

February 2, 2021

Liz Richter
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244-8016

Gift Tee
Director
Division of Practitioner Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Attention: Division of Practitioner Services, Potentially Misvalued Codes

Dear Acting Administrator Richter and Director Tee:

On behalf of LifeNet Health, I am writing to submit comments requesting agency review of **CPT 22551** (*Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophyctectomy and decompression of spinal cord and/or nerve roots; cervical below C2*) **and accompanying add-on codes** as potentially misvalued services as part of its annual Medicare Physician Fee Schedule rulemaking process.

LifeNet Health has been a trusted source of transplant and surgical solutions for nearly 40 years. We have provided more than seven million allograft implants to help restore patients' wellbeing and, in many cases, save lives. We work closely with clinicians and healthcare organization to understand clinical needs and provide the resources needed for efficient, effective, economical care.

POTENTIALLY MISVALUED SERVICES IN THE MEDICARE PHYSICIAN FEE SCHEDULE

Request for Placement of Additional Codes on List of Potentially Misvalued Services

As part of the CY 2021 annual rulemaking process, CMS agreed with the public nominations¹ it received that **CPT 22867** (*Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level*) is worthy of review as potentially misvalued and sought comment on the addition of this code to the list of potentially misvalued services.

¹ <https://www.cms.gov/files/zip/cy-2021-pfs-final-rule-public-nominations-potentially-misvalued-codes.zip>

The submitters nominated this code asserting that the work and malpractice relative value units (RVUs) for the procedure “significantly undervalue the procedure,” and requested that CMS raise the work RVU (wRVU) in order to reflect:

- The anomalous relationship between **CPT 22867** and **CPT 63047** (*Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; lumbar*)
- The work associated with the “insertion component of the procedure” in line with the wRVUs for **CPT 22868** (*Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure)*)
- A crosswalk with “surgical comparator,” citing retina surgery code, **CPT 67108** (*Repair of RD with vitrectomy (any method), including, when performed, air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique*)

As part of our response to the CY 2021 Medicare Physician Fee Schedule, we submitted that there are additional CPT code values related to spine procedures that are in need of contemporaneous review with CPT 22867. However, these comments were not acknowledged or responded to by CMS in the final rule. We now request that CMS evaluate these services as part of its annual potentially misvalued services review. While the code CMS finalized for the potentially misvalued services list is related to a non-fusion procedure, we believe CMS has an interest in reviewing associated anterior cervical discectomy and fusion (ACDF) procedures as well. In particular, the coding schema that results from use of primary procedure **CPT 22551** (*Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophylectomy and decompression of spinal cord and/or nerve roots; cervical below C2*) can result in cumulative RVUs that do not sufficiently reflect physician work, time, or outcomes.

Cervical degenerative disc disease is one of the most common diagnoses for patients suffering from neck and back pain. In addition to pain, patients may suffer from lack of function, immobility, and sensory loss. Initial treatments tend to be conservative, focusing on anti-inflammatory medicine and/or physical therapy. However, when these options fail, a surgical intervention may be needed. Such a procedure usually involves a discectomy and fusion, whereby the affected disc is excised, and the nerve root or spinal cord is decompressed. Following disc removal, the vertebral space is typically implanted with allograft bone or another option.

Historically, autografts, meaning implants from the patient’s own body, have been a standard practice. However, autografts have several disadvantages, such as extended operating time, donor site pain, limited supply, and variable quality depending upon the patient’s health. Thus, there has been a shift toward the use of alternative interbody spacers for treatment of degenerative disc disease. Two of the most common choices are structural allograft bone or synthetic cages.

Both allograft bone and synthetic cages have mechanical properties similar to autograft. However, synthetic cages may not integrate into the bone as well as autografts, which can lead the patient back to experiencing pain, immobility, and sensory loss, and potentially necessitating further surgery. By contrast,

structural allografts will integrate into the surrounding bone, which may result in superior clinical outcomes.^{2,3,4}

However, the values assigned to the codes for these different implant approaches vary. The primary procedure under either clinical scenario is **CPT 22551** (*Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophylectomy and decompression of spinal cord and/or nerve roots; cervical below C2*). The table below illustrates the coding scenarios for the use of 3 devices depending on whether the device selected is PEEK or structural allograft and how it results in wRVU differentials.

Work RVU Differentials Based on Implant Selection	
3 synthetic cage devices with plate	3 structural allografts with plate
CPT 22551 (<i>Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophylectomy and decompression of spinal cord and/or nerve roots; cervical below C2</i>) (50.42) wRVUs: 25.00	CPT 22551 (<i>Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophylectomy and decompression of spinal cord and/or nerve roots; cervical below C2</i>) wRVUs: 25.00
+CPT 22552 (x2) (<i>Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophylectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for separate procedure)</i>) wRVUs (6.5 x2): 13	+CPT 22552 (x2) (<i>Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophylectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for separate procedure)</i>) wRVUs (6.5 x2): 13
+CPT 22846 w Modifier 59⁵ (<i>Anterior instrumentation; 4 to 7 vertebral segments (List separately in addition to code for primary procedure)</i>) wRVUs: 12.4	+CPT 22846 w Modifier 59 (<i>Anterior instrumentation; 4 to 7 vertebral segments (List separately in addition to code for primary procedure)</i>) wRVUs: 12.4
+CPT 22853 (x3) (<i>Insertion of interbody biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each</i>)	N/A

² Nigeste Carter, Elena C. Gianulis and Mark A. Moore (July 16, 2019). Allograft Structural Interbody Spacers Compared to PEEK Cages in Cervical Fusion: Benchtop and Clinical Evidence [Online First], IntechOpen, DOI: 10.5772/intechopen.88091. Available from: <https://www.intechopen.com/online-first/allograft-structural-interbody-spacers-compared-to-peek-cages-in-cervical-fusion-benchtop-and-clinic>

³ Katie L. Krause, MD, PhD, James T. Obayashi, BS, Kelly J. Bridges, MD, Ahmed M. Raslan, MD, and Khoi D. Than, MD (January 2019). Fivefold higher rate of pseudarthrosis with polyetheretherketone interbody device than with structural allograft used for 1-level anterior cervical discectomy and fusion. *J Neurosurg Spine* 30:46–51, 2019 (Attached).

⁴ Nida Fatima, Elie Massaad, Ganesh M. Shankar, John H. Shin (April 2020). Structural Allograft versus Polyetheretherketone Implants in Patients Undergoing Spinal Fusion Surgery: A Systematic Review and Meta-Analysis. *World Neurosurgery*136: 101-109, 2020 (Attached).

⁵ Modifier 59 (*Distinct Procedural Service*)

<i>interspace (List separately in addition to code for primary procedure)) wRVUs (4.25x3): 12.75</i>	
+CPT 20930/6 (<i>Allograft, morselized, or placement of osteopromotive material, for spine surgery only (List separately in addition to code for primary procedure)) (0.00)</i>)	+CPT 20931 (<i>Allograft, structural, for spine surgery only (List separately in addition to code for primary procedure)) wRVUs: 1.81.</i>)
Total wRVUs: <u>63.15</u>	Total wRVUs: <u>52.21</u>

We are concerned that the variance in the total RVUs assigned to these procedures as outlined above do not reflect a variance in work, resources, or intensity. Therefore, we urge CMS to encourage review of these services.

Sincerely,



Bud Brame
Vice-President of Strategic Product Planning and Reimbursement Services