

## **16<sup>th</sup> Annual Meeting, February 23-26, Renaissance Esmeralda Resort, Palm Springs California**

The annual Spine Section meeting was held in Palm Springs this past February. The venue was breathtaking in its desert splendor, and the science was unsurpassed. Over 700 registrants attended the meeting, and enjoyed not only professional development but also golf, tennis, swimming, trail rides and many other extra-curricular activities. Forty oral presentations and over 100 posters complemented the lively symposia on controversies in spinal surgery and presentations from invited speakers including Drs. E Benzel, RG Fessler, A Menezes, and VKH Sonntag. Special courses on Lumbar Instability and Fusion and Practical Approaches to Selected Peripheral Nerve Injuries were well attended and received. Theatre-in-the-Round (pictured below) provided an opportunity for our colleagues in industry to present new innovations in spinal surgery. The Section wishes to thank each of the 40+ industry sponsors who displayed their cutting edge technology, and were critical to the success of the event.



The 17<sup>th</sup> Annual Meeting will be held in Phoenix, AZ from February 14-17. Pre-meeting courses will include new technologies in spine surgery (IDET, vertebroplasty, image guidance, BMP .... and .... you guessed it .... cages!) as well as peripheral nerve surgery. The deadline for abstract submission is September 15, 2000. Further

information can be found on our website at: [www.neurosurgery.org](http://www.neurosurgery.org). Mark your calendars now!

## **Awards**

### **Meritorious Service Award**

**Dr. Arnold Menezes** (pictured on the left below) was recognized by the Section for his longstanding and noteworthy contributions in the field of Spinal Surgery. Dr. Menezes has been active within the Section on Disorders of the Spine and Peripheral nerves for well over a decade. He is presently Professor and Vice Chairman of the Division of Neurosurgery at the University of Iowa in Iowa City, where he has practiced for over 25 years. He serves on 6 editorial boards and has contributed over 130 peer-reviewed papers and over 75 book chapters to our specialty. Perhaps most importantly, he has directly influenced the lives and practices of many neurosurgeons across the world through his teaching, a debt that can never be repaid. Many thanks Dr. Menezes for your countless contributions!



### **Mayfield Clinical Science Award 2000**

**Dr. Viswanathan Rajamaran** (Newark, NJ): **Use of Intensive Care Units for Patients with Spinal Disorders.** Dr. Rajamaran (pictured left below) concluded that a large number of patients with spinal disorders admitted to the ICU have a low probability of death and do not receive ICU specific interventions. Routine use of Illness

Severity Scoring systems can identify patients with low risk who might be cared for outside of the ICU. Congratulations Dr. Rajamaran!



Mayfield Basic Science Award 2000

**Dr. Neill M. Wright** (St. Louis, MO): **Bone Marrow Derived Mesenchymal Stem Cells Transduced with an Adenoviral Vector Carrying the Gene for Human BMP-2 can Induce Anterior Spinal Fusion.** Dr. Wright (pictured left below) successfully transduced porcine bone marrow-derived stem cells with an adenovirus expressing DNA for BMP-2. The stem cells were re-implanted into intervertebral discs, which led to new bone formation measured both histologically and radiographically. Clearly we may all be spreading viral infections on purpose in the operating rooms of the future. Congratulations Dr. Wright!



Medtronic Sofamor-Danek Fellowship Award 2000

This year's Medtronic Sofamor-Danek fellowship stipend has been awarded to Dr. Larry T. Khoo from South Pasadena, CA. He will be completing his formal training in spinal surgery with Dr. Richard Fessler at Rush University in Chicago.

Section on Disorders of the Spine and Peripheral Nerves Research Grants

This year we had several outstanding applications for peer-reviewed research support. Two grants were awarded:

**Characterization of Adaptive Changes in the Brain of Individuals with Spinal Cord Injury: serial evaluation using fMRI and electrophysiological testing.** Principle investigator Dr. David Mikulis, co-investigator Dr. Michael Fehlings; University of Toronto

**Ulnar Nerve Entrapment at the Elbow: improved diagnosis and treatment with MRI.** Principle investigator Dr. Gavin W. Britz, co-investigator Dr. Michel Kliot; University of Washington

Named Awards

The Section on Disorders of the Spine and Peripheral Nerves is pleased to announce the naming of three prestigious awards to individuals who have become

outstanding leaders in our sub-specialty. Starting next year (2001) our Fellowship Award will be recognized as the Cloward Spine Fellowship Award. It will continue to be graciously sponsored by Medtronic Sofamor-Danek. In addition, two clinical research grants have been named: the Sonntag and Larson Clinical Research Grants. Funds for these grants have been and will continue to be provided through proceeds from membership dues, meeting revenues, and industry support.

## **Deadlines**

- September 15, 2000: Abstracts for the 17<sup>th</sup> Annual Section on Disorders of the Spine and Peripheral Nerves Meeting
- September 15, 2000: Clinical and Basic Science Mayfield Awards 2001
- September 15, 2000: Cloward Spine Fellowship Award 2001
- December 1, 2000: Sonntag and Larson Clinical Research Grants 2001

Abstracts for the 2001 meeting can be submitted on-line. For more information about abstracts and awards please visit our website at [www.neurosurgery.org](http://www.neurosurgery.org).

Formal submission forms for the Mayfield Awards can be obtained from Keith Kuhlengel, MD, 1671 Crooked Oak Dr., P.O. Box 10247, Lancaster, PA 17605-4207 (tel. 717-569-5331). Application information for the Cloward Fellowship Award can be acquired from Michael G. Fehlings, MD, PhD, The Toronto Hospital, 399 Bathurst St., Suite 2-417, Toronto, Ontario M5T 2S8, Canada (tel. 416-603-5627). Application details for research grants are available from Ziya Gokaslan, MD, MD Anderson Cancer Center, 1515 Holcombe Blvd., Houston, Texas 77030-4095 (tel. 713-792-2400).

## **Coding Corner – by Greg Przybylski**

### Coding Approaches to Anterior Thoracolumbar Spine Surgery

Advances in spinal instrumentation and improved familiarity with anterior thoracolumbar spinal exposure have fostered a keen interest in anterior thoracolumbar spinal surgery. While some spinal surgeons perform the approach and closure themselves, many others utilize the assistance of a surgical colleague (thoracic surgeon, vascular surgeon, or general surgeon) for gaining access. However, describing this combined effort in terms of Current Procedural Terminology (CPT coding) has led to confusion and miscoding. Although examples of the accepted coding method have been described here previously, substantial discussions over the past several years may change the method entirely. Examining the evolution of approach coding for spinal surgery may help the spinal surgeon prepare for future changes as well as to understand the complex political process in attempting to refine the CPT coding of these and other procedures.

The purpose of CPT coding is to describe and track physician work. Although the process of describing work is considered separate from valuing that work, both are significantly interrelated. The American Medical Association developed and owns the rights to CPT. Through the efforts of the CPT Editorial Panel, obsolescent codes are eliminated, new codes are created, and current codes are revised to allow accurate descriptions of physician work with changing technology and techniques. Although early efforts at coding descriptions did not detail the physician work, all new changes require a detailed description (vignette) of the work involved in performing a procedure including preoperative, intraoperative and postoperative work. The valuation of this work is performed by a separate and relatively independent AMA structure called the Relative Value Update Committee (RUC). Through the use of physician surveys, data is collected on the time and intensity required to perform a given service. Based upon the frequency of pre- and postoperative visits, the length it requires to perform a procedure, and the complexity of the work, a relative value is assigned to the code. Recommendations are then submitted to the Health Care Finance Administration (HCFA), which often but not always follows these recommendations. Payment for the procedure by Medicare and many other payers is based upon this valuation. Although the coding and reimbursement considerations are separate, these two bodies are certainly interdependent.

The physician work for a given procedure typically includes the approach, the definitive procedure, and the closure. Certain add-on codes only describe additional incremental work that is always done with another procedure (e.g. additional level discectomy) and thus only the incremental intraoperative work is included. However, the development of codes for skull base surgery led to a distinction between exposure and the definitive procedure. The separation of this work was stimulated by the involvement of different surgeons of different specialties (typically an otolaryngologist and neurosurgeon) who may do only a component of the entire procedure. This template was considered a possible method for describing the approach and definitive procedure in anterior spinal surgery to account for different surgeons performing different components.

The current accepted method for describing the combined work of two surgeons performing components of a single procedure is the –62 co-surgeon modifier. Although this modifier was previously applicable to every code in which two surgeons shared the work, the use of the modifier was restricted to a single code in 1999. Concurrently, allowance was made to also use of the –80 assistant at surgery modifier if the work of additional codes was shared. Although other methods for describing the approach work including use of “exploratory” thoracotomy and laparotomy codes were used, extensive efforts at educating surgeons regarding the proper use of the co-surgery modifier were undertaken. Since the RUC understood that the value of the spine surgery codes included the approach, use of exploratory codes to describe the approach separately was considered inappropriate. The –62 modifier did help account for an additional surgeon’s work by increasing the combined reimbursement from Medicare (and others) by 25%. This was shared equally between the two co-surgeons unless coordinated arrangements

were made with the payer at the time of bill submission. Unfortunately, failure to use the modifier correctly by one co-surgeon could result in delayed or no reimbursement for the work performed. Consequently, a work group was formed to explore alternative methods, including emulating the skull base surgery model.

During this process, a pair of surgeons in Pennsylvania submitted a request to the CPT Editorial Panel for creation of an anterior lumbar approach code. Although requests for new codes can come from many sources including individual physicians, societies, industry, and HCFA, this request brought the issue of anterior spinal approaches to the forefront of the CPT agenda prematurely. Since this issue crosses specialty boundaries, there has been an intensive effort over the past year to reach a mutually agreeable consensus regarding spinal approaches among several specialty societies representing the general surgeons, thoracic surgeons, orthopedic surgeons, and neurosurgeons.

Initially, codes and vignettes were developed to separate approach from the definitive procedure. Several concerns included the method for valuing the approaches and how budget neutrality could be maintained in the Medicare Fee Schedule given that the current codes represented the approach and definitive procedure. Eventually, a compromise was achieved among the societies to maintain the –62 co-surgery modifier, but allow its application to the definitive procedure as well as additional levels of the definitive procedure. Despite presenting a unified consensus, opposition to the proposal by HCFA prompted consideration of a new alternative –61 spine-surgery specific modifier. There is substantial concern among the specialty societies involved regarding the non-uniform acceptance of modifiers among payers, the delay in implementation of modifiers, and the unknown method of valuing and reimbursing for a new modifier.

The eventual resolution of this process may not occur this year. Moreover, since the deadline for code changes for CPT 2001 has essentially passed, this may remain an unresolved issue for another year. Hopefully, this example illustrates the complicated political process involved in the evolution of CPT codes. Although many legitimate requests for CPT codes are received, the financial ramifications of change can sometimes be unexpected and adverse. Consequently, proposals for potential new codes or changes in old codes are best coordinated with your CPT representatives. This facilitates analysis of the requested change in the context of the other existing codes as well as its effect on the valuation of other codes in order to maintain an equitable system for all and reduce the likelihood of imaginative coding.

### **Comments, Submissions, or Suggestions for the Newsletter?**

Please e-mail John Hurlbert at [jhurlber@ucalgary.ca](mailto:jhurlber@ucalgary.ca) or contact through surface mail: Dr. R.J. Hurlbert, University of Calgary Spine Program, Foothills Hospital and Medical Centre, 1403-29<sup>th</sup> St. N.W., Calgary, AB Canada T2N 2T9