Winter ■ 2014

# 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

Congress of Neurological Surgeons — 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.***

In this issue, we present a brief update on RUC activity and quickly note upcoming changes in ICD-10 coding that will impact all neurosurgeons.

A new Aetna policy revising their coverage for spine cages for use in cervical spine surgery is reviewed in this issue. We also include content on recent positions taken by the Spine Section with regard to percutaneous image-guided lumbar decompression.

Coding issues are reviewed in much greater detail by the sponsored coding courses linked to on the back page of the Newsletter!

I know we promised to *not* focus on payer policy, the RUC, and other financial concerns in this issue. However, ongoing challenges at the RUC and in other continue to demand the attention of the editors. Any other content members would like to add, please contact us. We are open to suggestions of other content and would be happy to review and publish member generated submissions. We would like this to be **your** newsletter, but we need member direction to accomplish that goal!

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## CMS Issues Final Non-Coverage Decision for PILD

The Centers for Medicare and Medicaid Services (CMS) issued a final decision on January 9, 2014, not to cover percutaneous image-guided lumbar decompression (PILD) for lumbar spinal stenosis (LSS). CMS has determined that PILD is not reasonable and necessary and Medicare will only pay for it when provided in a clinical study under certain conditions through its Medicare Coverage with Evidence Development (CED) policy.
On Nov. 11, 2013, the AANS, CNS and the AANS/CNS Joint Section on Disorders of the Spine and Peripheral Nerves sent a letter, available at **http://bit.ly/1dsKy6P**, opposing coverage, stating, "overall our field of neurosurgery has not embraced the use of this procedure due to concerns regarding its effectiveness as compared to our current surgical options." The letter further notes that the "present literature...is of low quality and demonstrates that this technique is not indicated in patients with a significant element of bony stenosis, lateral recess stenosis, or foraminal stenosis." A copy of the CMS final decision memorandum is on the CMS website at: **http://go.cms.gov/1j7AALW**.

# Why Should a Spine Surgeon Care About ICD-10?

While we all have our plates full with regard to work, regardless of our bandwidth the transition of coding nomenclature from ICD-9 to ICD-10 is scheduled to occur in October 2014. A few months away, but close enough to be scary. Transition to ICD-10-CM has been mandated by the Centers for Medicare and Medicaid Services and the Department of Health and Human Services. This transition will occur whether our practices are prepared or not!

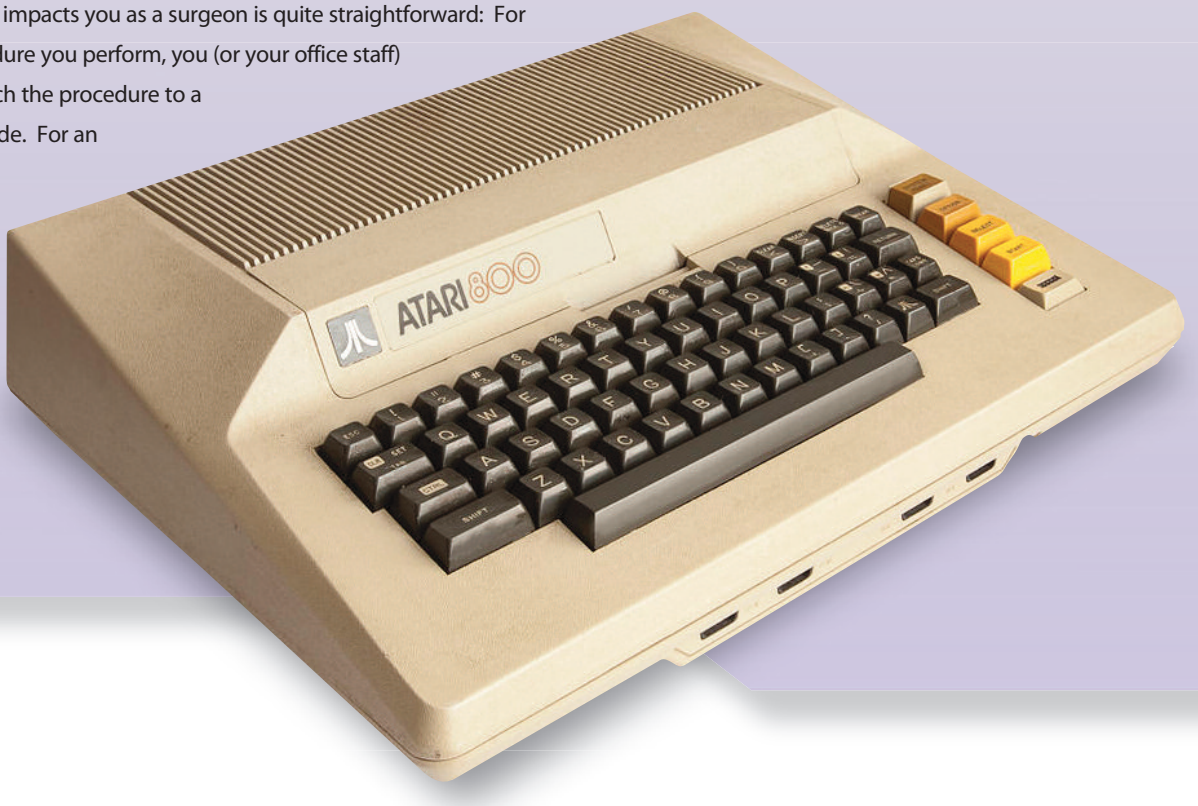
Right now, we use ICD-9-CM; the "CM" stands for Clinical Modification. The system establishes a set of diagnosis codes that are used to track patients in administrative databases. In Europe, coding is done more for research purposes and for tracking health related issues in populations. In the U.S., we use ICD-9-CM for coding and physician billing, and hospitals use it for identifying appropriate diagnoses to base Diagnosis Related Group (DRG) facility billing upon. The ICD system was created and is maintained by the World Health Organization.

We are transitioning to ICD-10-CM because ICD-9-CM is considered obsolete. It was first introduced in 1979. While numerous changes have been made in the ICD-9-CM system, it is still considered inadequate to capture the complexity of modern medical diagnosis. The Atari 800 was a cutting edge home computer system the last time we revisited diagnosis codes.

The way this impacts you as a surgeon is quite straightforward: For every procedure you perform, you (or your office staff) have to match the procedure to a diagnosis code. For an anterior cervical discectomy and fusion (22551), you might use the ICD-9-CM code for cervical disc displacement with myelopathy (722.71). Your procedure codes need to match your diagnosis codes; if you submit an ACDF procedure code with a lumbar herniated disc diagnosis code, you will probably get denied. Karen Zupko offers a great summation: You are paid based on procedure or CPT codes. You are denied based on diagnosis codes.

So, with transition to the new ICD-10-CM system, you have to change every single diagnosis code that you have been using since ICD-9-CM was adopted. Every bill you submit is going to require a new coding architecture.

Move to the new coding system does not decrease complexity or make coding more simple, exactly the opposite. Non-traumatic intracranial hemorrhage in ICD-9-CM is described by 5 distinct codes. In ICD-10-CM it is 35. Angioplasty in ICD-9-CM is 1 code. In ICD-10-CM it is 854 codes. While late night television has joked about it, it is still true: there is a family of ICD-10 codes for injury due to falling space debris.



What can you do to prepare? I prepared 2 articles on ICD-10-CM implementation for AANS Neurosurgeon, they are archived **here** and **here**. Other things to start thinking about:

**1. Buy an ICD-10 coding book.** You need to start learning these codes.

**2. Look at your headcount in the office.** Your coder/biller is going to become less efficient as they start to use ICD-10 codes.

**3. Anticipate disruptions in cash flow around October 1, 2014.** This transition is not going to be easy. Delays and denials of reimbursement may be very common in the initial transition.

**4. Look at your most common ICD-9 codes that you use in your practice.** Start putting together a list of comparable ICD-10 codes. This can be the "cheat sheet" you work from with the transition.

**5. Start dictating with a lot more information.** ICD-10 reviews laterality, so you cannot say "arm pain." Your dictations have to cover that. For trauma cases, your dictation requires information on whether the clinic encounter is for an initial evaluation, for follow-up with expected healing, for follow-up with delayed healing, etc. More information and more granular content is a necessity.

**6. Start practicing.** Start coding in ICD-9 and ICD-10. Yes, that is inefficient, and will slow down your coders. It will have much greater negative impact if this coding change is not anticipated and prepared for by your practice. I have personally started to use an ICD-10 conversion website, and have started practicing conversion by coding my procedures and consults in ICD-10 nomenclature today.

# *Aetna Revises Coverage Policy for Spine Cages*

In response to comments from the neurosurgery-led Council of Surgical Spine Societies (COSSS) and other organizations, on Dec. 24, 2013, Aetna issued an updated policy for spine surgery, stating spine cages for cervical fusion are considered medically necessary for individuals with any of the following indications for use: 1) multilevel corpectomy for tumors, compression fractures, retropulsed bone fragments, or central canal stenosis with myelopathy; 2) multilevel pseudarthrosis in persons with prior fusion; or 3) Jehovah's Witness with poor bone stock. In addition, Aetna will cover sacroiliac joint fusion for tumors involving the sacrum and for sacroiliac joint infection.

The policy revises a previous proposal not to cover spinal fusion with cages based on an Aug. 31, 2013, review. COSSS sent a letter on Dec. 11, 2013, requesting a change in the proposed policy, pointing out that the literature cited by Aetna designating the use of cervical cages as experimental and investigational was outdated, incomplete, and did not reflect standard best practice.

If you have any questions regarding this or other reimbursement issues, please contact Cathy Hill, AANS/CNS Senior Manager for Regulatory Affairs, at **chill@neurosurgery.org**.

# 30TH ANNUAL MEETING

OF THE AANS/CNS SECTION ON

## DISORDERS OF THE SPINE AND PERIPHERAL NERVES

PUTTING **PATIENTS FIRST** IN AN ERA OF CHANGE: SOLUTIONS FOR THE FUTURE

**Date:** March 5 to March 8, 2014

**Where:** The Walt Disney World Swan and Dolphin Resort, Orlando, Florida

**New for 2014!**
**Innovative Technologies in Spine and Peripheral Nerve Surgery (Cadaver Course)**

### Preliminary program available! (Click Here)

Learn about the latest technologies, techniques and indications in spine and peripheral nerve surgery as well as complication avoidance and management strategies during the new **Innovative Technologies in Spine and Peripheral Nerve Surgery cadaver course!**

Taking place on Friday, March 7, this course covers Lateral, MIS TLIF, Percutaneous Screws, Endoscopic Discectomy and Peripheral Nerves with an expert faculty led by Daniel J. Hoh and Eric J. Woodard. For only $500, the new cadaver course is only one of the many outstanding opportunities for you to stay current, exchange information and find solutions for the future at the **2014 Annual Meeting of the AANS/CNS Section on Disorders for the Spine and Peripheral Nerves,** including:

- **Daily Scientific Sessions**
- **Nine Pre-courses**
- **Three Luncheon Symposia**
- **Five David Cahill Memorial Controversies Sessions**
- **Hundreds of accepted abstracts**
- **Multiple Networking Opportunities**
- **And so much more!**

### Walt Disney World Swan and Dolphin

**Orlando, Florida**

Taking place at the spectacular Walt Disney World Swan and Dolphin, this meeting will provide the latest advances and developments in the field, with an atmosphere that your whole family will enjoy.

Surround yourself with the magic of Disney! The Swan and Dolphin is located in the heart of Walt Disney World® in between Epcot® and Disney's Hollywood Studios™.

Staying at the Swan and Dolphin allows you and your family to enjoy many exclusive Disney benefits such as:

- **Extra Magic Hours at the theme parks.**
- **Complimentary scheduled transportation throughout Disney.**
- **Character Dining.**
- **Advance tee times on championship Disney golf courses.**

# Orlando, Florida

# Neurosurgeons Making Headlines on Spine Care

Although spine therapies — surgical and nonsurgical — have grown over the last decade, it's overly simplistic and simply inaccurate to conclude that this phenomenon has been primarily fueled by a profit motive. Improvements in technologies have contributed substantially to this growth. Simply put, more patients with debilitating spine disorders are now eligible for therapies to help relieve pain and improve their well-being.

To this end, Brian R. Subach, MD, a practicing spine-neurosurgeon from northern Virginia, was recently invited to serve as a panelist on National Public Radio's (NPR's) Diane Rehm Show. The program, "Concerns About The Increase In Spinal Fusion Surgery," featured a number of other panelists, including Richard Deyo, MD (a professor, physician and researcher from the Oregon Health and Science University), and Dan Keating (a reporter from The Washington Post). This program was an outgrowth of an article in The Washington Post and subsequent letter to the editor that Dr. Subach submitted.

Dr. Subach did an outstanding job highlighting the benefits of spinal fusion surgery for appropriate indications, while supporting continued outcome studies to refine those indications. He also firmly supported the benefits of appropriate conservative therapy.

Furthermore, neurosurgery, as a specialty, is working to better understand which patients will benefit from certain surgical interventions, which is why the American Association of Neurological Surgeons launched the National Neurosurgery Quality and Outcomes Database project — the largest prospective, longitudinal clinical data collection effort in spine care in the U.S.

Addressing the clinical registry topic, Becker's SpineReview recently published an article, with Jonathan Slotkin, MD, and Matthew McGirt, MD, who share their thoughts on the most important benchmarking initiatives in spine care and how data will impact care delivery in the future.

As Dr. McGirt states, *"Medical and surgical spine care is first and foremost designed to help improve patients' health status and quality of life. Evolving our understanding of what works and what doesn't in each setting for each individual patient is how we can begin evolve using intelligent analytics of outcomes data. We want to identify the right treatment, in the right patient, at the right time to optimize outcomes and reduce healthcare waste."*

This quote drives home the point that neurosurgeons share with the public a sense of urgency and responsibility to meet the challenges of creating a value-based, sustainable healthcare system. As such, we are committed to the creation of intelligent, long-term, strategies for achieving quality care using real world, patient-specific, objective information (not anecdote or data from narrowly focused controlled trials).

For this and more information, follow us on the **Neurosurgery Blog**!

# What's up with the RUC

As we reviewed in our last issue, the Councils of Medicare and Medicaid Services (CMS) employ screens of procedure codes to identify when codes may be mis-valued. This may have significant impact on physician reimbursement. When a potential mis-valued code is identified, it is referred to the RBRVS Update Committee (RUC) for review.

A number of spine codes have been recently noted by the RUC process. Codes identified by the screening process are referred to the Relativity Assessment Workgroup (RAW) of the RUC to develop action plans. This led to our surveying last year **63047** | ***Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar***. We received solid reponses from the survey that we sent out to Section membership, and were able to argue for maintaining current value for this code.

I know it may seem odd to celebrate having no change in our code value, but in the same RUC cycle our orthopedic colleagues took significant hits in valuation for total hip arthroplasty (decrease from 21.79 to a 20.72 RVUs) and total knee arthroplasty (23.25 to 20.72 RVUs). An issue has arisen in the final iteration of code valuation from CMS that is requiring further work by your Coding and Reimbursement team, but at present and for 2014 the values of 63047 and 63048 are unchanged.

Other spine codes remain actively under review. **22612** | ***Arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique)***. This code was recently reviewed as part of forming the new combined interbody/posterolateral lumbar fusion code, 22633. The utilization of 22612 will be followed with the introduction of the new code; if 22612 remains high expenditure it may need to be re-surveyed. A final decision on the future of this code is pending.

**22851** | ***Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), methylmethacrylate) to vertebral defect or interspace*** has been picked up by multiple screens, previously in 2009 under the CMS Fastest Growing procedure screen, another means that CMS has of identify mis-valued codes. At that time an editorial change was made to the code to remove reference to threaded bone dowels, which are now reported with CPT code 20931. This change was part of CPT 2011. More recently, this code was picked up again by the highest expenditure screen and was reviewed at the RAW again. The RAW agreed to re-assess the data on 22851 in 2014, to see if utilization of 22851 changed with elimination of bone dowels from the code's application. Examination of 22851 with re-survey may be required. This may mean development of new codes through the CPT process.

New codes are under development at CPT. We anticipate new procedure CPT codes that will require Spine Section surveys in the first quarter of 2014. We encourage all members who receive a survey to honestly and accurately fill it out; the survey process is laborious but is also the best way for your RUC advisors to make sure that spine procedure codes remain appropriately valued!