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

This is the largest newsletter we have published recently; the DSPN is excited to be offering this content to our members.

John O’Toole has joined the Newsletter team and conducts a Q&A with our most recent Past Chair of the Joint Section, John Hurlbert. We will try to continue to interview each of the Chairs and Past Chairs in future editions.

The Nerve Update expands substantially in this issue. Raj Midha is interviewed by Cheerag Upadhyaya and gives an overview of the history of peripheral nerve in the Joint Section. Zack Ray and Thomas Wilson provide a quick review of the clinical importance of eversion and inversion. Finally, there is a nerve member update focusing upon course offerings and grant opportunities. Thanks to Line Jacques and Lynda Yang for putting together a great nerve section for the Newsletter!

I offer an update on the RUC and on the recent drama with 63047 and 22630/22633 coding.

Bradley Jacobs, Chair of the DSPN Rules and Regulations Committee, has a review of the Rules and Regs changes that are up for review by our membership.

John Ratliff, MD, jratliff@stanford.edu
John O’Toole, MD, john_otoole@rush.edu

Interview with Past Chair John Hurlbert

John O’Toole: Your year as Chair of the AANS/CNS Section on Disorders of the Spine and Peripheral Nerves was marked by a number of exciting changes and daunting challenges. What would you say you were most proud of and most challenged by during that year?

John Hurlbert: As a Spine Section I think this past year provided two major challenges, one professional and one personal. Our professional challenge was not unexpected and relates to our annual meeting. The political and economic landscape of Spine Surgery is changing now more than ever. Keeping the Spine Section not only viable but vital means that we have to adapt to these changes. Finding the right recipe towards which to allocate our energies and resources has become a very fluid endeavor. We benchmark our impact and our success from membership attendance and industry participation at our annual general meeting. We continue to meet our target in these respects but it gets harder every year. We may end up having to change not only what we do, but how we measure it.

This year brought a challenge of a very personal nature to the Spine Section. As a cataclysmic example of how ground zero can change suddenly and permanently we lost one of our biggest assets, Dr.
Interview with Past Chair John Hurlbert

Continued from page 1

Charles Kuntz III. One day he was with us and the next he wasn’t. It was way more than just about losing our astute and insightful treasurer. Over the past decade Charlie had become a highly respected voice on the Executive Committee, known for both his patience and his wisdom. When Charlie spoke everyone listened; what he said often changed the way we thought. He represented a tangible piece of the future for our Spine Section. The void he has left behind will be felt for many years to come. We miss you Charlie.

We were able to accomplish some important behind-the-scenes pieces that I hope will serve the Section well into the future. As the Spine Section’s mandate and activities have grown, it has become an increasingly difficult task to coordinate the efforts of those involved. We attacked this issue from two directions. First we tightened up the Executive Committee structure and function by revising our Rules and Regulations to better reflect operational efficiencies that had naturally evolved over the years. Second we re-incarnated a document used nearly a decade ago to track individual activities on the executive committee affectionately termed the “Grid”. It’s basically a spreadsheet that displays officers and committee members in a top-down matrix over time providing an opportunity to recognize people’s strengths and skillsets, allow them to grow, and to secure the lineage of the Spine Section. From the hard work of a few key individuals this new grid not only allows us to define the next decade of the Section but it also provides a permanent record of our history.

Beyond a doubt John, I am most proud simply about having had the honor to serve as Chairperson for a year. I think it’s probably much like commanding an aircraft carrier; there’s a lot of traffic coming and going but the course is set and most of it is already taken care of by the people working for you. They know their jobs and they do them well. In my opinion the privilege is more about the posting rather than any individual or their actions.

John O’Toole: The re-organization of the Annual Section Meeting into the “Spine Summit” was a resounding success in bringing together representatives from the sundry spine societies that exist today. Do you think there is greater potential for the academic and political integration of spine organizations?

John Hurlbert: I appreciate the compliment. Thanks John. But it really was just a baby step. The mandate of the Spine Section can be summarized into three broad categories: (1) Education; (2) Research; and (3) Advocacy. The idea behind the Spine Summit was to acknowledge to our Ortho-Spine Surgeon colleagues that they have an equal stake in this agenda. And that we could accomplish all three goals so much better working together rather than separately. As you can imagine – this kind of commitment can only be part of a process. Change doesn’t happen overnight. Re-branding our meeting and reaching out to Orthopedics was only the first step. The commitment has to mature and grow into all of our activities before I think we can expect our Ortho-Spine colleagues to become passionate about the Section.

So yes, there is a far greater potential for academic and political integration of Spine Surgery organizations and the benefits are hugely obvious. But I think it’s more than just a “potential”. The reality that I think we all realize is that the dollars available to fund Education, Research, and Advocacy come from a shrinking pool. But the number of Spine Societies and meetings continue to grow. From a standpoint of resources, efficiency, manpower, and efficacy we must either integrate or become obsolete. I know that the future leadership of the Spine Section shares this vision. It’s been an honor to help catalyze the process.

John O’Toole: What technical aspects of spine surgery do you think will have the greatest impact over the next 5 to 10 years?

John Hurlbert: I think the potential for greatest impact lies where there is greatest need. And as far as I can tell that need will continue to involve the aging spine. Without a doubt Spine Surgeons of tomorrow will have to be well-versed in integrating image-guidance with deformity correction as real-time imaging modalities become available. I also think it is likely that robotics will be used to augment percutaneous techniques. But I truly believe the Neurological Spine Surgeon’s most important contribution to society at large will be an ongoing ability to provide skillful, direct, and long-lasting decompression for the treatment of spinal cord and nerve root impingement. Instrumentation will always play a secondary role to that.

John O’Toole: You have been a prominent figure in the generation and propagation of clinical practice guidelines in spine surgery. What do you imagine the future holds for the intersection of evidence-based medicine, payer policy challenges and medicolegal issues for spine surgery in the next 10 years or so?
John Hurlbert: I think you’ve nailed it already in your question John. Payers want accountability. Regional variations in practice patterns don’t sit well in multi-national companies who need to manage budget forecasts through population statistics. Whoever pays the bills is going to have the biggest say in service delivery. We are going to see more and more involvement of third-party payers in patient care decision-making. These people are not surgeons, so they naturally look to societies such as ours to provide guidelines. The guidelines we write in the future will be aimed just as much at the insurance providers as they are for Spine Surgeons. Perhaps even more. I see this as a win-win situation. Building relationships with insurers is an exciting and innovative way to help us strengthen our Advocacy role. Stay tuned!

I hope we can maintain “arms-length” when it comes to medicolegal guidelines. Unlike insurance companies, lawyers inherently tend to interpret position statements in a very literal manner and to the benefit of their client at the time. Providing medicolegal guidelines on a regular basis would not be a good use of our skills in my opinion.

John O’Toole: You have had a unique perspective as a Canadian neurosurgeon leading the Section. Are there ways we can better integrate both the educational and administrative aspects of neurosurgery across all of North America?

John Hurlbert: I have to say John, it has been very disappointing for me to watch the rift that has grown between Canadian and American Neurosurgical Reciprocity as it pertains to licensure over the past 10 years. I know many others (American and Canadian alike) feel the same way. I find it somewhat ironic that a few key Neurosurgical opinion leaders are so very intent on keeping Spine within the specialty of Neurosurgery, yet at the same time have been very eager to cleave training ties between the US and Canada. In as much as Spine has traditionally been a part of Neurosurgery, our Neurosurgical roots share a deep history of both Canadian and American content. Spine should always be a part of Neurosurgery. Canada and the United States should always graduate the best Neurosurgeons in the world. Together. Just like our forefathers did. We are SO much richer for it. I see the political winds that have torn us apart as a step backwards.

So yes, there are much better ways to integrate educational and administrative aspects of Neurosurgery across North America. We all used to benefit from them. It will take a significant amount of time and energy to rebuild these bridges. But most importantly it will take an appetite.

John O’Toole: As evidenced during your term as Section Chair, you are well known for your equanimity during difficult situations. How do you personally achieve balance as a spine surgeon with increasing clinical, academic, administrative and personal demands?

John Hurlbert: Balance is very much a moving target. There are different phases to personal life just as there are different phases to professional life. I don’t think there is a perfect formula. Instead balance is fluid and has to be a very individual experience. Perhaps what I’ve learned most could be summarized into three points.

1. Never feel guilty for the work you do or the hours you spend doing it. To be a Neurosurgeon is one of the greatest privileges you will ever have. Very few people in the world ever get a similar opportunity. Every minute you spend feeling guilty about it is a minute of your talent wasted. And a minute of your life wasted.

2. Balance the patient and your family in a way that works for you. Happiness will not be yours if you live your life by someone else’s standards. Your children will always love you. Unconditionally.

3. For all other matters in life (besides patient and family) learn to say “no” from time to time. Even within our own profession volunteer work (boards, societies, committees etc.) can and will overwhelm you. In my opinion tempering these activities is where true balance lies.

John O’Toole: What advice would you give to young spine surgeons who aspire to become involved in the Section and contribute to our organization?

John Hurlbert: Despite my reservations noted above, volunteer work is a very critical component of our profession. Self-governance is a founding cornerstone of medicine. Every ounce of energy we put into education, research, and advocacy is energy reinvested in the present and future of Spine Surgery. If we don’t put this effort into our specialty, we will lose the ability to ensure the future of it. Although volunteer work can be consuming, it can fit into a balanced lifestyle if one remains focused and strategic.

My advice to young spine surgeons is to be passionate. Channel that passion into selected, worthy causes. The Spine Section is absolutely a worthwhile cause. It has accomplished so much its 35 years. It will accomplish a lot more in the next 35. Come to the meetings. Introduce yourself to me or any of the other officers. Not just one year, but every year. Volunteer. It’s a small community. You’ll be seen. You’ll be engaged. And you’ll be appreciated.

John O’Toole: There is no doubt that all of us in the Section and beyond are grateful for your service and leadership. Congratulations on a great year as Chair and thank you for your ongoing commitment to our society!!

John Hurlbert: Thank-you John. This year as Chair of the Nominating Committee has been very rewarding as well. I’m really looking forward to providing continued presence and support on the Executive Committee for our new leadership as it evolves. It remains an honor to be part of such an outstanding organization.
Dear Members,

As part of the Section for Disorders of Spine and Peripheral Nerves, we would like to keep our members updated with news related to upcoming peripheral nerve meetings, announcements, and topics of interest – this month, we are featuring (1) an interview with Dr. Rajiv Midha on the “History of Peripheral Nerve as an Integral Part of DSPN,” (2) a “Learning Corner,” and (3) updates for our members.

We hope the inclusion of this information will facilitate communication among our members and other interested participants – and serve as a useful tool. We welcome your feedback, and member contributions of any news are appreciated. Please do not hesitate to contact Line Jacques (line.jacques@ucsf.edu) or Lynda Yang (ljsyang@med.umich.edu) with any comments or questions.

Respectfully submitted,
Line and Lynda

Interview with Dr. Rajiv Midha, MD, MSc, FRCSC, FAANS
(Professor of Neurosurgery and Head, Department of Clinical Neurosciences, University of Calgary)

by Cheerag Upadhyaya, MD, MSc (University of Missouri, Kansas City, MO)

How did peripheral nerve become part of DSPN?

Peripheral Nerve has been an integral part of DSPN since the inception of the Section. In the 1970s, the leadership of organized neurosurgery formed an ad hoc working committee to answer the challenge from orthopedic spine surgery. This committee was composed of Dr. Robert B King, Dr. William Collins, Jr., Dr. Charles A Fager, Dr. David L Kelly, Jr., and Dr. David G Kline. Dr. Kelly chaired this committee, and Dr. Kline “represented” peripheral nerve.

This ad hoc committee’s actions ultimately resulted in the establishment of DSPN as a separate section. Indeed, the Section on Disorders of the Spine and Peripheral Nerves was formally founded at the suggestion of Albert L. Rhoton, MD in 1978 to Charles Drake, MD, President of the AANS in 1978. Also instrumental were Stewart B. Dunske, MD and Russell Travis, MD. Concurrently, the leadership of AANS felt that peripheral nerve would not have enough financial viability and critical mass as an independent section. Therefore, Dr. Stewart B Dunske was an early and avid proponent of combining peripheral nerve surgery with spine surgery within a single section – since spine and peripheral nerve are intellectual complements.

As the DSPN matured, an Executive Committee was formed, and peripheral nerve was represented by an ad hoc member-at-large. Early representatives to the DSPN Executive Committee included Dr. John E McGillicuddy, Dr. James N Campbell, and Dr. Allan Belzberg, and more recently, Dr. Eric Zager. In 2001, Dr. Regis Haid asked me [Midha] to lead the establishment of a peripheral nerve task force to create an organized sub-structure within DSPN. The original goals were to improve the educational content of the DSPN meetings and to increase the market share of peripheral nerve surgery (since peripheral nerve surgery is also performed by orthopedic surgeons and plastic surgeons) – and the current Peripheral Nerve Division continually strives to meet these aims.

What is the history of the Peripheral Nerve Division

Neurosurgeons with an interest in peripheral nerve surgery did not formally assemble in...
the very early years of neurosurgery. Rather, peripheral nerve surgery developed with the second generation of neurosurgeons after Dr. Harvey Cushing. For example, Dr. Frank E. Nulsen reported the management and assessment of peripheral nerve injuries; Dr. Frank H. Mayfield published techniques of posterior interosseous nerve surgery, meralgia paresthetica, and compression syndromes; Dr. Barnes Woodhall published the management of traumatic peripheral nerve injuries, injection injuries to peripheral nerves, and the impact of chemotherapy on peripheral nerves; and Dr. Kemp Clark reported a series of injection injuries.

Subsequently, Dr. David G. Kline (1st peripheral nerve representative to DSPN) and Dr. Alan R. Hudson (University of Toronto, Toronto, Canada) defined the early years of peripheral nerve surgery; they met at a breakfast seminar at an AANS meeting in Honolulu and subsequently had a long collaboration, including many invited seminar and courses at national AANs and CNS meetings, followed by the the shared authorship of the 1st Edition of the Textbook: Nerve Injuries and later, the Atlas of Peripheral Nerve Surgery. Subsequently, Dr. John E. McGillicuddy became involved within the leadership of peripheral nerve surgery, followed by Dr. Allan H. Friedman and Dr. James N. Campbell.

What are some Peripheral Nerve Division accomplishments?

I believe that the peripheral nerve division has matured with several important accomplishments. First, peripheral nerve surgeons have become an integral part of organized neurosurgery via active representation through the DSPN and independently at all national levels. Second, peripheral nerve has an increased presence at the national meetings. For example, the importance of peripheral nerve is supported by a separate dedicated session at the annual AANS meetings. Indeed, Dr. Regis Haid was instrumental to helping establish this dedicated session. Third, the peripheral nerve division has helped in the diffusion of peripheral nerve surgery knowledge and techniques. As a consequence, there are an increasing number of neurosurgeons who are peripheral nerve surgeons, with leadership now in the hands of Lynda Yang and Line Jacques.

Fourth, peripheral nerve surgeons have been competitive for research awards. For example, since I won the Mayfield Award in 1992 from DSPN, there have been a number of neurosurgeons who have been awarded for basic science and clinical peripheral nerve research.

What is the role of the peripheral nerve neurosurgeons in an interdisciplinary field of orthopedic surgeons, plastic surgeons, etc?

Similar to neurosurgeon spinal surgeons in interdisciplinary organizations such as NASS and SRS, peripheral nerve neurosurgeons are also involved in the leadership of several interdisciplinary organizations (e.g., American Society for Peripheral Nerve, Sunderland Society) by supporting / creating scientific programs and presenting original research.

Two models are developing in North America regarding the evolution of peripheral nerve surgery within neurosurgery. We are at the forefront in the interdisciplinary approach to the treatment of peripheral nerve injuries with the development of multi-specialty clinics across North America. In addition, neurosurgeons are also training in aspects of peripheral nerve surgery that have traditionally been part of other specialties such as free muscle transfers, so they can independently offer these approaches.

How did the Dr. David Kline Research Award and Lectureship become established?

This was the product of a collaborative relationship between peripheral nerve surgeons and industry. A productive relationship with Integra and Simon Archibald, PhD (then the Chief Scientific Officer, Integra Life Sciences) resulted in the establishment of the Dr. David Kline Research Award within DSPN. Similarly, when the dedicated peripheral nerve session was assigned annually at the AANS meetings, Integra graciously agreed to sponsor the Kline Lectureship.

What do you see as the future of peripheral nerve neurosurgery in terms of research, education, clinical practice, and finances?

The development of interdisciplinary peripheral nerve clinics and an increasing level of sub-specialization will define the future of peripheral nerve neurosurgeons. Clinically, there will be an increasing number of neurosurgeons who develop the full complement of skills required to perform all aspects of peripheral nerve surgery. In research, while there will be continued efforts directed at the basic science of nerve repair/regeneration, there will be increased efforts at translational research to apply the various biologic approaches such as cell therapeutics, electrical stimulation, and medications to clinical treatment. Clinical research that provides high-level evidence to support current clinical practice and to define preventive measures (especially in the prevention of brachial plexus injuries) will also be important. Finally, studies regarding the socio-economic aspects of peripheral nerve injuries and the cost effectiveness of peripheral nerve operations are coming to the forefront.

In terms of education, bedrock fundamental knowledge of the basics of peripheral nerve entrapments, injuries, and operative techniques will always be important to lay the foundation. However, there will be an increasing number of fellowships to help train dedicated peripheral nerve surgeons who can lead the development of interdisciplinary peripheral nerve clinics. Additionally, neurosurgeons will increasingly train across disciplines to adopt the techniques traditionally employed by plastic surgeons and orthopedic surgeons.

As with other subspecialties within neurosurgery, peripheral nerve surgery has been undervalued. The increasing sub-specialization, translation research, and clinical research will allow peripheral nerve neurosurgeons to demonstrate their value within the rapidly changing healthcare environment.

Furthermore, the value of peripheral nerve neurosurgeons will be enhanced with the development of large accountable care organizations and integrated healthcare networks.
Learning Corner

Why Inversion and Eversion Matter

by Wilson (Zack) Ray, MD (Washington University, St. Louis, MO), and Thomas J Wilson, MD (University of Michigan)

When patients present with foot drop (weakness of the tibialis anterior), the main neurologic differential diagnosis includes L5 radiculopathy versus Peroneal neuropathy. This is where inversion and eversion are of particular importance in differentiating a lumbar versus a peripheral etiology. The sciatic nerve divides into the common peroneal nerve and posterior tibial nerve proximal to the popliteal fossa. The most common site of isolated peroneal neuropathy is at the fibular head distal to the division of the peroneal and tibial contributions to the sciatic nerve. Entrapment of the common peroneal nerve at the fibular head produces dorsiflexion, extensor hallucis longus (deep peroneal n.), and eversion weakness (superficial peroneal n.).

The following chart shows a breakdown of exam maneuvers and their corresponding innervation:

<table>
<thead>
<tr>
<th>Peroneal</th>
<th>Tibial</th>
</tr>
</thead>
<tbody>
<tr>
<td>L5</td>
<td>Dorsiflexion</td>
</tr>
<tr>
<td>S1</td>
<td>Eversion</td>
</tr>
</tbody>
</table>

Dorsiflexion weakness with associated eversion weakness quickly moves the pathology to a peripheral location. Conversely, dorsiflexion weakness with associated inversion weakness moves the pathology proximal to the fibular head (L5 radiculopathy or Sciatic neuropathy). Electrodiagnostics can be useful, often demonstrating a focal slowing across the fibular head with a common peroneal neuropathy. While all radiculopathies do not have associated weakness, inversion and eversion are useful in helping rapidly localize the pathology causing foot drop.

Nerve Member Updates

1. The date and location for the Peripheral Nerve Division Business Meeting/Dinner, to be held during the 2015 CNS Annual Meeting

   September 27th 2015, 7:30pm
   Le Foret Restaurant New Orleans (private dining)
   1229 Camp Street
   New Orleans
   504 553-6738
   www.leforetneworleans.com

2. The 2016 Kline Lecture will be presented by Dr. Robert Spinner (Mayo Clinic) on May 3, 2016, during the 2016 AANS Annual Meeting in Chicago, IL. Title of the presentation TBD.

3. The current leadership of the peripheral nerve division is pleased to welcome Dr. Mark Mahan (University of Utah) as our next elected Secretary/Treasurer and Dr. Holly Gilmer as our Chair (Oakland University William Beaumont School of Medicine, Detroit, MI) for 2016-19.

4. The Kline Research Award will be offered again this year to support either basic or clinical research related to peripheral nerves with funding in the amount of $10,000. This research award provides a means of peer-review for clinical research projects, and therefore, enhance competitiveness for potential National Institutes of Health (NIH) funding.

   An awardee, Dr. Zarina Ali (laboratory of Dr. Eric Zager, University of Pennsylvania) will present a talk entitled “A “backdoor” surgical approach to repair nerve root avulsion injury in a piglet model” on Tuesday, May 3, 2016, during the 2016 AANS Annual Meeting in Chicago, IL.

5. Upcoming meetings (besides AANS and CNS meetings):

   World Federation of Neurosurgical Societies (www.wfnsinterimrome2015.org/)
   2015 Interim Meeting
   September 8-12, 2015
   Rome, Italy

   Contact Mariano Socolovsky (socolovsky@fibertel.com.ar) for peripheral nerve abstracts and program

   American Society for Peripheral Nerve (www.peripheralnerve.org)
   2016 Annual Meeting
   January 15-17, 2016
   Scottsdale, Arizona
Revisions to the DSPN Rules & Regulation for Membership Review

The DSPN Executive Committee has proposed a number of revisions to the Section’s Rules & Regulations document. These by-law modifications have been presented to, and ratified, by both the CNS Executive Committee and the AANS Board of Directors. They now require final approval by the DSPN general membership at the time of the Annual Business Meeting during the 2016 DSPN Annual Meeting. The changes are summarized below.

A more detailed review, with the individual changes to the specific bylaws sections highlighted, is available here. The entire Rules and Regulations of the Joint Section, current to July, 2015, is available here.

1. Addition to ARTICLE II of a “Mission Statement”.

2. To clarify/formalize the process for succession planning within the DSPN, specifically with respect to the inability of an EC member to fulfill their designated role during their term of commitment, an addition to ARTICLE IV (Officers & Executive Committee) of a new Section (Section 4.06 Vacancies) has been proposed.

3. Education Committee Addendum (Section 5.01): The current Rules and Regulations document does not specify the structure or term of the Education Committee. This committee is now proposed to have a chairperson serve a three-year term. Addition subcommittees can be created at the discretion of the Education Committee chairperson in conjunction with the Executive Committee.

4. Changes to the Nominating Committee structure, function and timing of activity:

A) Membership: In Section 5.02, Nominating Committee membership is proposed to now have five members (Section Chairperson, Chairperson-elect, immediate past-Chairperson and the previous two past-Chairpersons), increased from three (immediate past-Chairperson and the previous two past-Chairpersons).

B) Function: In Section 5.02, the Nominating Committee, in addition to selecting candidates for the officer positions, is proposed to now also provide nominations for the chairs of the standing committees to the Section Chairperson.

C) Timing of Officer Candidate Presentation: There was a discrepancy between “Section 4.05 Duties #8” and “Section 5.02 Nominating Committee” regarding the timing of Nominating Committee presentation of candidates for the officer positions (to occur at the AANS vs. CNS Annual Meetings, respectively). The proposed change would bring Section 4.05 in line with Section 5.02 so that presentation of candidates for the officer positions occurs at the CNS Annual Meeting.

D) Process for Officer Candidate Election: A discrepancy currently also exists between “Section 4.05 Duties #8” and “Section 5.02 Nominating Committee” regarding the process of officer candidate election. The proposed change would bring Section 5.02 in line with Section 4.05 to state that voting on the officer candidates will occur at the Joint Section Annual Business meeting and delete the current Section 5.02 stipulation for circulation of mail-in ballots for officer candidate selection to the full membership.

E) Nominating Committee Chairperson: It is proposed to add a description of the duties of the Immediate Past-Chairperson to “Section 4.05 Duties”, with an explicit statement that the Immediate Past-Chairperson be the chair of the Nominating Committee.

5. It is proposed to create a new standing committee, the Peripheral Nerve Task Force Standing Committee (formerly an ad hoc committee), with the longitudinal goal of promoting peripheral nerve surgery as a subspecialty within neurosurgery. As such, a new section (Section 5.08 Peripheral Nerve Task Force) has been added to ARTICLE V (Committees).

6. Ad Hoc Committees: Addition of an explicit statement about the formulation and dissolution of ad hoc committees has been added to Article V.

Prepared by:
W. Bradley Jacobs, MD, FRCSC
Chair, DSPN Rules & Regulations Committee

What Happened with 63047 and 22630/22633?

We reviewed this topic in the “What’s Up With the RUC?” column last Newsletter. As promised, here is an update to bring everyone up to speed with the issue.

We received a letter from Niles Rosen, MD, and the NCCI on September 1, 2015, reporting that CMS would not overturn the NCCI edit. This precludes surgeons from reporting a laminectomy at the same level where they are performing an interbody fusion.

On January 1, 2015, the National Correct Coding Initiative (NCCI) published a new guideline that stated:

CMS payment policy does not allow separate payment for CPT codes 63042 (laminotomy...; lumbar) or 63047 (laminectomy...; lumbar) with CPT codes 22630 or 22633 (arthrod...; lumbar) when performed at the same interspace. If the two procedures are performed at different inter
What Happened with 63047 and 22630/22633?  

spaces, the two codes of an edit pair may be reported with modifier 59 appended to CPT code 63042 or 63047.

Previous convention was that a laminectomy for decompression, if it exceeds the work necessary for doing a lumbar interbody fusion, should be reported in addition to the interbody fusion code. Hence you would report the laminectomy (63047) with a -59 modifier, telling the payer that the laminectomy should not be bundled with the interbody fusion.

While CMS and other private insurers may deny this, it is appropriate to appeal and the coding convention follows CPT terminology. For physicians that are RVU based, this correct coding is significant. The new CCI edit completely reverses that policy. As we discussed in the last Newsletter, NCCI edits are treated as gospel, and as the Medicare Law of the Land.

The worst part is that this NCCI edit is absolutely wrong and ignores CPT and RUC policy. We recently reviewed the combined lumbar interbody and posterolateral fusion code at the RUC. It was valued specifically with the assumption that a laminectomy, when performed, would be separately reported from the work of the interbody fusion.

Unfortunately, it conforms to an error published in the NASS SpineLine Journal, where the exact same coding policy was erroneously stated (SpineLine August 2014). We brought this to NASS's attention it was corrected in the following issue (SpineLine October 2014).

We drafted a letter to the NCCI asking them to reconsider, attached here. Dr. Niles Rosen, who is the Medical Director for the NCCI, seemed receptive to our concerns. The NCCI asked for and reviewed our cited literature and then forwarded the concern to CMS for their assessment. In August, Joseph Cheng, Lou Tumialan, and John Ratliff held a conference call with Edith Hambrick, CMS Medical Officer, and Dan Duvall from CMS Program Integrity. They listened to our concerns and heard out our arguments that the NCCI edit should be reversed. We did not leave the call with a lot of hope that would occur, however.

A suggestion was made that the specialty societies consider an add-on code to cover the additional work of a laminectomy for decompression when an interbody fusion is performed. Your Coding and Reimbursement team will consider these options and follow-up with the Section membership.

Global Challenges, Universal Solutions

Join hundreds of leading spine surgeons from around the world for Spine Summit 2016 "Global Challenges, Universal Solutions" at the exquisite Loews Royal Palace Resort, located minutes from Universal Studios most popular attractions, including the Wizarding World of Harry Potter. Renew old friendships and catch up on the latest in spinal neurosurgery while your whole family enjoys Floridas most thrilling theme park.

Highlights include:
- Hands-on cadaver course with the masters
- Sessions on navigating quality measures and reimbursement changes
- Symposia on reducing peri-operative infections, the surgical impact of bone quality, and complication avoidance with the masters

2016 Annual Meeting of the Section on Disorders of the Spine and Peripheral Nerves
March 16-19, 2016
Loews Royal Pacific Resort at Universal Studios Orlando, Florida

The 32nd Annual Meeting of the Section on Disorders of the Spine and Peripheral Nerves
Spine Summit 2016
March 16-19, 2016 - Loews Royal Pacific Resort at Universal Studios - Orlando, Florida

G O B L I N  C H A L L E N G E S
U N I V E R S A L
S O L U T I O N S

SECTION CHAIR
PRAVEEN MUMMANENI, M.D.
University of California, San Francisco

HONORED GUEST
CHRIS SHAFFRY, M.D.
University of Virginia

HONORED GUEST
LARRY LENKE, M.D.
Columbia University

American Association of Neurological Surgeons
Congress of Neurological Surgeons
email: info@1cns.org
phone: 847-240-2500
web: http://www.spinesection.org

Email your suggestions, meeting information, or other newsletter topics to jratliff@stanford.edu.