

# Washington Update

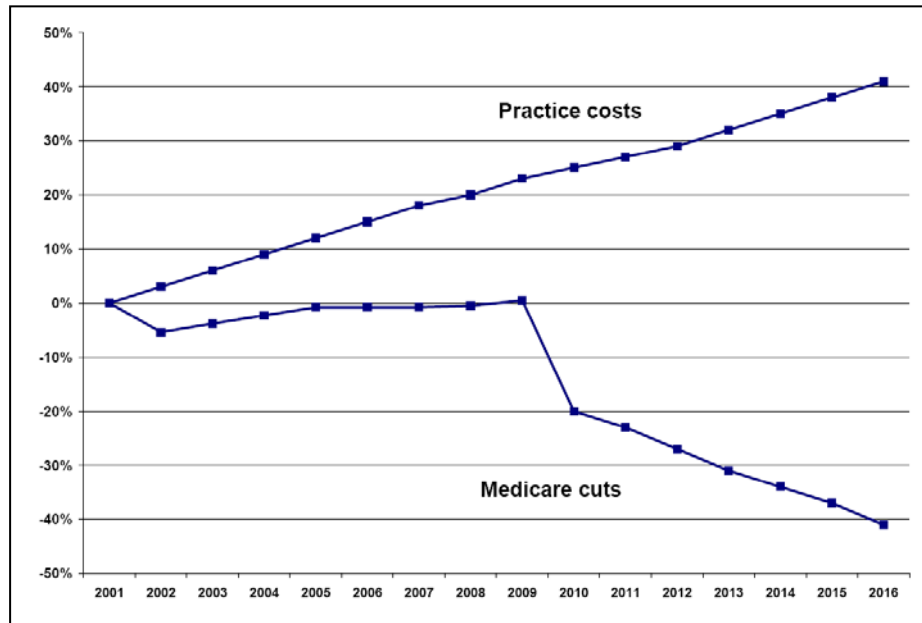
## May, 2009



## CODING AND REIMBURSEMENT

### Medicare Physician Payment Update

Absent legislative change in 2009 projected reimbursement trends are as follows (with a 21% cut in 2010 and a total of over 40% through 2016):



The principle obstacle to reform is **cost**. The Congressional budget office's estimated costs of reform continue to escalate and CBO now expects various reform proposals to cost the following:

- \$439 billion to replace system w/MEI updates (\$556 billion if beneficiary premiums held harmless)
- \$318 billion to replace system w/ a pay freeze for 10 years
- \$50 billion for short-term modest update for a year

If CMS would retroactively remove Part B drugs administered by physicians from the SGR formula – retroactively – this would put \$100 billion back into the physician payment baseline. Efforts to urge CMS to do this continue, but with a legal opinion from CMS counsel against this position, prospects for this option may be dim.

### ***The Baucus White Paper***

To date, only one detailed proposal (in the Senate) has been proposed. On November 12, 2008, Senator Max Baucus (D-MT), Chairman of the Senate Finance Committee, released an 89-page outline of his comprehensive vision for health care reform entitled, "Call to Action: Health Reform 2009." Included in this White Paper are a number of proposals related to Medicare physician payment. ***Most disturbing about the document is Sen. Baucus' proposal to provide increased payments to primary care providers in a budget-neutral fashion at the expense of specialty physicians.*** Key aspects of the Baucus plan include:

- Strengthening role of primary care and chronic care management
- Refocusing payment incentives towards quality, including: expand use of clinical data registries; move from bonus to punitive reimbursement tied to quality
- Promoting provider collaboration and accountability, including: bundling, gainsharing
- Improving the health care infrastructure, including: HIT, comparative effectiveness research

The complete document is available at: <http://finance.senate.gov/healthreform2009/home.html>

### ***MedPAC Recommends 1.1 % Physician Payment Update for 2010***

In its March 2009 report, the Medicare Payment Advisory Commission (MedPAC) recommended a physician payment update of 1.1%. A copy of the March report is available at [http://www.medpac.gov/documents/Mar09\\_EntireReport.pdf](http://www.medpac.gov/documents/Mar09_EntireReport.pdf)

### ***House and Senate Pass Budget Resolutions***

The House and Senate approved separate versions of the fiscal year (FY) 2010 Congressional Budget Resolution on April 2, by votes of 233-196 and 55-43, respectively. The budget resolutions lay out five-year Congressional plans for taxes and spending.

The House Budget Resolution contains provisions that would facilitate passage of legislation to replace the flawed sustainable growth rate (SGR) formula. Specifically, it would provide budgetary protection for such legislation that is consistent with the view that the current Medicare physician spending budget baseline, which assumes payment cuts totaling 40 percent over the several years, is unrealistic. Congress will still have to enact additional legislation to replace the SGR. The House Budget Resolution also includes a provision known as a "budget neutral reserve fund" that represents support for health system reform legislation. Of note, it would require the costs of health system reform to be fully offset by other spending cuts or revenue increases. Additionally, the resolution contains budget reconciliation instructions that would require both the Committee on Ways and Means and the Committee on Energy and Commerce to report legislation by September 29 that produces savings of \$1 billion over 5 years. These savings could be used to advance health system reform legislation. Reconciliation bills are significant because they are not subject to a filibuster in the Senate and need only 51 votes for passage.

The Senate version of the Budget Resolution contains a budget-neutral reserve fund to avert projected Medicare physician payment cuts. However, it does not provide funding to stop the cuts or provide budgetary protection to legislation that would replace the SGR. The Senate resolution also contains a budget neutral reserve fund for health system reform legislation.

The AANS and CNS, along with the AMA and other national specialty societies recently sent a to congressional leaders involved in reaching consensus on a fiscal year 2010 congressional budget resolution. The budget resolution passed April 2 by the U.S. House of Representatives included provisions that would facilitate the passage of legislation to replace Medicare's sustainable growth rate (SGR) and establish a path toward long-term physician payment reform. The Senate-passed budget resolution did not include the same budgetary protections for eliminating the SGR. It is anticipated that a final budget resolution will be considered on the House and Senate floors by the end of this month.

The House and Senate are currently negotiating the final conference agreement.

### ***Congressional Budget Office Warns of Access Problems***

In late March, the Congressional Budget Office (CBO) told the House Budget Committee that the effect of a 21% reduction in Medicare physician payment rates in January 2010 and a cumulative cut of 40% by 2014 would likely result in reduced physician participation in Medicare. CBO said that while some doctors would stop participating, others would no longer accept new Medicare patients, and others would compensate by increasing the volume and/or intensity of services. CBO also said that if beneficiaries are compelled to receive care at emergency departments, the quality and continuity of care received could decline, possibly leading to poorer health outcomes.

The CSNS is finalizing a Medicare survey that will be conducted each year and will ascertain neurosurgeons' Medicare participate status.

## **Organized Medicine's Activities**

The AANS and CNS continue to work with Congress and others to improve payment policies. Since December, working with the American College of Surgeons and the Alliance of Specialty Medicine, we have held over 20 meetings with Congressional staff outlining our current position on various Medicare issues.

- **American Medical Association.** The American Medical Association continues to work on achieving a unified position on Medicare physician payment reform within organized medicine. Given the divide between primary care and the specialists, unity remains elusive. Within the past several months, the AMA has convened several meetings of staff and physician leaders and the House of Delegates has met (although no definitive policy or strategy was forthcoming from this meeting, other than the endorsement of the medical home principles). At these meetings, the AMA is currently evaluating a number of proposals for reform, including:
  - Gainsharing and Accountable Care Organizations
  - Pay-for-Performance on Quality Measures
  - Bundling (Physician episodes of care/bundling of hospital and physician payments)
  - Patient-Centered Medical Homes
  - SGR Targets (Service or specialty-specific/state or regional/other)
  - Other Payment Policy Changes (e.g., balance billing, GPCIs, HIT)

Again, no consensus on the major issues (i.e., no budget neutral shift of money from specialty physicians to primary care doctors and no acceptance of a short term fix) has been reached.

Thanks to the AANS and CNS, however, we were successful at finally getting the AMA on record in opposition of this budget neutral shift of funds from specialists to primary care. Leaders from the AANS and CNS (Drs. Bean, Tippett, Adelson and Ms. Orrico), along with representatives from the American College of Surgeons, American Association of Orthopaedic Surgeons and the American Society of Cataract and Refractive Surgeons met with approximately 10 members of the AMA Board of Trustees. This high-level meeting produced an op-ed by Dr. Joseph Heyman, Chairman of the AMA Board, published in the February 2, 2009 *AMNews*. In this piece, entitled, "Physicians need one voice to fight for payment reform," Dr. Heyman writes:

The American Medical Association absolutely opposes applying budget-neutrality rules that confine off-sets to the physician payment pool. Congress should not rob Dr. Peter, the surgeon, to pay Dr. Paul, the primary care physician.

We will continue to work with the AMA to achieve reforms that work for neurosurgery.

- **American College of Surgeons.** The AANS and CNS are working with the American College of Surgeons on a comprehensive strategy for promoting the value of surgical care and the need to ensure that payment systems and other health policies do not favor primary care at the expense of surgical care. Thus far, we have developed "**Surgery's United Agenda for Medicare Physician Payment Reform,**" which is endorsed by 15 major surgical organizations. Specifically, the agenda advocates for, among other things:
  - Repeal of the current sustainable growth rate (SGR) and establishment of a new baseline for the physician payment system;
  - Replacement of the current SGR with a system of multiple conversion factors; and
  - Assurance that any additional payments that are made to primary care physicians are not budget neutral within the physician payment pool.

Organized surgery is currently in the process of finalizing the actual legislative proposal outlining the multiple conversion factor approach. The new proposal will have 4 separate categories: primary care E&M; all other E&M; major surgery (defined as procedures with 90 and 10 day global periods and associated add-on codes); and all other services.

To help promote our agenda, on March 24, 2009, organized surgery launched a new communications campaign. Spearheaded by the American College of Surgeons and involving a number of surgical specialty societies (including the AANS and CNS), rural health organizations and other groups, the Web-based campaign addresses a range of issues including comparative effectiveness research, work force, trauma systems and resident work hours. For more information about **Operation Patient Access** go to: <http://operationpatientaccess.facs.org/>

- **Alliance of Specialty Medicine.** The Alliance of Specialty Medicine, of which the AANS and CNS are members, has also developed its own advocacy materials on Medicare issues. The Alliance is revamping its own website to use as a tool for demonstrating the importance of specialty care. Like the surgical initiative, the Alliance is also seeking repeal of the SGR and opposes increasing reimbursement for primary care at the expense of specialists' reimbursement.

### ***Medicare Balance Billing***

Representative Tom Price, MD (R-GA) has introduced legislation (H.R. 1384) that would allow physicians to balance billing for the full value of their services under Medicare and for certain non-Medicare patients. H.R. 1384 would allow physicians who elect "non-participating" status in Medicare to balance bill patients by removing the current 115 percent limiting charge on the non-participating Medicare fee schedule amount. The bill would also preempt state laws that prohibit balance billing.

### **Medicare Physician Fee Schedule**

On December 29, 2009, AANS and CNS submitted comments to the Center for Medicare and Medicaid Services (CMS) regarding provisions in the final 2009 Medicare Physician Fee Schedule (MPFS) published on November 19, 2008. The comments focused primarily on the objections of AANS and CNS to the arbitrary reduction of reimbursement for new codes for cranial and spinal stereotactic radiosurgery (SRS) procedures. The 2009 Medicare Fee Schedule final rule is available at: <http://edocket.access.gpo.gov/2008/pdf/E8-26213.pdf>

In addition to submitting comments to CMS to protest the SRS cuts, Washington office staff sent out an e-blast alert to neurosurgeons urging them to submit their own comments objecting to the CMS imposed cuts in SRS reimbursement. Between 15-20 neurosurgeons (that we know of) took the time to submit comments to CMS, with copies to their Members of Congress. The AMA Relative Value Update Committee (RUC) also objected to the SRS cuts and included the AANS/CNS wording in their letter to CMS regarding the fee schedule. Washington Office staff asked the American College of Surgeons (ACS) to support the RUC-passed values and John Wilson, MD, asked the ACS RUC Member and Advisors for support. However, despite many conversations, ACS did not ultimately support the RUC-passed SRS values in their Medicare Fee Schedule letter. When new CMS leaders are in place, Washington Office staff will request a meeting to discuss the issue and will request that the codes be sent to a refinement panel for reevaluation.

### **CPT Coding Issues**

#### ***February 2009 CPT Panel Meeting***

The CPT Panel met February 5 through 8, 2009. Jeffery Cozzens, MD, attended as a CPT Editorial Panel member. Patrick Jacob, MD, AANS Advisor to CPT, Joseph Cheng, MD, CNS Advisor to CPT and Washington Office staff also attended. The following issues were addressed:

- **Facet Injection Codes.** AANS, CNS, and NASS joined several other societies in a code change proposal for Facet Joint Injection Codes. The procedures were identified by CMS and the RUC Five Year Review Committee on the "fastest growing procedures" list. The specialty societies felt

that the growth in volume was probably due to improper coding of other procedures such as trigger point injections. The new code set specifically requires the use of CT or Fluoroscopic Guidance in order to help clarify the difference between Facet Injection and other injection codes.

- **Body Radiosurgery.** At the October 2008 CPT Editorial Panel meeting the American College of Surgeons (ACS), the Society of Thoracic Surgeons (STS), and the American Urological Association (AUA) presented a CPT Coding Proposal for ten new codes for Stereotactic Radiosurgery (SRS) performed in the abdomen, prostate, and thorax. AANS and CNS did not become involved except to urge the groups to coordinate their proposal with the American Society for Therapeutic Radiation and Oncology (ASTRO). ASTRO opposed creation of body SRS codes because they believe that these codes duplicate Stereotactic Body Radiotherapy (SBRT) codes used by radiation oncologists and do not represent additional necessary physician work. ASTRO submitted an alternative proposal for a code for fiducial placement by the surgeon. The panel decided to form a workgroup to consider the codes. Ken Simon, MD, CMS Medical Officer, asked that the group explore the use of the -62 co-surgeon modifier for the procedure and to determine if the procedures require two physicians or can be performed alone by one physician.

The Workgroup met by conference call on January 14, 2009. Patrick Jacob, MD, and Washington office staff participated in the call. The group decided to go forward with the fiducial placement codes and hold two additional meetings during CPT to discuss other codes for surgeons. On February 7, 2009, the fiducial marker code was passed by the CPT Editorial Panel. However, the workgroup did not have the opportunity to discuss the codes for additional surgeon work in body SRS. ACS, AUA, and STS suggested a workgroup meeting be held with just the surgical groups and ASTRO, followed by a full workgroup conference call on April 14, and another workgroup meeting at the June 2009 CPT Editorial Panel Meeting.

As planned, a meeting of the surgical groups and ASTRO was held in Washington DC on March 22, 2009. Attending on behalf of AANS and CNS were Troy Tippet, MD, John Wilson, MD, Joseph Cheng, MD, Frederick Boop, MD, and Washington Office staff. AMA CPT staff and CMS staff were not at the meeting. The group spent four hours discussing the existence and lack of literature for SRS and SBRT, respectively; the definition of SRS and SBRT; and the possible appropriate coding options for SBRT. The group generally agreed with AANS and CNS that SRS for brain and spine was different than SBRT, because by definition, SRS always requires the presence of a neurosurgeon. Other surgeons may sometimes use SBRT to treat lesions but having a surgeon present for SBRT is not the typical case. For that reason, the possibility of a -62 "co-surgeon" type modifier just for areas of the body other than brain and spine was proposed. Dr. Tippet stated that AANS and CNS would support the -62 for SBRT only if the codes for brain and spine SRS (for which there is incontrovertible stellar literature and which were developed with all CPT and RUC standards rigorously adhered to) were not part of the -62 scenario and only if ASTRO agreed. Based on the tenor of the meeting, it is unlikely that ASTRO would agree. STS representatives will come back to the group with a better sense of the literature, frequency, and service description for SBRT use by surgeons other than neurosurgeons.

### ***June CPT Editorial Panel Meeting***

AANS and CNS will join eight other specialty societies in presenting code change proposals for a series of transforaminal epidural injection codes, CPT Codes 64479 through 64484, to the CPT Editorial Panel at its June 2009 meeting. The codes were identified by the RUC Five Year Review Identification Workgroup as typically being performed with fluoroscopy or CT Guidance and, therefore, the RUC asked that the codes be revised and resurveyed to include the image guidance.

### ***Dr. Cozzens Named PMAG Co-Chair***

On March 6, 2009, Jeffrey Cozzens, MD, was named as a co-chair of the Performance Measures Advisory Group (PMAG). The PMAG is an advisory body to the CPT Editorial Panel and the CPT

Health Care Professionals Advisory Committee (CPT/HCPAC) responsible for reviewing CPT “Category II” codes used to report quality measures. The PMAG is comprised of performance measurement experts representing the Agency of Healthcare Research and Quality (AHRQ), the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Committee for Quality Assurance (NCQA), and the Physician Consortium for Performance Improvement.

## **RUC Issues**

### ***January 2009 RUC Meeting***

The RUC met January 29 through February 1, 2008. Attending for the AANS and CNS were Greg Przybylski, MD, John Wilson, MD, Edward Vates, MD, Alexander Mason, MD, and Washington Office Staff.

- **Five Year Review Identification Workgroup.** The main activity of interest at the January RUC was the Five Year Review Identification Workgroup consideration of specialty society comments submitted in response to codes identified by CMS in the 2009 Medicare Physician Fee Schedule proposed rule as “Fastest Growing Procedures.” These are procedures for which the volume reported to Medicare has grown by at least 10% per year for the last three years. On December 1, 2008, AANS, CNS, AAOS, and NASS submitted joint comments on codes identified and on January 29, 2009, John Wilson, MD, defended these comments before the Five Year Review Workgroup. The workgroup agreed with all of Dr. Wilson’s comments except for CPT Code 63655 *Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural*. The Workgroup recommended that CPT Code 63655 be included in the survey with the spinal neurostimulaor implantation codes to be presented at the April RUC meeting.
- **Nerve Conduction Codes.** At its January 2009 meeting the RUC valued a set of codes for nerve conduction studies. The codes were first submitted to CPT in October 2007 and referred to a workgroup. Ultimately a Category I code was approved by the CPT Editorial Panel in October 2008. The device used for the nerve conduction studies were developed by the NeuroMetrix company who had contacted several AANS and CNS leaders to urge them to support Category I codes for the procedures.
- **Spinal Neurostimulator Electrode.** AANS and CNS along with NASS, ASA, and several pain societies presented a code change proposal at the October 2008 CPT meeting to delete CPT Code 63660 and establish new codes, 636X1—636X4, to more distinctly define the work involved in the revision and removal of a percutaneous electrode. CPT 63660 was a code identified by the RUC Five Year Review Workgroup as having had a change of site of service and, therefore, potentially misvalued. However upon attempting to revalue the code, the pertinent specialties discovered that work involved could be better described if the code were split into several new codes. A RUC survey was conducted in March 2009 and recommended values for the codes will be presented at the April 2009 RUC meeting. As was stated above, the survey included CPT Code 63655.

### ***RUC/CPT Joint Workgroup on Bundled Services***

On February 24, 2009, AANS and CNS received a letter from CPT and RUC leaders in response to a November 5, 2008, letter from AANS, CNS, the American Academy of Orthopaedic Surgeons (AAOS) and the North American Spine Society (NASS) disagreeing with the RUC/CPT Joint Workgroup on Bundled Services request that a code be developed to bundle CPT Code 22554 *Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression);cervical below C2* and 63075 *Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophylectomy; cervical, single interspace*. The letter from CPT and RUC stated that they do not agree with the specialties and expect a CPT code change proposal to

bundle CPT Codes 22554 and 63075 to be submitted by July 15, 2009 deadline for the October 2009 CPT Editorial Panel meeting.

### ***Multispecialty Practice Expense Survey***

The joint AMA Specialty Society Physician Practice Information Survey conducted by the St. Louis research firm Dmrkynetec is completed. AANS and CNS have been active in alerting neurosurgeons that they may receive a survey and encouraging them to fill it out. Ultimately, 99% of the neurosurgeons contacted returned the survey. The AMA contracted with CMS to provide the practice expense per hour data by March 31, 2009.

### ***New RUC Chairman***

The term of current RUC Chairman, William Rich, MD, will expire in April 2009. AANS and CNS nominated Gregory Przybylski, MD, for the position, however, the AMA Board of Trustees selected Barbara Levy, MD, an obstetrician/gynecologist from Seattle, Washington. Dr. Levy has served as the Chair of the RUC Five Year Review Identification Workgroup.

### **Coverage Issues**

Activity regarding coverage of neurosurgical procedures continues to increase with Medicare national, Medicare local, state, and private payer proposals. Below are some of the issues being tracked by the Washington Office.

### ***Positron Emission Tomography (PET) for Solid Tumors***

On April 3, 2009, CMS issued a final decision memorandum regarding FDG Positron Emission Tomography (PET) for Solid Tumors. The origin of the review was developed during an August 20, 2008, meeting of the CMS Medicare Evidence Development & Coverage Advisory Committee (MedCAC) held to discuss the scientific evidence for oncologic indications of PET for nine cancers, including brain tumors. Andrew Sloan, MD, participated in the panel. In the final decision memorandum, CMS states that they are “adopting a coverage framework that replaces the four-part diagnosis, staging, restaging and monitoring response to treatment categories with a two-part framework that differentiates FDG PET imaging used to inform the initial antitumor treatment strategy from other uses related to guiding subsequent antitumor treatment strategies after the completion of initial treatment. We are making this change for all NCDs that address coverage of FDG PET for the specific oncologic conditions addressed in this final decision memo.” Specifically for PET for brain the decision would allow coverage for the initial scan but would be a “coverage with evidence development” policy for subsequent scans. More information is available on the web at: <https://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?from2=viewdecisionmemo.asp&id=218&>

### ***Carotid Artery Stenting Coverage***

On March 18, 2009, CMS issued a seventh reconsideration of its coverage policy for Percutaneous Transluminal Angioplasty (PTA) of the Carotid Artery Concurrent with Stenting. CMS is requesting public comments on coverage of the procedure for Medicare beneficiaries who are at high risk for CEA due to anatomic risk factors and have asymptomatic carotid artery stenosis  $\geq 80\%$  following the release of additional industry-sponsored data. Comments are due on April 17, 2008. John Wilson, MD, and the AANS/CNS Section on Cerebrovascular Surgery leadership are reviewing the decision. In the previous several reconsiderations, AANS and CNS have suggested that the information resulting from the National Institute of Neurological Disorders and Stroke (NINDS) Carotid Revascularization Endarterectomy Versus Stenting Trial (CREST) should provide guidance regarding appropriate indications for carotid artery stenting, and recommend that coverage for this procedure not be expanded until the completion of the CREST trial and a thorough analysis of the data produced by it.

On April 4, 2009, the American Society for Neuroradiology (ASNR) circulated a draft letter to the Neurovascular Coalition recommending approval of the CAS reconsideration and the group has asked for a response by April 10, 2009.

More information is available at:

<https://www.cms.hhs.gov/mcd/viewtrackingsheet.asp?from2=viewtrackingsheet.asp&id=230&>

### ***Wisconsin Physicians Services Medicare Part A Cranial Stereotactic Radiosurgery and Radiotherapy Coverage Policy***

AANS President, James Bean, MD, received a letter dated January 22, 2009, from Wisconsin Physician Service (WPS) Part A Medicare Carrier requesting input on a draft policy for facility payment for “Cranial Stereotactic Radiosurgery and Radiotherapy.” The issue was referred to the AANS/CNS Coding and Reimbursement Committee and reviewed by Jeff Cozzens, MD. Dr. Cozzens is on the Carrier Advisory Committee for WPS. In addition, Clarence Watridge, MD, informed the Washington Office that the policy was also sent to the American College of Surgeons and referred to the ACS Advisory Committee on Neurosurgery for comment. Dr. Cozzens has written a response that will be sent to WPS. The policy is available on the web at

[http://www.wpsmedicare.com/part\\_a/policy/rad018.pdf](http://www.wpsmedicare.com/part_a/policy/rad018.pdf)

### ***Washington State Health Care Authority Health Technology Assessment Panel – Total Disc Arthroplasty***

March 20, 2009, the Washington State Health Care Authority Health Technology Assessment (HTA) Clinical Committee held a conference call to discuss a number of issues, including questions surrounding the finalization of a draft proposal for coverage of Total Disc Arthroplasty (ADR) issued on December 11, 2008. On January 30, AANS and CNS joined NASS, AAOS, SRS, and SAS in sending a letter to the committee questioning requirements that “patients must first complete a structured, intensive, multi-disciplinary program for management of pain, if covered by the agency” before being permitted to receive a lumbar or cervical artificial discs. The language was the same as the language for the spinal fusion coverage decision but inclusion of such language for artificial spinal discs was not discussed at the October 17, 2008 public meeting. In the letter, the specialty societies expressed concern about this requirement, especially for ADR in the cervical spine and asked that requirement be removed from the coverage decision.

Several members of the AANS/CNS/NASS/AAOS/SRS/SAS coalition called into the March 30 discussion but public comment was not permitted. On the call, the HTA staff indicated that they agreed with comments submitted that if a structured, intensive multidisciplinary program for management of pain was required for the lumbar ADR, it should not be required for cervical ADR.

### ***Washington State Health Care Authority Health Technology Assessment Panel- Procedures for Coverage Review in 2009***

On December 12, 2008, the Washington State Health Care Authority published the list of procedures that it plans to review in 2009. The procedures are:

- Sleep Apnea Diagnosis and Treatment
- Calcium Scoring for Cardiac Disease
- Vagal Nerve Stimulation
- Hip Resurfacing
- Bone Growth Stimulators
- Transcutaneous Electrical Neural Stimulation (TENS)
- Glucose Monitoring

More information is available on the web at: [http://www.hta.hca.wa.gov/press\\_release/hca-administrator-selects-health-technologies.html](http://www.hta.hca.wa.gov/press_release/hca-administrator-selects-health-technologies.html)

### **Wellpoint and Blue Cross/Blue Shield Tech Assessment Requests**

Over the last year the Washington Office has been contacted by Wellpoint Technical Assessment for possible input on many items. These requests have been referred to the pertinent clinical sections.

In particular, Wellpoint has requested input on many spine procedures and these requests have been referred to the AANS/CNS Spine Section. Joseph Cheng, MD, Spine Section Representative to the AANS/CNS Coding and Reimbursement Committee is coordinating the response efforts. The recent requests are:

- **Interspinous Distraction Devices (Spacers).** NASS has decided not to comment. AAOS has developed comments and shared them with AANS and CNS for possible joint submission. On March 13, 2009, Washington Office forwarded a Spine Section response on this issue to the AANS and CNS Presidents for approval. Essentially, the Spine Section recommended expressing support for interspinous spacers as an improvement on the natural history of neurogenic claudication in appropriately selected patient. However, the section did not feel the data was sufficient to judge the devices as compared with laminectomy procedures.
- **Manipulation under Anesthesia for Treatment of Chronic Spinal or Pelvic Pain.** Upon initial review the Spine Section opinion is that it would not be typical for a neurosurgeon to perform these procedures and therefore input from AANS and CNS would likely not be forthcoming
- **Axial Lumbar Interbody Fusion (axialLIF).** Members of the Spine Section and the Coding and Reimbursement Committee continue to discuss this issue. Dan Resnick, MD, has suggested that AANS and CNS may prefer to stay silent on this issue or, alternatively, could provide literature to Wellpoint without further comments of support or disapproval. The Coding and Reimbursement Committee will discuss this issue at its May 2009 meeting.
- **Intradiscal Decompression Procedures (such as IDET).** The Spine Section is in the process of discussing this issue. Initially the preference was to remain silent, as the procedure is not routinely performed by neurosurgeons, however concerns were expressed about whether remaining silent implies acceptance of the procedure.
- **Percutaneous and Endoscopic Spinal Surgery.** Joseph Cheng, MD, formulated a response to Wellpoint emphasizing that the draft policy statement provided by Wellpoint appears to inappropriately combine percutaneous techniques and minimally invasive spinal techniques when the endoscope is used. Dr. Cheng stated that AANS and CNS do not agree with the policy that minimally invasive endoscopic spinal surgical techniques are considered investigational and not medically necessary.

Procedures for which Wellpoint has requested input previously are:

- **Percutaneous Thermal Neurolysis for Chronic Back Pain and Trigeminal Neuralgia.** Referred to the AANS/CNS Pain Section
- **Adjustable Banding as a Treatment of Plagiocephaly.** This issue has been referred to the AANS/CNS Pediatric Section. Mark Proctor, MD, and Shenandoah Robinson, MD, have co-authored an article on the issue on behalf of the section for publication in the Journal of Neurosurgery. The section discussed the development of a position statement at its December 2008 meeting and will discuss the issue further in May at the AANS meeting.
- **Magnetoencephalography/Magnetic Source Imaging.** Referred to the AANS/CNS Section on Stereotactic and Functional Neurosurgery

- **Artificial Intervertebral Disc: Lumbar Spine.** Referred to the AANS/CNS Spine Section.
- **Artificial Intervertebral Disc: Cervical Spine.** The request was referred to the AANS/CNS Spine Section and a response was sent to Wellpoint on December 8, 2008.
- **Percutaneous Vertebroplasty and Percutaneous Kyphoplasty.** This issue was referred to the AANS/CNS Spine Section and Joseph Cheng, MD, who coordinated a response to Wellpoint.
- **Stereotactic Radiosurgery and Stereotactic Radiotherapy.** Referred to the AANS/CNS Spine Section, Section on Stereotactic and Functional Neurosurgery, and Tumor Section.

### ***United Health Care Request for Artificial Total Disc Coverage***

On March 3, UnitedHealthcare notified the AANS/CNS Washington Office that it was in the process of reviewing their coverage policy for Artificial Total Disc. The request has been referred to the Spine Section and can likely be answered with documents recently prepared for other payers.

### **Other Medicare Issues**

#### ***Medical Home***

On January 1, 2009, CMS began the Medicare Medical Home Demonstration (MMHD), a three year demonstration designed to provide “targeted, accessible, continuous and coordinated, family-centered care to high need populations (i.e. Medicare beneficiaries with prolonged or chronic illnesses that require regular medical monitoring, advising, or treatment). In December 2008, the Center for Health System Change and Mathematica Policy Research, Inc. published an analysis of the Medical Home concept.

#### ***ICD-10 Coding***

On January 15, 2009, in response to comments by AANS, CNS and other physician organizations, CMS issued a regulation that would delay by two years the compliance deadline for converting from the currently used International Classification of Diseases, Ninth Revision (ICD-9), which includes 17,000 procedure codes to the International Classification of Diseases, Tenth Revision (ICD-10), with 155,000 codes. The new implementation date is October 1, 2013.

#### ***APC Panel Nominations***

On March 13, 2009, AANS and CNS sent a letter nominating Gregory Przybylski, MD, to the CMS Medicare Ambulatory Payment Classification (APC) Panel. The panel advises CMS on issue related to APC groups and relative payment weights that are components of the Medicare Hospital Outpatient Prospective Payment System (OPPS). Dr. Przybylski was asked by CMS Medical Officer Edith Hambrick, MD, JD, Chair of the panel, to apply for one of the APC panel vacancies occurring in August 2009. Dr. Przybylski currently serves on the HHS Practicing Physician Advisory Council (PPAC) but will be eligible to serve on the APC Panel, as his PPAC term expires in June 2009. More details are available at <http://edocket.access.gpo.gov/2008/E8-30454.htm>

#### ***February 2009 APC Panel Meeting***

On February 18, 2009, Jeffrey Cozzens, MD, appeared before the APC Panel on behalf of AANS and CNS to recommend changing CPT 61885 *Brain and Cranial nerve pulse generator implantation* from its current APC 0039 to APC 0222 which includes spinal cord stimulators. The change was deemed more appropriate because the cranial neurostimulators are similar clinically and in terms of risk to the

spinal stimulators. This would result in a higher facility payment for the neurostimulators used in Vagal Nerve Stimulation (VNS) and in Deep Brain Stimulation (DBS) in the hospital outpatient setting.

### ***Medicare Recovery Audit (RAC) Contractors***

On February 6, 2009 CMS announced that the Medicare RAC program that had been put on hold for a few months due to protest by several companies that had bid for contracts and not received awards was going forward following resolution of the complaints. In October 2008, CMS had announced the award of RAC contracts, but those contract awards were protested and a stop work order was put in place.

As mandated by section 302 of the Tax Relief and Health Care Act of 2006, CMS will implement a permanent and national RAC program by January 1, 2010. The national RAC program is the outgrowth of a demonstration program that used RACs to identify Medicare overpayments and underpayments to health care providers and suppliers in California, Florida, New York, Massachusetts, South Carolina, and Arizona.

The new RACs are:

- Diversified Collection Services, Inc. (DCS) of Livermore, California, in Region A, initially working in Maine, New Hampshire, Vermont, Massachusetts, Rhode Island and New York.
- CGI Technologies and Solutions, Inc. of Fairfax, Virginia, in Region B, initially working in Michigan, Indiana and Minnesota.
- Connolly Consulting Associates, Inc. of Wilton, Connecticut, in Region C, initially working in South Carolina, Florida, Colorado and New Mexico.
- HealthDataInsights, Inc. (HDI) of Las Vegas, Nevada, in Region D, initially working in Montana, Wyoming, North Dakota, South Dakota, Utah and Arizona.

As part of the settlement of the protests, the four RACs listed above will contract with subcontractors to supplement their efforts. PRG-Schultz, Inc. will serve as a subcontractor to HDI, DCS and CGI in Regions A, B and D. Viant Payment Systems, Inc. will serve as a subcontractor to Connolly Consulting in Region C. Each subcontractor has negotiated different responsibilities in each region, including some claims review.

On February 27, 2009, AANS and CNS joined other medical specialty societies in signing a letter coordinated by AMA expressing concerns about the RAC process. In the letter, the signatories reminded CMS that problems with over and/or underpayments of Medicare claims are best resolved through physician outreach and education, asked CMS to exempt Evaluation and Management codes from RAC Audits, and recommended raising the minimum claim amount for review from \$25 to \$100 in order to reduce the burden on physicians.

More information on the RAC program is available on the CMS website at <http://www.cms.hhs.gov/RAC/>.

### **Miscellaneous Issues**

#### ***AANS/CNS Reponse to ASTRO Brochure***

On December 13, 2008, AANS and CNS sent a letter to Patricia Eifel, MD, Chair of the American Society for Therapeutic Radiology (ASTRO) Board of Directors, to object to several items in an ASTRO published brochure entitled "Plain Talk for Radiation Therapy Patients: Stereotactic Radiotherapy." Specifically, AANS and CNS objected to the inappropriate equating of SRS with Stereotactic Body Radiotherapy (SBRT), and the omission of any reference to the role of the

neurosurgeon in SRS. The letter emphasized that brochure is not in keeping with the agreed upon definition of SRS published by both organizations in their respective journals. On February 27, 2009, ASTRO staff notified the AANS/CNS Washington Office Director Katie Orrico that ASTRO was in the process of changing their brochure for both the web and print to reflect the correct SRS definition, as requested by AANS and CNS. The revised brochure is available on the web at: <http://www.ranswers.com/treatment/stereotactic.htm>

### ***Neurovascular Coalition***

On February 18, 2009, the Neurovascular Coalition (NVC) discussed two draft documents for Stroke Intervention Training Guidelines. One draft document was developed by the Society for Neurointerventional Surgery (SNIS). This draft document was preferred by AANS, CNS, the American Academy of Neurology (AAN), and the Society of Vascular Interventional Neurology (SVIN), as those societies agree that optimal training standards for interventional stroke should be set high and should require the completion of a neuro-interventional fellowship. The second document, developed by the American Society of Neuroradiology (ASNR) and supported the Society of Interventional Radiology (SIR), allowed for an abbreviated training course. The Neurovascular Coalition, which is chaired by John Wilson, MD, includes AANS, CNS, SNIS, ASNR, AAN, and SVINS. The group was not able to reach a compromise and asked ASNR and SIR to come back with a revised document within one month.

On March 27, 2009, ASNR circulated a revision of their draft that differed from the original in that it would require additional experience in vascular and micro catheter procedures; provides more detail for education; require a written exam; require direct observation using simulators and proctored cases; and require participation in a registry with outcomes analysis. NVC members are currently reviewing the revised ASNR documents.