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Note From The Editor

When is a Spine Fellowship Necessary?



Robert F. Heary, MD

Is spine fellowship training necessary? The answer depends upon who is being asked the question.

In order to determine the need for spine fellowship training, the neurosurgical resident needs to assess his or her own career goals. For someone considering an academic neurosurgical spine career, a spine fellowship has essentially become a mandatory prerequisite. However, the debate surrounding neurosurgeons entering private practice still drags on. Is a formal fellowship necessary for these residents?

Presently, two-thirds of all neurosurgical cases in private practice are spine surgeries. These spine cases range from relatively routine decompressive surgeries to complex instrumented fusion procedures. The need for advanced training depends upon the resident's degree of training, both didactic and hands on, during his or her residency. The level of comfort that a particular resident has acquired upon completion of his neurosurgical residency will greatly dictate the need for advanced training.

Over the past 40 years, spine surgery has changed dramatically. Surgical procedures on the spine have become significantly more complex. The increased awareness surrounding spinal stability, as well as the traditional concerns regarding adequate decompression of the neural elements, has provided neurosurgical residents with ample opportunity to gain experience with, and exposure to, complex spine surgery.

With the possible exception of spinal deformity, most major academic neurosurgi-

cal programs now provide training in complex spinal surgery. As such, a fellowship is probably unnecessary for most graduating residents entering private practice.

In spite of the fact that most private practice neurosurgeons perform the majority of their surgeries on the spine, their formal didactic training during residency centers predominantly on the study of disorders related to cerebral pathology. Neurosurgical trainees, as such, need to increase their formal reading on spinal anatomy, biomechanical principles, and spine surgery techniques. Ideally, this should be completed during the neurosurgical residency; however, a spine fellowship offers the opportunity to expand on these principles.

Finding the Perfect Fellowship

The ideal spine fellowship should include a wide variety of cases extending from simple discectomies to complex reconstructive procedures, including spinal deformity. The opportunity to work with multiple spine surgeons, in order to broaden one's knowledge, is preferable.

A significant outpatient component also is essential to the fellowship. Outpatient experience allows the trainee the opportunity to participate in the decision-making process as to which patients need surgery and which patients do not, as well as to evaluate the surgical results in the postoperative period.

Lastly, a program that allows for some dedicated time working with orthopaedic surgeons is desirable. Regardless of any ideological differences between neurological and orthopaedic surgeons, the orthopaedic spine surgeons perform some procedures in a different manner from which a neurosurgical spine fellow could benefit. The prospective spine fellow should critically evaluate his

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Plans for the 15th Annual Meeting Solidify

Participants attending the 15th Annual Meeting of the AANS/CNS Section on Disorders of the Spine and Peripheral Nerves will be exposed to a plethora of topics related to the practice of spinal neurosurgery. The meeting will be held February 10–13, 1999 at Disney's Yacht and Beach Club Resorts in Lake Buena Vista, Florida.

This year, the Section is offering four one-hour "Theater in the Round" workshops, to be held in the Exhibit Hall. These innovative workshops will consist of a 15-20 minute "how do I do it" presentation by a renowned surgical expert, followed by a 40-45 minute "exhibit sponsored" hands-on session. This new and exciting element to the program will provide participants with a hands-on setting to demonstrate and discuss a bevy of spine-related topics.

Topics for the "Theater in the Round" workshops include:

Thursday, February 11, 1999

Cervical Spine Instrumentation Techniques

9-10 AM

Moderator: H. Louis Harkey, MD

Faculty: Edward Benzel, MD; Michael Fehlings, MD; Regis Haid, MD; Mitch Gropper, MD; and Hansen Yuan, MD

This program will discuss the clinical and surgical treatment of cervical spine instability. Both anterior and posterior stabilization techniques will be covered, including the occipital-cervical and cervical-thoracic areas. Specific surgical decision making and surgical techniques will be emphasized.

Operative Image-Guided Surgery in the Spine

2:35-3:35 PM

Moderator: Iain Kalfas, MD

Faculty: Kevin Foley, MD; J. Patrick Johnson, MD; and Bruce Northrup, MD

Participants in this workshop will examine advances and technological applications of image-guided frameless stereotaxy. Indications and advantages of this operative technique will be emphasized, and specific surgical scenarios will be highlighted.

Friday, February 12, 1999

Pedicle Fixation Revisited

9:55-10:55 AM

Moderator: Eric Woodard, MD

Faculty: Chris Schaffry, MD; Nevan Baldwin, MD; Paul Arnold, MD; Andrea Halliday, MD; and Chris Paramore, MD

With recent improvements in the regulatory climate regarding pedicle screws, this program will revisit clinical decision making and operative techniques. Applications will be demonstrated, specifically for the treatment of degenerative disease, deformity, trauma, and tumors.

Saturday, February 13, 1999

Interbody Fusion Techniques

9:31-10:31 AM

Moderator: Curtis Dickman, MD

Faculty: Charles Ray, MD; Kevin Foley, MD; Gerald Rodts, MD; and John Thalgot, MD

This session will address the growing interest and popularity of interbody fusion techniques, with a special emphasis on anterior and posterior techniques in the lumbar spine, as well as anterior techniques in the thoracic and cervical spine. Open and minimally invasive approaches also will be discussed.



Discover the Magic at Disney's Yacht and Beach Club Resorts

Within footsteps of some of the world's most famous vacation attractions, Disney's Yacht and Beach Club Resorts offers something for the young and the young-at-heart. The full service resort complex is located in the EPCOT Resort area on the shores of a 25-acre lake, and offers guests a unique mini water park, six themed restaurants, a white sand beach, marina with watercraft fleet, championship golf courses, volleyball and croquet courts, and array of specialty shops.

Annual Meeting Symposia At-A-Glance

Thursday, February 11, 1999

Cervical Spondylosis and Clinical Decision Making

Moderator: Regis Haid, MD

This session is designed to help participants examine the pathogenesis and history of cervical spondylosis and the clinical implications for laminectomy and posterior fusion following laminectomy. A panel of expert faculty will discuss surgical and non-surgical treatment modalities, and explain the key factors involved in avoiding and managing complications that arise in patients with cervical spondylosis.

Peripheral Nerve Tumors: Spinal Implications

Moderator: Allan Belzberg, MD

Participants in this session will discuss the pathological mechanisms of peripheral nerve tumors and their relationship to spinal conditions. Using clinical cases, they will work with the expert faculty to recognize the appropriate indications for spinal decompression and stabilization, and the complications that may arise when treating patients with peripheral nerve tumors.

Friday, February 12, 1999

Lumbar Interbody Fusion: Indications, Techniques, and Complications

Moderator: Edward Benzel, MD

In this session, participants will examine the indications and biomechanical considerations in lumbar interbody fusion. Those who attend will have ample opportunity to refine their skills and work closely with expert faculty to increase their knowledge in this area.

Saturday, February 13, 1999

Controversies in Spinal Surgery

Moderators: Richard Fessler, MD; and Mark Hadley, MD

Participants will gain an appreciation for the plethora of treatment modalities used in managing disorders of the spine and peripheral nerves. The implications that may arise from these treatment modalities also will be discussed.

Spine Highlights for the 1999 AANS Annual Meeting

Plans are well underway for the 67th AANS Annual Meeting to be held April 24-29, 1999 in New Orleans, Louisiana. Some of the meeting highlights include the following practical courses:

Saturday, April 24

- Spinal Biomechanics
- Surgical Anatomy of the Thoracic and Lumbar Spine
- Cervical Spine Instability: Instrumentation and Other Methods of Management

Sunday, April 25

- Stereotactic Spine Surgery: Techniques and Applications
- Thoracic Lumbar Stabilization and Fusion
- Lumbar Interbody Fusion and Interbody Techniques

Mayfield Award Winners

At this year's Section meeting, Steven Casha, MD, a resident at the University of Toronto, will be recognized as the 1999 Basic Science Mayfield Award winner, and Nicholas Theodore, MD, a senior resident at Barrow Neurological Institute, will be presented the 1999 Clinical Science Mayfield Award.

The Mayfield Award is presented annually to a neurosurgical resident(s) or fellow(s) who has submitted an outstanding research manuscript regarding a laboratory or clinical investigation in the area of spinal or peripheral nerve disorders.

Are you constantly searching the Web for neurosurgical information relating to the spine? Do you wish that there was one site you could visit to speak with others in your specialty and find out the latest information on topics emerging in the neurosurgical arena? Well, stop looking. This information and more can be found on the official Web site of The American Association of Neurological Surgeons and Congress of Neurological Surgeons—**NEUROSURGERY://ON-CALL®**.

N://OC® provides Spine Section members with a plethora of information ranging from preliminary program details for the upcoming Section meeting to Section meeting abstracts and from an e-mail discussion list to links to other spine sites of interest.

To access the Spine Section site of **NEUROSURGERY://ON-CALL®**, visit <http://www.neurosurgery.org> and click on the “Professional Pages.” On the welcome page, select the “Sections” link and explore all of the information and services that the Spine Section has to offer.

If you have any questions about the Spine Section of **N://OC®**, please contact Allison Casey, AANS Interactive Media Manager, at (847) 692-9500.



continued from front page Editor's Note

own residency experience and select a fellowship that would cover any perceived deficiencies which occurred during the residency training process.

Searching for a Competitive Edge

A comparison can be drawn to the spine surgeons in the field of orthopaedic surgery. At this time, essentially all orthopaedic surgeons performing spine surgery have completed formal spine fellowship training. Many of the best orthopaedic residents enter into a spine fellowship and, following their completion, enter both academic and private practice as spine surgeons.

This situation has placed many competent, board certified, neurosurgeons at a disadvantage. To combat this problem, organized neurosurgery needs to better increase the awareness in the general population that neurosurgeons are all fully trained spine surgeons.

Although spine surgery has greatly evolved over the last 40 years, the line between orthopaedic surgery and neurological surgery, with respect to the spine, is becoming vague. For the graduating resident interested in a career in academic spine surgery, there is no choice but to complete a spine fellowship. And, for the majority of neurosurgeons who will enter private practice, a spine fellowship is not mandatory, but is certainly an opportunity.

As a final note, the next time a neurosurgical department chairman explains that his graduating residents do not need spine fellowship training, ask him which fellowship his program's spine surgeon attended.

Volunteers Needed

The AANS/CNS Section on Disorders of the Spine and Peripheral Nerves is looking for member volunteers. If you are interested in contributing an article to the newsletter, working on a Section-sponsored project, or volunteering in another capacity, please contact Vincent C. Traynelis, MD, at (319) 356-2774.

We Want to Hear From You

The AANS/CNS Section on Disorders of the Spine and Peripheral Nerves is interested in hearing your questions on CPT-coding, concerns about surgical techniques or drug treatments, comments on organized neurosurgery, or queries about this newsletter.

Please send your comments to:
Robert F. Heary, MD
90 Bergen Street, Ste. 7300
Newark, New Jersey 07103
E-mail: heary@umdnj.edu

Pedicle Screw Reclassified

Years of debate surrounding the U.S. Food and Drug Administration's (FDA) classification of pedicle screws came to an end in July 1998, when the FDA issued a final rule reclassifying the devices from Class III to Class II for certain indications.

As a Class II device, the pedicle screw spinal system is now clinically approved to provide immobilization and stabilization of spinal segments in skeletally mature patients as an adjunct to fusion in the treatment of the following acute and chronic instabilities or deformities of the thoracic, lumbar, and sacral spine: degenerative spondylolisthesis with objective evidence of neurologic impairment, fracture, dislocation, scoliosis, kyphosis, spinal tumor, and failed previous fusion (pseudoarthrosis). The reclassification, however, does not include spinal systems intended for use in the cervical spine or in pediatric populations.

"The reclassification of this device has been long awaited," said Edward C. Benzel, MD, Program Director of Neurosurgery at the University of New Mexico. "I think that the FDA's ruling confirms what we have known for a long time, that pedicle screw fixation often provides the best treatment for a number of spinal conditions."

Under the FDA ruling, the pedicle screw labeling must contain a warning stating that the safety and efficacy of the devices has been established only for certain spinal conditions.

Moreover, the label must contain the following precaution: "The implantation of pedicle screw spinal systems should be preformed only by experienced surgeons with specific training in the use of this pedicle screw spinal system because this is a technically demanding procedure presenting a risk of serious injury to the patient." According to the FDA, the precaution is intended to alert surgeons to the necessity of receiving appropriate training in the use of the devices.

AANS Dismissed From Lawsuit

In the wake of the reclassification, the legal council for the plaintiffs dismissed the lawsuit filed against The American Association of Neurological Surgeons. The suit which accused the organization of acting as a "promotional agent" for the device and conspiring with the device manufacturers to harm patients for monetary gain.

The litigation still continues against the device manufacturers, implanting surgeons who are charged with individual malpractice, and other medical associations.

Highlights of Pedicle Screw Reclassification

- Pedicle screw has been reclassified by the FDA from a Class III to a Class II device
- Pedicle Screw is now clinically approved for use as an adjunct to fusion in the treatment of:
 - Acute and chronic instabilities or deformities of the thoracic, lumbar, and sacral spine
 - Fractures
 - Dislocation
 - Degenerative spondylolisthesis with objective evidence of neurologic impairment
 - Scoliosis
 - Kyphosis
 - Spinal tumors
 - Failed previous fusion (pseudoarthrosis)
- Pedicle screw is not approved for use in:
 - Cervical spine
 - Pediatric populations

Mark Your Calendars Now
for the
2000 AANS/CNS Section on
Disorders of the Spine and
Peripheral Nerves Annual Meeting
at the
Renaissance Esmeralda Resort in
Indian Wells (Palm Springs), California
February 23-26, 2000



Spectacular Scientific Program Planned for the 1999 AANS/CNS Section on Disorders of the Spine and Peripheral Nerves Annual Meeting



Meeting highlights include:

- New this year: The Scientific Program has been expanded to flow into the exhibit hall where attendees will have an opportunity to participate in Surgical Techniques Workshops. The topics include:
 - Techniques in Cervical Spine Stabilization
 - Operative Image Guided Surgery in the Spine
 - Pedicle Fixation- Revisited
 - Indication and Techniques for Interbody Fusion
- Presentation of 34 oral scientific papers
- Presentation of over 100 scientific posters
- Scientific Sessions presented by leading experts in spine and peripheral nerve surgery to include:
 - Controversies in Spine and Peripheral Nerve Surgery
 - Interbody Fusion
- Over 60 exhibits displaying the latest advances in spine and peripheral nerve surgery and technology
- Each physician is eligible to earn a maximum of 18 hours in category 1 toward the American Council for Continuing Medical Education

**February 10-13, 1999
Disney Yacht and
Beach Club Resort,
Lake Buena Vista (Orlando),
Florida**

**For registration
information contact:
Spine Section Meeting Office
Phone: 847.692.9500
Fax: 847.692.2589**

Coding Corner

Gregory J. Przybylski, MD

The proper use of the co-surgeon modifier -62 is a frequent area of discussion at AANS coding and reimbursement courses. Spinal neurosurgeons who prefer to work with orthopaedic, general, and/or thoracic surgeons will frequently need to use this modifier when describing their combined efforts in the surgical treatment of patients. Consequently, it may be helpful to first review the general use of this modifier before applying it in your practice.

This modifier appends a surgical CPT code that is shared by two surgeons of different specialties (not subspecialties). If the work described in a particular CPT code is done in part by two surgeons of different specialties, both surgeons should dictate separate operative notes identifying each other as “co-surgeons,” and should use the same code appended with the -62 modifier. In the surgical treatment of a patient, a surgeon cannot be an assistant surgeon (modifier -80) and a co-surgeon at the same time.

Medicare reimbursement rules for the -62 modifier allow an additional 25 percent reimbursement (i.e. 125 percent of the allowable) split equally (62.5 percent to each co-surgeon). Although the reimbursement is equally split by default, a similar letter from each co-surgeon can be submitted with the individual claims requesting a different split. However, this may delay receipt of the payment.

The RVU (relative value unit) provided with each code is a measure of the work associated with that code, and is commensurate with the reimbursement expected. When applicable, the RVU shown reflects a 50 percent reduction when multiple procedures are listed with the -51 modifier; reflects a 62.5 percent portion of the allowable when the procedure is modified with -62; and reflects only 25 percent of the total value if listed with the -80 assistant surgeon modifier.

Q. What coding procedures should be used for anterior cervical discectomy and fusion with iliac autograft?

A. The neurosurgeon performing the entire procedure would code:

22554	Anterior Cervical Arthrodesis 41.95 RVU
63075-51	Anterior Cervical Discectomy with Osteophyctectomy 20.10 RVU
20938	Harvest Structural Autograft 6.37 RVU
	Total 68.42 RVU

The neurosurgeon performing the discectomy and orthopaedist performing the graft harvest and arthrodesis would code:

- **Neurosurgeon**
63075 Anterior Cervical Discectomy with Osteophyctectomy 40.19 RVU

- **Orthopaedist**

22554	Anterior Cervical Arthrodesis 41.95 RVU
20938	Harvest Structural Autograft 6.37 RVU
	Total 48.32 RVU

The neurosurgeon and orthopaedist working together as co-surgeons would code:

22554-62	Anterior Cervical Arthrodesis 26.22 RVU
63075-51,62	Anterior Cervical Discectomy with Osteophyctectomy 12.57 RVU
20938-62	Harvest Structural Autograft 3.98 RVU
	Per surgeon total 42.77 RVU

Two neurosurgeons working together with one assisting would code:

- **Primary Neurosurgeon**

22554	Anterior Cervical Arthrodesis 41.95 RVU
63075-51	Anterior Cervical Discectomy with Osteophyctectomy 20.10 RVU
20938	Harvest Structural Autograft 6.37 RVU
	Total 68.42 RVU

- **Assistant Neurosurgeon**

22554-80	Anterior Cervical Arthrodesis 10.49 RVU
63075-51,80	Anterior Cervical Discectomy with Osteophyctectomy 5.03 RVU
20938-80	Harvest Structural Autograft 1.59 RVU
	Total 17.11 RVU

A general neurosurgeon performing the discectomy and the partner spinal neurosurgeon performing the arthrodesis and graft harvest would code:

- **General Neurosurgeon**

63075	Anterior Cervical Discectomy with Osteophyctectomy 40.19 RVU
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- **Partner Spinal Neurosurgeon**

22554	Anterior Cervical Arthrodesis 41.95 RVU
20938	Harvest Structural Autograft 6.37 RVU
	Total 48.32 RVU

Several important observations should be made regarding these examples. In the last example, the payor identification number will not allow the carrier to differentiate between the two neurosurgeons. Since subspecialists are not recognized, one of the partners should expect a 50 percent reduction in either 63075 or 22554, as seen in the first example. There are no examples of two neurosurgeons as co-surgeons since the -62 modifier applies to surgeons of different specialties.

Also, there are no examples of one surgeon acting as the primary surgeon for the discectomy while the other is assisting and, then, vice versa. One surgeon must either be the primary or assistant in a single operative session, but not both.

Q. What coding procedures should be used for anterior lumbar interbody fusion with threaded cages and iliac autograft?

A. The neurosurgeon performing the entire procedure would code:

22558	Anterior Lumbar Arthrodesis 47.17 RVU
22851	Placement of Single/Paired Threaded Cages 14.16 RVU
20937	Harvest Cancellous Autograft 5.89 RVU
Total 67.22 RVU	

The neurosurgeon performing the discectomy and arthrodesis with a general surgeon providing the exposure would code:

- **Neurosurgeon**

22558-62	Anterior Lumbar Arthrodesis 29.66 RVU
22851	Placement of Single/Paired Threaded Cages 14.16 RVU
20937	Harvest Cancellous Autograft 5.89 RVU
Total 49.71 RVU	
- **General Surgeon**

22558-62	Anterior Lumbar Arthrodesis 29.66 RVU
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The neurosurgeon and general surgeon working together through the whole case as co-surgeons would code:

- **Neurosurgeon and General Surgeon**

22558-62	Anterior Lumbar Arthrodesis 29.66 RVU
22851-62	Placement of Single/Paired Threaded Cages 8.85 RVU
20937-62	Harvest Cancellous Autograft 3.68 RVU
Per surgeon total 42.19 RVU	

The neurosurgeon performing the arthrodesis with the general surgeon assisting would code:

- **Neurosurgeon**

22558	Anterior Lumbar Arthrodesis 47.17 RVU
22851	Placement of Single/Paired Threaded Cages 14.16 RVU
20937	Harvest Cancellous Autograft 5.89 RVU
Total 67.22 RVU	
- **Assistant General Surgeon**

22558-80	Anterior Lumbar Arthrodesis 11.79 RVU
22851-80	Placement of Single/Paired Threaded Cages 3.54 RVU
20937-80	Harvest Cancellous Autograft 1.47 RVU
Total 16.80 RVU	

Several important observations should be made regarding these examples. The current AMA interpretation of the services involved in an anterior lumbar arthrodesis includes the exposure, preparation of the disc space with discectomy, placement of anterior graft, and closure. Consequently, if two surgeons are participating in an anterior lumbar arthrodesis, they must either share 22558 as co-surgeons using the -62 modifier, or as primary and assistant surgeons as shown in the last example.

There is no example of a neurosurgeon, orthopaedic surgeon, and general surgeon performing an anterior lumbar arthrodesis, since the -62 modifier applies only to two surgeons sharing the work of a single CPT code. There are efforts in progress to develop "approach codes" similar to those used to describe skull base surgery, which separate the exposure from the remainder of the procedure.

In summation, the -62 modifier is used to alert the carrier that two surgeons of different specialties shared the appended surgical procedure code. Each surgeon must dictate a separate operative note and refer to each other in that operative note as co-surgeons. The reimbursement is increased by Medicare to 125 percent of the allowable split equally by the two surgeons unless other arrangements are coordinated. The CPT editorial panel has been discussing a change in the use of the -62 modifier so that it can only be applied to a single code in one operative session. However, if this change occurs, it is anticipated that the -80 assistant surgeon modifier could then be applied to additional codes within that operative session.

Free Section Membership for Residents

The AANS/CNS Section on Disorders of the Spine and Peripheral Nerves is offering free Section membership to neurosurgical residents.

Residents must fill out an application form and the yearly membership fee will be waived for the duration of their residency.

If you, or someone you know, is interested in joining the Section, please see the membership application on page 9.

Application for Membership

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



Biographical

Name: _____

Home Address: _____

Phone: _____

Office Address: _____

Office Phone: _____

E-mail Address: _____

Category of Membership Requested: (Must be a member of the AANS or CNS).

Active Associate International Resident

Membership, Certification and Practice:

Are you certified by the American Board of Neurological Surgery?

Yes No

Are you a member of

1. The American Medical Association? Yes No

2. A Local or Regional Medical Society? Yes No

Name:

3. A State or Provincial Medical Society? Yes No

Name:

4. The American Association of Neurological Surgeons? Yes No

5. The Congress of Neurological Surgeons? Yes No

Signature: _____ Date: _____

** Membership dues are waived for applicants currently enrolled in a neurosurgical residency program.*

**Please return the completed application with your membership fee of \$50 to:
AANS/CNS Section on Disorders of the Spine and Peripheral Nerves
Dept. 77-7586
Chicago, Illinois 60678-7586**

**AANS/CNS Section on Disorders of the
Spine and Peripheral Nerves**
22 South Washington Street
Park Ridge, Illinois 60068-4287

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1999 Spine Section Nominees

At this year's Section meeting, the membership will be asked to vote upon the slate of candidates for Section Officers, as recommended by the Nominating Committee. They include:

Past-Chair
Stephen M. Papadopoulos, MD
Ann Arbor, Michigan

Members-At-Large
Srinath Samudrala, MD
Los Angeles, California

Lloyd Zucker, MD
Boca Raton, Florida

Chair
Vincent C. Traynelis, MD
Iowa City, Iowa

Chair-Elect
Curtis A. Dickman, MD
Phoenix, Arizona

Secretary
Nevan G. Baldwin, MD
Albuquerque, New Mexico

Treasurer
Curtis A. Dickman, MD
Phoenix, Arizona