

AMERICAN ASSOCIATION OF
NEUROLOGICAL SURGEONS

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American
Association of
Neurological
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CONGRESS OF
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September 24, 2023

John G. Finkenberg, MD, President
North American Spine Society
7075 Veterans Blvd.
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SUBJECT: NASS Intraoperative Neurophysiological Monitoring Policy

Dear Dr. Finkenberg:

On behalf of the American Association of Neurological Surgeons (AANS), the Congress of Neurological Surgeons (CNS) and the AANS/CNS Joint Section on Disorders of the Spine and Peripheral Nerves (DSPN), we appreciate the opportunity to comment on the North American Spine Society's (NASS) Draft Coverage Policy for intraoperative neurophysiological monitoring (IONM). The DSPN Payor Response Committee has reviewed the North American Spine Society's (NASS) coverage policy, and we have several recommendations.

1. Our biggest concern centers around this statement on page 3: **“Provision of IONM.** Multimodality IONM should be performed by a credentialed technologist and overseen by a physician with training/experience in IONM (who is not the operative surgeon or anesthesiologist) or a doctorate-level professional who is board-certified to interpret IONM signals and supervise technologists (Rationale 2).” This indicates that individuals who are not physicians are permitted to oversee IONM. However, this stance is in direct contradiction with the American Medical Association's (AMA) policy — Intraoperative Neurophysiologic Monitoring H-410.957 — which states:

Our AMA policy is that supervision and interpretation of intraoperative neurophysiologic monitoring constitutes the practice of medicine, which can be delegated to non-physician personnel who are under the direct or online real time supervision of the operating surgeon or another physician trained in, or who has demonstrated competence in, neurophysiologic techniques and is available to interpret the studies and advise the surgeon during the surgical procedures.

Furthermore, it conflicts with the Centers for Medicare & Medicaid Services (CMS) policy on Intraoperative Neurophysiological Testing (L35003), which specifies that this “test must be ordered by the operating surgeon and the monitoring must be performed by a physician who is other than the operating surgeon; the technical/surgical assistant; or the anesthesiologist rendering the anesthesia.”

The AANS, CNS and DSPN agree with the AMA and CMS policies that a licensed **physician** with specialized expertise in IONM monitoring should oversee intraoperative neuromonitoring and urge NASS to adjust the policy accordingly.

2. The phrase **“Coverage is recommended on a conditional basis”** (found on page 4) may introduce ambiguity and potentially result in insurance companies denying coverage for many procedures listed within this category. How would an insurance company interpret the vague term “on a conditional basis?” What condition does the surgeon have to demonstrate to get the approval for using IONM for the procedures in this category? Does the surgeon need to engage in an appeal

process each time they wish to employ IONM for procedures in this category?

We recommend changing the term to “Coverage is recommended as an option and should be determined by the treating physician in consultation with the patient.” For instance, numerous surgeons choose to employ electromyography (EMG) to monitor the lumbar plexus when safely navigating the psoas muscle during lateral approaches such as lateral lumbar interbody fusion (including extreme lateral interbody fusion, direct lateral interbody fusion, etc.). Whether to utilize EMG for this procedure should be at the surgeon’s discretion, based on their experience, comfort level, and the patient’s unique anatomy. This procedure should be either in the category of “coverage is recommended” or the term “on a conditional basis” should be precisely defined for clarity.

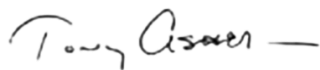
3. Likewise, many surgeons would like to use trigger EMG to assess the integrity of pedicle screws following their placement in the thoracic or lumbar spine regions. In the current draft, instrumented spinal fusion procedures not part of the interbody fusions are listed under the “**Coverage is recommended on an exceptional basis**” (found on page 5). This could create substantial obstacles for surgeons who use trigger EMG to assess pedicle screw integrity.

We recommend changing it to be under the category of “**Coverage is recommended as an option.**” This adjustment would better accommodate surgeons’ preferences for using trigger EMG in evaluating pedicle screw integrity during instrumented spinal fusion procedures.

4. On page 3, the policy states, “Whenever the clinical scenario requires IONM, the standard multimodality IONM plan for spine should typically involve use of all three primary IONM modalities of MEPs, SSEPs, and EMG.” However, this statement is not accurate. In numerous scenarios, the necessity for IONM may only call for one or two of these modalities, as exemplified by the situations mentioned earlier.
5. On page 5, the policy stated, “Coverage is not recommended” for lumbar discectomy. While this is generally true for most cases, it’s worth noting that in the context of endoscopic transforaminal lumbar discectomy surgery, IONM, particularly EMG monitoring of nerve function in the targeted foramen, can be a valuable tool, especially when the surgeon chooses to do the surgery under general anesthesia. Having EMG as an available option is important for endoscopic transforaminal lumbar discectomy.

Thank you for the opportunity to provide our feedback. The AANS, the CNS and DSPN look forward to further collaboration with NASS on coverage recommendations to provide valuable clinical expertise and guidance to payors and other stakeholders.

Sincerely,



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