COUNCIL OF SURGICAL SPINE SOCIETIES

AANS/CNS Joint Section on Disorders of the Spine and Peripheral Nerves
American Association of Neurological Surgeons
AOSpine North America
Cervical Spine Research Society
Congress of Neurological Surgeons
Lumbar Spine Research Society
Scoliosis Research Society

5550 MEADOWBROOK DRIVE, ROLLING MEADOWS, ILLINOIS USA 60008 TELEPHONE (847) 378-0500 FAX (847) 378-0600

August 7, 2014

Thomas L. Simmer, MD
Chief Medical Officer
Blue Cross and Blue Shield of Michigan
600 Lafayette Blvd.
Detroit, MI 48226-2927

RE: Blue Cross Blue Shield of Michigan Transpsoas Approaches Medical Policy

Dear Dr Simmer:

On behalf of the members of the Council of Surgical Spine Societies (COSSS), we wish to thank you for providing us with the opportunity to review the Blue Cross Blue Shield of Michigan medical policy statement dated May 1, 2013. COSSS is dedicated to the best possible care for patients with spinal disorders through investigation, education and advocacy.

In this policy statement, it is the position of Blue Cross Blue Shield of Michigan that transpsoas approaches to the lumbar spine are considered experimental, investigational, and not medically necessary. The basis of this statement is what is perceived to be the limited evidence in the literature about the efficacy of this approach and concerns about its safety. The authors of the current policy statement believe that further comparative studies are needed. Our response addresses these assumptions and we urge you to amend your policy pursuant to our recommendations outlined below.

Regarding the safety of this procedure, while early reports of neurological deficits related to plexus injury may have been a concern, several recent studies have revealed much lower rates of plexus injuries. As with any procedure, complications will often be recognized in the early experience. It is this recognition that allows for surgeons to modify and evolve the procedure. We invite the medical policy writers to review the more recent literature on this topic. Rodgers et al., in 2010, reported a series of 600 patients undergoing lateral transpsoas approaches. There was a rate of 0.7% transient postoperative neurological deficits. In this same series, there were no wound infections, no vascular injuries, and no intraoperative visceral injuries. This more recent data suggests a comparable complication profile to standard open anterior fusions.[1] As such, we do not believe that the lateral transpsoas procedure is unsafe, and

hence, experimental by default. Numerous recent studies have reported more concrete understanding of the lumbosacral plexus anatomy and its relationship to the particular levels of the lumbosacral spine.[2-4] It is through this better understanding of the anatomy that a reduced rate of nerve injuries is being achieved. Furthermore, when nerve injuries were encountered, it is important to note that the vast majority of reported injuries have been transient. The more recent literature demonstrates that these neuropathies and neuropraxias are self-limited. [5, 6] As a result of the recent published studies on the transpsoas approach, we believe that CPT code 22558 accurately describes the work performed, and thus, this code should be correctly utilized for surgeries where a discectomy and fusion from the lateral approach is performed.

The current policy statement is the basis for recommending that surgeons performing transpsoas procedures use the code 22899, an unlisted code, instead of 22558. We have concerns with this recommendation as it is counter to the position and the recommendations of the American Association of Neurological Surgeons (AANS) Coding Committee. From an anatomical standpoint, approaches to a lumbar disc space may be through the posterior elements, where a laminectomy, facetectomy, or a combination, thereof, provides the surgeon with an access corridor into the lumbar spine. The work performed by the surgeon in a posterior approach is distinct from that performed for anterior approaches to the lumbar spine. Transpsoas and direct anterior approaches, on the other hand, have more similarities than differences. While the access corridor for a transpsoas approach involves navigating the lumbosacral plexus, a direct anterior approach involves mobilization of the iliac arteries and veins. Upon exposure of the disc space, a discectomy is performed, vertebral bony endplates are prepared and a structural interbody graft is placed. All of this work is accurately described by the current CPT description of 22558 (arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace). Furthermore, this approach has been used for many years with thoracoabdominal approaches for scoliosis reconstruction. The revised technique of the transpsoas lumbar interbody fusion is accomplishing the same surgery by using a smaller portion of the incision.

Given these similarities between the direct anterior and transpsoas approaches, with a CPT description that accurately captures the work performed, utilization of an unlisted code is difficult to reconcile. Unlisted codes are used for new technology until a new CPT code that describes the procedure is generated. There is no such code in formulation nor is there a need for one with the current CPT code of 22558. For this reason, we have concerns regarding the coding recommendation that Blue Cross Blue Shield of Michigan has rendered.

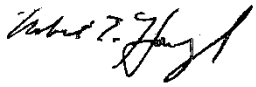
These CPT codes are not based on the safety or efficacy of a procedure; rather, they represent an accurate description of the work performed by the surgeon. On a larger scale, the purpose of the terminology is to provide a uniform language that will accurately describe a procedure, and thereby, provide an effective means for reliable nationwide communication between physicians and third parties. The recommendation to use an unlisted code for a procedure, which is currently and accurately described by a listed code of 22558, is disruptive to this process. The AANS Coding Committee carefully considers each CPT code, relative to the procedure, before recommending and teaching surgeons how to correctly code a procedure. In our estimation, the current description of CPT code 22558 accurately describes the approach and captures the work

performed by a surgeon in transpsoas lumbar interbody fusions.

Again, thank you for this opportunity to comment and we look forward to seeing a revision to your medical policy. We would also be pleased to discuss this on a telephone conference call before the policy is reviewed and updated again. If you have any questions, please feel free to contact Joseph Cheng, MD, AANS/CNS Payor Policy Committee at joseph.cheng@vanderbilt.edu or Cathy Hill, Senior Manager, Regulatory Affair AANS/CNS at chill@neurosurgery.org.

Sincerely,

Robert F. Heary, MD, FAANS, Chair
Council of Surgical Spine Societies



Robert E. Harbaugh, MD, FAANS
American Association of Neurological Surgeons

John Hurlbert, MD, FAANS
AANS/CNS Joint Section on Disorders
of the Spine and Peripheral Nerves

Michael G. Fehlings, MD, PhD, FAANS, FRCS
AOSpine North America

Bruce Darden, II, MD
Cervical Spine Research Society

Daniel K. Resnick, MD, AANS
Congress of Neurological Surgeons

Jeffrey S. Fischgrund, MD
Lumbar Spine Research Society

Steven D. Glassman, MD
Scoliosis Research Society

cc: Alison Waxler, NASS
Shweta Trivedi, NASS

References

1. Rodgers WB, Gerber EJ, Patterson J. Intraoperative and early postoperative complications in extreme lateral interbody fusion: an analysis of 600 cases. *Spine (Phila Pa 1976).* Jan 1 2010;36(1):26-32.
2. Uribe JS, Arredondo N, Dakwar E, Vale FL. Defining the safe working zones using the minimally invasive lateral retroperitoneal transpsoas approach: an anatomical study. *J Neurosurg Spine.* Aug 2010;13(2):260-266.
3. Spivak JM, Paulino CB, Patel A, Shanti N, Pathare N. Safe zone for retractor placement to the lumbar spine via the transpsoas approach. *J Orthop Surg (Hong Kong).* Apr 2013;21(1):77-81.
4. Banagan K, Gelb D, Poelstra K, Ludwig S. Anatomic mapping of lumbar nerve roots during a direct lateral transpsoas approach to the spine: a cadaveric study. *Spine (Phila Pa 1976).* May 15 2011;36(11):E687-691.
5. Lykissas MG, Aichmair A, Hughes AP, et al. Nerve injury after lateral lumbar interbody fusion: a review of 919 treated levels with identification of risk factors. *Spine J.* Sep 5 2013.
6. Ahmadian A, Abel N, Uribe JS. Functional recovery of severe obturator and femoral nerve injuries after lateral retroperitoneal transpsoas surgery. *J Neurosurg Spine.* Apr 2013;18(4):409-414.