotomies? Take our survey at: https://www.surveymonkey.com/s/Spinesectionnewslettersurvey

Results and the correct answer will be in the next issue of the Newsletter!

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