Welcome

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

Welcome to the Newsletter of the Disorders of the Spine and Peripheral Nerve Joint Section of the American Association of Neurological Surgeons and Congress of Neurological Surgeons. In this issue, we offer a Q&A between the most recent Past Chair of the Joint Section, Mike Groff, and John Ratliff. We will try to continue to interview each of the Chairs and Past Chairs in future editions.

Charles Sansur brings us up to date with recent Rapid Response Team activity. Also new in this issue is a Nerve Update, focusing upon course offerings and grant opportunities from Line Jacques and Lynda Yang.

There are a lot of changes in the PQRS system for 2015, these are briefly outlined in this edition and a more thorough review prepared by Rachel Groman of Hart Health Strategies is provided for your review. The financial impact of the changes may be significant. In other good news, we also review recent RUC activity relevant to spine surgeons.

In closing and with great sadness, we report the passing of Charlie Kuntz, one of the giants of our Section. His eulogy is attached at the end of our Newsletter. We will be honoring him at the upcoming Spine Section meeting. He will be missed.

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Spine Rapid Response

Team Members

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- Joseph Cheng (Director)
- Charles Sansur (Assoc Dir)
- Peter Angevine (NE Quad)
- Karin Swartz (SE Quad)
- John Ratliff (NW Quad)
- Lou Tumialan (SW Quad)

Contributing Members
- Kurt Eichholz
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- Daniel Hoh
- Kai Ming Fu
- Daryl Fourney
- Cheerag Upadhyaya
- John O’Toole
- Sharon Webb
- Todd Francis
- Greg Smith, DO
- Jim Harrop
Interview with Michael Groff

Michael W. Groff, M.D. is the Immediate Past Chair of the Disorders of Spine and Peripheral Nerves section, having served as chair in 2013-2014. He the Director of Spinal Neurosurgery at the Brigham and Women's Hospital and earned his MD at the University of Pittsburgh. He then went on to the Mount Sinai Hospital in New York for internship and residency training in Neurological Surgery. He completed his training at the Medical College of Wisconsin with a fellowship in Spinal Surgery.

Dr. Groff is active in the American Association of Neurological Surgeons (AANS), NeuroPoint Alliance (NPA), and the Neurosurgical Research and Education Fund (NREF). His academic interests include process improvement, health services research, outcome measures, and guideline development. He was interviewed for the newsletter in February 2015.

John Ratliff: What was your favorite part about being chair of the Spine Section?

Michael Groff: I think it’s a very dynamic group of people who are completely committed to improving the quality of operative spine care. It was a very rewarding experience.

John Ratliff: Did you have any significant difficulties during your year as president?

Michael Groff: I think that some of the big challenges revolved around trying to document and ascertain the evidence for the treatments that we offer.

Another big challenge was trying to create an environment that would foster a greater collaboration between orthopedic and neurological spine surgeons. I think that it really is one of the most important things to help move the field forward. The vast majority of members in both communities are very committed to it, and yet at the same time, they are institutional and bureaucratic obstacles.

John Ratliff: Do you think the primary challenge is a personal one between surgeons that are still competing for patients or is it more institutional between different departments?

Michael Groff: As you know, all politics are local, but I think, in general, the collaboration in their trenches is very strong. I believe there is a great degree of mutual respect and a recognition of a common mission. There are challenges on the national level, not that people don’t want it to happen, it’s just that we are beholden to different communities.

John Ratliff: What advice would you give someone who wants to become more involved in this section?

Michael Groff: I think the Spine Section’s strongest element is the participation in its membership and that it really is a very much a meritocracy. My advice would be to get plugged in at whatever level possible and start contributing. In my own experience the first thing that I did was just manning sawbones stations at national meetings. One thing leads to another, for doing good work you get recognized, and if you do a good job you are rewarded with bigger and bigger jobs to do.

One of things that is very unique about the Spine section, in contrast to other societies, is that the Spine section really has a strong culture of promoting the young members within its group. Young people that are interested can take over positions of leadership much earlier than they would in other organizations.

John Ratliff: Is there anything in particular that you wish you had known 10 years ago? Any advice you would give a young Mike Groff?

Michael Groff: I guess the one thing I would say I didn’t appreciate at that time is how much you continue to learn after you finish training. I think we have all heard the expression that being a physician is a process of life-long learning. I don’t think that statement has the same kind of immediacy when I heard just coming out of fellowship. I thought I had learned all the things that I needed to know I really found in my first 5 years that I learned so much that I didn’t know in the 5 years prior. I think it’s important that we plan our career and put ourselves in an environment to learn as much as possible.

John Ratliff: Spine surgery has a stigma in the media, with a number of high profile articles contesting the value of spine surgery. What can organized medicine, specifically spine surgery, do to counteract that?

Michael Groff: I agree that there is a stigma and I think it is a very pervasive problem. Really it affects all of medicine. I think if you look at physicians as a group, physicians are amongst the most well-intentioned members of our society. And so you have to wonder why there is such a disconnect.
Our society as a whole is struggling with the fact that healthcare is costly and it takes a big toll on our priorities in other areas. What we can do is to celebrate the great things that physicians do for their patients on a daily basis in their practices.

**John Ratliff:** Do you see any other significant challenges to spine surgery in our near future?

**Michael Groff:** I think there is a challenge as it relates to access, and the bar has been raised higher and higher. Preserving access for our patients means we need to focus on both the quality and the cost of the care we provide. I think the Spine Section has done a great job of providing leadership in the effort to demonstrate the value of the care we provide, but the bar is constantly being raised. Sometimes it feels like we are chasing after a rabbit and can never quite catch it.

When I started training, we used to think of iliac crest graft site donor pain in patients having anterior cervical fusions as an unavoidable consequence of treatment. This is no longer considered necessary or in most cases even acceptable. I think it’s appropriate to set the bar high. If you look at it objectively, we have done so and the field continues to move forward.

**John Ratliff:** What do you think the next things are going to be in terms of how we refine the treatments we provide for our patients?

**Michael Groff:** Although our technique and tools are critically important, I think we will make more progress by studying our indications. I do believe we will continue to improve our techniques, but I think those changes will be largely incremental. I think we really need to study which patients will benefit most from operative therapy. What we really need to study are the indications for intervention, which patients are appropriate for operative therapy, and which patients may not do well with surgery.

That is a point that gets confused in the lay press, when articles come out discussing success or lack of success of a particular procedure, like a lumbar fusion. Those of us in the field recognize the success of the technique depend upon the reasons for which it is being performed. An increased understanding of indications will play a dramatic role in pushing the field forward.

I think that is an area where we are paying a lot of attention, whether through appropriate use criteria, or guidelines, or other efforts to understand who benefits most from a particular intervention.

**John Ratliff:** How can the Section contribute to those efforts?

**Michael Groff:** That plays right to the Section’s sweet spot when it comes to evidence generation or pushing research in a given direction, and then through disseminating that information through our meetings.

**John Ratliff:** Do you think registries are the future with regard to capturing this data? Or do you think we will go back to more prospective, IDE-style studies of spine care?

**Michael Groff:** I think a lot of these questions are not amenable to a randomized, prospective clinical trial. Very appropriately, registries will play an increasingly important role in understanding the best indications for operative techniques and in documenting the value of the care we provide.

**John Ratliff:** You have seen the entirety of the Section, from running sawbones stations to being Chair. Is there anything you would change?

**Michael Groff:** Yes, I think the Section is also evolving. My fondest memories of the Section revolve around the informal and collaborative interaction between very senior surgeons and newcomers. That informality has been at the heart of the Section for a long time.

As the Section has grown in size and become even more successful, maintaining that informality and keeping those aspects of the Section that make it great has been a challenge. Some of the things that we have been struggling with in terms of continuity in leadership, our corporate strategy, our relationship with various stakeholders—all those things need to be formalized in a way that provides consistency but that do not sacrifice the collegiality that is at the root of who we are. We have been working on this for several years, and we have made a lot of progress, but there is still work to be done.

**John Ratliff:** With the OpenPayments.gov Website, and with new public scrutiny of industry and pharmacy payments to physicians, what do you think is the future of partnership between physician innovators and industry? Do you think the OpenPayments approach is healthy transparency or missing the point?

**Michael Groff:** First and foremost, you need to recognize that interactions between surgeons and industry have been very productive. If we look at the innovations in spine surgery over the last 10 years, or going back even further, virtually all have come from interactions between surgeons and industry, as opposed to other more traditional funding of research.

Now that does come with some risk. Although there is an area of overlap between the appropriate concerns of surgeons and the appropriate concerns of industry, it is obvious to everyone that there are also areas where their interests do not align. I think transparency is exactly the way to make sure interactions take place in an ethical and productive manner.

**John Ratliff:** I think the entire Section would join me in thanking you for all of your hard work and service to our organization. You have given tons of time and tons of effort to make the Section successful, and we would all like to thank you for that.

**Michael Groff:** It is nice of you to say that. I would say it was a distinct honor and my pleasure to be able to serve as chairman. I hope some good came out of it, and it was a tremendous education for me.
As part of the Section for Disorders of Spine and Peripheral Nerves, we would like to keep our members updated with news related to upcoming peripheral nerve meetings, announcements, and topics of interest. We hope the inclusion of this information will facilitate communication among our members and other interested participants – and serve as a useful tool. We welcome your feedback, and member contributions of any news are appreciated. Please do not hesitate to contact Line Jacques (line.jacques@ucsf.edu) or Lynda Yang (ljsyang@med.umich.edu) with any comments or questions.

1. The Kline Research Award supports either basic or clinical research related to peripheral nerves with funding up to $15,000 yearly. This research award provides a means of peer-review for clinical research projects, and therefore, enhance competitiveness for potential National Institutes of Health (NIH) funding.

The 2014 awardee, Dr. Yuval Shapira (laboratory of Dr Rajiv Midha, Calgary, CA) will present a talk entitled “Schwann cell therapy to reduce axonal attrition and misdirection in the injured nerve” on May 5, 2015, during the 2015 AANS Annual Meeting in Washington, D.C.

The 2015 recipient will be announced at the 2015 Disorders of the Spine and Peripheral Nerves Meeting in Phoenix.

2. The 2015 Kline Lecture will be presented by Dr. Thomas Brushart (Johns Hopkins University) on May 5, 2015, during the 2015 AANS Annual Meeting in Washington, D.C. The presentation is entitled “Preferential motor reinnervation - in perspective.”

3. The date and location for the annual Peripheral Nerve Division Business Meeting/ Dinner, to be held during the 2015 AANS Annual Meeting, will be announced soon.

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

   Sunderland Society
   (www.sunderlandsociety.org)
   2015 Biannual Meeting
   June 7-9, 2015
   Ann Arbor, Michigan

   World Federation of Neurosurgical Societies
   (http://www.wfnsinterimrome2015.org/)
   2015 Interim Meeting
   September 8-12, 2015
   Rome, Italy
   Contact Mariano Socolovsky (socolovsky@fibertel.com.ar)
   for peripheral nerve abstracts and program

   American Society for Peripheral Nerve
   (www.peripheralnerve.org)
   2016 Annual Meeting
   January 15-17, 2016
   Scottsdale, Arizona

Respectfully submitted,
Line Jacques and Lynda Yang
Big Changes in PQRS
Will Affect Physician Reimbursement

The biggest issue in the Quality Improvement world, and an issue that may have significant financial impact on spine surgeons, is the changes in the Physician Quality Reporting System (PQRS) enacted with the 2015 Medicare Physician Fee Schedule. Here are the key elements you need to know:

1. 2014 was the last year that physicians were eligible for an incentive payment under the PQRS. Starting in 2015, the program becomes punitive, with negative Medicare reimbursements applied in 2017 for physicians who do not successfully participate in 2015.

The cut in 2017 will be 2% of all Medicare reimbursement for physicians that fail to report in 2015.

2. Successfully reporting for 2015 has become much harder. Previously, we taught that neurosurgeons could successfully comply with PQRS by reporting the perioperative services measures group in a total of 20 patients. These measures dealt with perioperative antibiotics and DVT prophylaxis. Incorporation of these measures was so successful that CMS and the National Quality Forum feel they are “topped out”, or that there is no longer significant room for improvement. So the perioperative measures group has been eliminated. Only one of the perioperative group measures has been deleted (timing of antibiotic administration), though, hence you can still use these measures for reporting. But, what you did in 2014, even if successful, will not work in 2015.

3. New requirements require that you report 9 different PQRS measures in 3 different quality domains with one “cross cutting” measure. This content is reviewed succinctly in the attached document prepared by Rachel Groman. This is a huge issue, since most PQRS metrics do not apply to neurosurgical practice. Finding appropriate measures may be a challenge.

4. Tony Asher, Jack Knightly, and the NPA are trying to make the N2QOD platform a qualified registry, where physicians reporting to N2QOD will be able to satisfy their PQRS requirements. We are waiting to hear from CMS for feedback on that proposal.

5. It gets worse. If you do not satisfy PQRS reporting requirements, you face further cuts with implementation of the Value Based Payment Modifier (VBM). As of 2015, VBM is being applied to all physicians and may generate further Medicare cuts for 2017 reimbursement. The VBM may apply another 4% cut in reimbursement, depending upon quality and cost criteria. So, the total cut that a neurosurgeon could be exposed to would be 6% of Medicare reimbursement.

What can you do? If you report some measures, but do not reach the 9 PQRS measure cut off, you still may be held blameless for the negative adjustment through the Measures Applicability Validation process. Basically this says if you report something, even if it is fewer than 9 measures, and there are no other relevant measures that you could have reported, and you report a cross-cutting measure, then you do not face the cut in 2017. So continuing to report peri-operative services, if you add an additional measure that is cross-cutting, should prevent any cuts for 2017.

Cross cutting measures are reviewed in the attached document, and are general measures like Medication Reconciliation or Pain Assessment. Unfortunately, they have to be reported in at least 50% of Medicare beneficiaries to be deemed successful.

Other efforts are considering developing a neurosurgery-specific measures group and neurosurgery-specific PQRS measures. We will keep you apprised of further developments in this area.

Rapid Response Team Answers Anthem Request on Thoracic and Thoracolumbar Fusion for Scoliosis

On Feb. 5, 2015, the AANS and CNS responded to a request from Anthem (formerly WellPoint) for comment on Thoracic and Thoracolumbar Fusion for Scoliosis. Charles Sansur, MD, coordinated the response with the AANS/CNS Spine Section Rapid Response Team (RRT).

Specifically, the response expressed concerns that the proposed policy was too broad in using the term scoliosis defined as a coronal deformity greater than 10 degrees, and did not address the various causes of spinal deformity. In addition, the AANS and CNS comments emphasized that spinal deformities are a heterogeneous disorder with different surgical indications and coverage policy should consider subgroups including but not limited to idiopathic, iatrogenic or post-laminectomy, degenerative, traumatic, and other forms of scoliosis.
What’s up with the RUC

The 2015 Medicare Physician Fee Schedule (MPFS) had a lot of content focused on the PQRS system, reviewed elsewhere in the Newsletter. There are other RUC issues that are vitally important to spine surgeons, and new RUC activity that may affect your practice. Here is a quick overview:

1. **Global period threatened** | The 2015 MPFS proposed a radical change in how surgery is paid for. At present, most major surgical codes have 90 day global periods, meaning that the care you provide just before and for the 90 days after the procedure is bundled into the code value. So your post-op hospital and clinic visits are already paid for in the single payment for the procedure.

This is one of the elements that surveys review and that we use when valuing codes. The Evaluation and Management (E&M) services provided after surgery can routinely account for up to 40% of a given code’s value.

CMS thinks that some physicians are not providing the post-operative care that they are being paid for with the 90 day global payment. So, CMS has proposed scrapping the global period altogether and having surgeons bill for their post-op care the same way they would bill for routine E&M services. The deadline CMS has set for instituting this change is 2017 for 10 day globals and 2018 for 90 day globals.

A considerable amount of effort at the AMA and in organized medicine is being marshalled to answer this proposal. Instituting it would be quite difficult, with a mandate to revalue essentially the entire fee schedule. It took 6 years for the RUC to figure out the intricacies of practice expense; the Panel does not feel that it is feasible to institute this change in that quick a fashion.

One option for revaluing codes would be to subtract out the value of the E&M services that will be eliminated. This does not work in most codes, and creates a number of codes that would have negative values. The RUC does not feel using this building block approach is an option.

We will keep you apprised as these efforts progress

2. **22851** | We have talked about 22851 (Application of intervertebral biomechanical device[s] [e.g., synthetic cage(s); methylmethacrylate] to vertebral defect or interspace) before. It has been picked up by different screens that identify potentially mis-valued codes as part of the RUC process.

At the last RUC meeting, we reviewed 22851 again and direction was given to re-survey the code. After reviewing how the code is used with our colleagues at AAOS and NASS, it seems appropriate to develop new codes that will take the place of 22851, covering insertion of expandable cages, cages with integrated locking mechanisms, etc. This work is underway, and will likely lead to a number of surveys either later in 2015 or 2016, depending upon the progress of the CPT Panel.

3. **63047 and 22630/22633** | This is not a RUC issue, but directly affects coding. On January 1, 2015, the National Correct Coding Initiative (NCCI) published a new guideline that stated:

CMS payment policy does not allow separate payment for CPT codes 63042 (laminotomy...; lumbar) or 63047 (laminectomy...; lumbar) with CPT codes 22630 or 22633 (arthrodiasis; lumbar) when performed at the same interspace. If the two procedures are performed at different interspaces, the two codes of an edit pair may be reported with modifier 59 appended to CPT code 63042 or 63047.

Previously, we have consistently taught that the work involved in a laminectomy for decompression, if it exceeds the work necessary for doing a lumbar interbody fusion, should be reported in addition to the interbody fusion code. Hence you would report the laminectomy (63047) with a -59 modifier, telling the payer that the laminectomy should not be bundled with the interbody fusion. While CMS and other private insurers may deny this, it is appropriate to appeal and the coding convention follows CPT terminology. For physicians that are RVU based, this correct coding is significant. The new CCI edit completely reverses that policy.

NCCI edits are treated as gospel, and as the Medicare Law of the Land. If you are hospital or academic based, your coders have probably already started to follow this guideline.

At present, if you report 63047 with a -59 modifier in addition to an interbody fusion code (22630 or 22633), then Medicare will assume that you have done a laminectomy at a different level. (I.E. you did the TLIF at L4-L5 and a laminectomy at L3-4). They may pay for the code, but if they audit your practice you are in trouble. To report 63047, now you use a -51 modifier, noting that it is an additional procedure. This decreases the value of the code by ~50%.

The worst part is that this NCCI edit is absolutely wrong and ignores CPT and RUC policy. Unfortunately, it conforms to an error published in the NASS SpineLine Journal, where the exact same coding policy was erroneously stated (SpineLine August 2014). We brought this to NASS’s attention and they fixed it (SpineLine October 2014), but the NCCI edit came out anyway.

We have drafted a letter to the NCCI asking them to reconsider. We attach the letter here. We will keep you posted of any changes.
Dr. Charles Kuntz, IV, MD, dies at age 50.

February 26, 2015—One of Cincinnati’s most well known and respected neurosurgeons, Charles Kuntz IV, M.D., passed away on Thursday, February 26, 2015, at the age of 50. Dr. Kuntz lived in Indian Hill and is survived by his two children, Chaz and Maya.

Dr. Kuntz joined the Mayfield Clinic in 2000, and served as professor in the Department of Neurosurgery at the University of Cincinnati (UC) College of Medicine. He was also Vice Chairman of Education and Clinical Affairs, and Director of the Division of Spine and Peripheral Nerve Surgery for the Department of Neurosurgery. He had privileges at many hospitals throughout Cincinnati, but practiced primarily at the UC Medical Center, where he was also a member of the Neurotrauma Center of the UC Neuroscience Institute.

Dr. Kuntz graduated with honors from Cincinnati’s St. Xavier High School and was a chemistry scholar at the College of the Holy Cross, graduating magna cum laude and earning induction into Phi Beta Kappa. He received his medical degree from Case Western Reserve University School of Medicine in 1991 and was inducted into Alpha Omega Alpha, the national medical honor society. He performed his neurosurgery residency at the University of Washington and completed orthopaedic and neurosurgical fellowships in London and Seattle before joining Mayfield.
Dr. Kuntz built his Cincinnati practice by specializing in complex spine surgery. During marathon procedures, he rebuilt the spines of patients whose deformities and curvatures were incredibly severe. He was loved by his patients for his gentle, caring presence.

Dr. Kuntz once said “It’s a big deal when you have a patient who can’t stand up straight, who can’t look you in the eye, who’s embarrassed to go out. I want to help him or her become a person who’s not only attractive to others, but also attractive to himself or herself.”

Dr. Kuntz was honored with a listing in the national database of Best Doctors in America® every year since 2005. In October 2014, he was named nationally outstanding in the Castle Connolly Top Doctors, which was developed by U.S. News & World Report in collaboration with Castle Connolly Medical Ltd., publisher of America's Top Doctors®. Dr. Kuntz appeared in Castle Connolly’s Top Doctors listing every year since 2011. Dr. Kuntz also appeared in Cincinnati Magazine's regionally developed list of top doctors from 2007-2014.

According to Arthur Arand, MD, Chairman of Mayfield’s Board of Directors, “Charlie was an extremely talented surgeon and a valued member of our organization. He took great pride in leading and teaching. We all learned a great deal from him about neurosurgery and life in general. Along with his family, his patients were always the top priority. He will be greatly missed.”

Dr. Kuntz’s commitment to neurosurgery went beyond patient care. Over a five-year period, he led the creation of a new spinal deformity classification system that was later published in the journal Neurosurgery. The system defines deformity in relation to the healthy, normal curve of the spine.

He also served as a principal or co-investigator in numerous clinical trials, and gave more than 100 invited lectures around the world. He served on education and research committees at UC and directed UC’s spine fellowship. On a national level, he served on the board of the American Association of Neurological Surgeons/Congress of Neurological Surgeons Section on Disorders of the Spine.

Dr. Kuntz enjoyed reading and sailing and was an active board member of Cincinnati Opera. He previously served as a volunteer physician in the Appalachian Mountains and Andes Mountains, and he was a foster parent for several years.

According to Mario Zuccarello, MD, Mayfield Professor and Chairman of the UC Department of Neurosurgery, “Charlie’s many contributions to the academic and research missions of the UC Department of Neurosurgery and leadership within the UC Medical Center will be sorely missed. He was well respected as a leading spine surgeon and scholar. He was a dedicated and loving father. He enjoyed and contributed to the fine arts of the Cincinnati community. God bless Charlie.”

* * *

Funeral arrangements are pending, and will be shared as soon as they are available. Mayfield will be posting a memorial tribute on MayfieldClinic.com later today, including a blog where visitors can post comments.