



February 10, 2020

Seema Verma, MPH
Administrator,
Centers for Medicare & Medicaid Services
Attention: CMS-1693-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via MedicarePhysicianFeeSchedule@cms.hhs.gov

RE: Nomination of CPT 22867 as a Misvalued Code

Dear Administrator Verma:

The International Society for Advancement of Spine Surgery (ISASS), a multi-specialty association dedicated to the development and promotion of the most current surgical standards, as well as the highest quality, most cost-efficient, patient-centric, and proven cutting-edge technology for the diagnosis and treatment of spine and low back pain is writing to request that the Centers for Medicare & Medicaid Services (CMS) propose corrected values for this procedure in the proposed 2021 Medicare physician fee schedule rule (2021 Proposed Rule). We set forth below our recommendations and rationale for establishing appropriate work and malpractice relative value units (RVUs) for spinal procedures reported with this code. We also refer CMS to ISASS comments to the 2020 Medicare Physician Fee Schedule Proposed Rule (submitted September 27, 2019) where ISASS previously proposed nomination of CPT 22867 as potentially misvalued.

Insertion of an interlaminar stabilization distraction device is described by the following code:

CPT 22867 Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level

We are nominating CPT 22867 as a potentially misvalued code because the current physician work and malpractice RVUs that CMS has assigned to CPT 22867 decompression/stabilization significantly undervalue this procedure. Below we provide evidence to support:

Increasing the work RVU value for CPT 22867 to 17.13, instead of 13.50, based on:

- an anomalous relationship between this code and CPT 63047 Laminectomy with decompression, single vertebral segment, lumbar (15.37 RVU).
- the addition of at least 4.0 work RVUs to represent the necessary insertion component of the procedure, based on the work values associated with CPT code 22868.
- a crosswalk to an appropriate surgical comparator, CPT 67108, Repair of retinal detachment; with vitrectomy, to reflect the additional physician effort.

Increasing the malpractice (MP) RVU value for CPT 22867 to at least 4.51, instead of 3.88, based on an anomalous relationship between this code and CPT 63047 and other similar spine procedures. It would be more accurate, however, for CMS to provide an additional 1.18 MP RVUs – which reflects the MP RVUs in CPT 22868, which isolates the insertion procedure, for a total of 5.69 MP RVUs.

We present compelling evidence below, including survey and retrospective study data validating our finding that CPT 22867 is misvalued, along with evidence that incorrect assumptions have been made in the valuation of the service. This documentation underscores the necessity of CMS review of CPT 22867 as a potentially misvalued/undervalued code. We recommend that CMS propose correcting the valuation in the 2021 Proposed Rule, rather than sending this code back to the RUC for resurvey, given the urgent need to rectify the significant rank order anomaly and preserve patient access to this procedure.

I. CPT 22867 Work RVU is Misvalued

The Work RVU for CPT code 22867 is misvalued according to several standards established by CMS as well as the AMA RUC, as set forth below. We recommend that CMS adopt a work value of **17.13** for CPT 22867, as detailed below.

A. Reliable Data Demonstrate Increased Physician Work Time for CPT 22867 Compared to CPT 63047, Creating an Anomalous Relationship

CPT 22867 laminectomy, decompression, stabilization procedure, **always** requires performance of an open decompression/laminectomy, and then the surgeon performs the **additional** work to implant the interspinous stabilization/device. If an open decompression/laminectomy is not performed, CPT 22867 may **not** be reported according to CPT coding instructions. Specifically, CPT coding instructions provide that insertion of an interlaminar/interspinous process stabilization/distraction device **without** open decompression or fusion is be reported with:

CPT 22869, Insertion of interlaminar/interspinous process stabilization/distraction device, **without open decompression or fusion**, including image guidance when performed, lumbar; single level; or

CPT 22870, Insertion of interlaminar/interspinous process stabilization/distraction device, **without open decompression or fusion**, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)

Decompression/laminectomy is the inherent major component of the procedure described by CPT 22867. If a surgeon performs a decompression/laminectomy as a stand-alone procedure, it is reported with the following CPT code:

CPT 63047 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar

In fact, AMA CPT and payer billing instructions for the decompression/laminectomy with CPT 22867 confirm that the decompression/laminectomy (e.g., CPT 63047) may not be reported in addition to CPT 22867 (i.e., because it is already incorporated into CPT 22867).

Thus while both CPT 22867 and CPT 63047 involve the common procedural steps of a laminectomy followed by an open decompression procedure, CPT 22867 also requires the surgeon to implant an interspinous stabilization/device. It therefore should be impossible for CMS to assign lower work RVUs to CPT 22867 than CPT 63047, since it involves the same work as CPT 63047 plus the additional work involved with implanting the stabilization device. In fact, the RUC has noted that CPT 22867 “is **more intense and complex than reference code 63047**, especially with respect to **technical skill required.**”¹

The surgical steps involved in performing CPT 22867 and CPT 63047 are illustrated below:

Steps	63047 Laminectomy, decompression	22867 Laminectomy, decompression, with implant of stabilization device
Position patient	X	X
Make midline incision in skin and subcutaneous tissue	X	X
Expose L4 spinous process and lamina with subperiosteal dissection	X	X
Remove the spinous process and lamina of L4 with a drill or bone-biting instruments	X	X
Remove the ligamentum flavum, exposing the thecal sac and nerve roots	X	X

¹ See February 2016 RUC Recommendations for CPT 2017.

Steps	63047 Laminectomy, decompression	22867 Laminectomy, decompression, with implant of stabilization device
Remove the medial L4-L5 facets with a drill or bone-biting instruments, exposing the L5 nerve roots	X	X
Perform a foraminotomy for the L5 nerve root	X	X
If a discectomy is necessary to complete the foraminotomy, it is performed	X	X
Trials are used to define the appropriate implant size. The trial instrument is placed to evaluate proper contact with the spinous process and the amount of facet distraction. Bony resection of the spinous process may be needed to ensure proper contact of the implant		X
Prior to insertion, the wings are opened slightly using the bending plier to ensure appropriate depth of insertion.		X
The implant is introduced via impaction utilizing a mallet.		X
Proper depth is determined if a ball tip probe can be passed freely leaving 1–2 mm separation from the dura.		X
Once proper placement is achieved, the wings of the implant are securely crimped using the crimping plier		X
In case of ligament reconstruction, the fascia and the supraspinous ligament are closed in one layer over the spinous processes. A surgical drain may be placed as per surgeons' preference. Paraspinal muscles are reattached to the supraspinous ligament.		X
Skin is closed in the usual manner.	X	X

Despite the additional physician work, for CY 2020, CMS assigned the following work RVUs to these two procedures:

CPT 22867 laminectomy with implantation of interspinous device - **13.50 work RVUs**, while

CPT 63047 laminectomy *without implantation* of interspinous device - **15.37 work RVUs**.

This disparity has created a rank order anomaly between the two procedures, with the procedure involving *less work* having an approximately *14% higher work value* than the procedure with the additional surgical steps. This payment policy provides a serious impediment to physicians furnishing this higher-resource procedure, given that payment for CPT 22867 is reduced compared to CPT 63047 even though physicians perform additional work and have higher practice expenses.

B. Physician Time/Effort Surveys Support Higher Work RVUs for CPT 22867

Two RUC surveys were conducted to assess the work RVUs for CPT 22867. In addition, an independent physician work survey was conducted by RUC-experienced orthopaedic consultants in August 2018 to evaluate the appropriateness of the current work RVUs of 13.50 for CPT 22867. The 2018 survey involved approximately 60 orthopedic and neurosurgeons who routinely perform CPT 22867 laminectomy, decompression, and insertion of stabilization device, and the specialty mix was evenly divided with **50% neurosurgeons and 50% orthopedic surgeons** responding to the survey request. Key takeaways from the survey include the following:

- For both RUC surveys and the independent work survey, the surveyed surgeons' modal response for a reference procedure was CPT code 63047 – Laminectomy, facetectomy and foraminotomy ... , single vertebral segment; lumbar.
- For each survey, the median response indicated that CPT 22867 is **more intense and complex** than CPT 63047. The RUC acknowledged that CPT 22867 “is more intense and complex than reference code 63047, especially with respect to technical skill required.”²
- The median work RVU was 18.00 to 20.00 – far higher than the current 13.50 work RVUs.

For each of these surveys, the intraservice time for CPT 22867 was 90 minutes – the same as the intra-service time for CPT 63047.

The comparative responses from the three CPT 22867 surveys are summarized below:

CPT 22867 -- Physician Survey Results

Description of service	Median Time in Minutes		
	RUC Survey July 2015	RUC Survey Nov 2015	Independent Survey Aug 2018
Pre-service evaluation face-to-face time prior to day of surgery	60	60	40
Pre-service evaluation face to face time day of surgery	15	15	15

² See February 2016 RUC Recommendations for CPT 2017.

Pre-service patient positioning time day of surgery	15	15	15
Pre-service scrub, dress and wait time day of surgery	15	15	15
Intra-service time	90	90	90
Immediate post-service time	30	20	21
Median Work RVU	20.00	18.00	20.00
Median survey 25 th percentile	17.00	16.47	18.28
Most commonly chosen key reference service	63047	63047	63047
Median number of post-op office visits	3	3	3
Complexity/intensity relative to reference service, CPT 63047	Median response CPT 22867 is more intense & complex	Median response CPT 22867 is more intense & complex	Median response CPT 22867 is more intense & complex
Median number of times performing procedure in the past 12 months	3	2	12.5

In fact, **the survey results support establishing work RVUs at 18.28 for CPT 22867.** This survey involved experienced surgeons that performed more procedures and thus the evaluation of the work is more reliable.

C. Retrospective Study Documents Higher Intraservice Time/Increased Work RVUs for CPT 22867

A retrospective study examining hospital operating room data, including intraservice (procedural) time, for CPT code 22867 was completed in October 2018. This study assessed total intraservice time, defined as incision to closure time. Intraservice time did not include patient positioning or the physicians scrub and wait time.

Hospital intraservice time was collected for 117 procedures at 5 different hospitals across the country. The data show a mean surgery/intraservice time of 121 minutes and a median intraservice time of 110 minutes.

This data provides objective and reliable evidence that **both the mean and median surgery times are significantly greater than the 90 minutes intraservice time included in all three of the physician work surveys** – and greater than the intraservice time for CPT 63047. This supports a significant increasing the work RVUs for CPT 22867 (as high as 18.0 RVUs) based on survey data of experienced surgeons.

D. Incorrect Assumptions Made in Previous Valuation of CPT 22867

CPT 22867 has been undervalued since the code became effective January 1, 2017. There is a long history of confusion surrounding CPT 22867 (lumbar decompression procedures with open decompression and stabilization) and a separate procedure, CPT 22869 (lumbar decompression without open decompression). Misleading code descriptors generated confusion about the two procedures and negatively influenced the valuation of CPT 22867.

CMS criteria indicate that incorrect assumptions made in the previous valuation of the service, such as a misleading vignette, survey, or flawed crosswalk assumptions in a previous evaluation support the nomination of a code as being potentially misvalued.

The following is a brief overview of the coding/valuation history for CPT 22867; we request a meeting with CMS to discuss the details.

2014

The North American Spine Society (NASS) instructed surgeons to bill unlisted spine code CPT 22899 for the insertion of interlaminar stabilization distraction device procedure. According to NASS, two Category III codes available at the time, 0171T and 0172T, were **not** the appropriate codes to use for the insertion of interlaminar distraction devices with open decompression. These codes described the X-stop procedure, a somewhat similar spine procedure that notably does not involve an open decompression.

NASS submitted an application for the 22867 laminectomy, decompression, stabilization distraction device procedure and codes were approved by the CPT Panel:

22867 Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion ... with open decompression, lumbar; **single level**

22868 Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; **second level** (List separately)

2015

CPT codes 22867 and 22868 were surveyed for the first time in July 2015. The RUC delayed these new codes, however, after learning that new CPT codes were approved for X-Stop. In November 2015, CPT codes 22867 and 22868 laminectomy, decompression with stabilization and without stabilization were surveyed again, together with new CPT codes for X-Stop (CPT 22869 and add-on CPT 22870).

2016

CPT codes 22867 and 22868 and X-Stop codes were presented for valuation at the January 2016 RUC meeting, but the RUC and CMS confused the two procedures. The parties erroneously indicated that two Category III codes for X-Stop were converted to two Category I CPT codes – CPT 22867 and 22869 – even though CPT 22867 actually describes the laminectomy, decompression, and insertion of stabilization distraction device procedure . CPT 22867 was never assigned a Category III CPT code and could never be reported with the 22869 code.

Combining the two surveys of two different procedures (22869 and 22867) clearly created confusion for all parties and resulted in erroneous statements about coding for these procedures – which we believe triggered the misevaluation of CPT code 22867.

2017

The RUC recommended that CMS adopt a work RVU of 15.00 for CPT code 22867 (temporarily designated at the time as 228X1), based on a crosswalk to CPT 29915, Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)

However, CMS asserted that the RUC recommendation overestimated the work involved in furnishing this service – we believe because of the confusion between the two procedures.

Instead, CMS crosswalked CPT 22867 to CPT 36832 (Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft), with a work RVU of 13.50. CMS asserted that this is an accurate comparison because it has similar total time, work intensity, and number of visits. However, the Journal of Vascular Surgery³ describes the procedure reported with CPT 36832 as a *secondary* procedure performed to “maintain patency, excise an aneurysm or bypass a stenosis in an existing AV fistula.” We respectfully believe that this is not an accurate proxy for the work involved with CPT 22867 an open decompression/laminectomy with implantation of an interspinous stabilization device.

In the 2017 MPFS Final Rule, CMS stated: “We recognize that the RUC crosswalk of CPT code 29915 for CPT code 22867 has a total time that is more similar to the new code than the crosswalk we proposed (CPT code 36832).” Yet, CMS claimed CPT code 36832 “is a more accurate comparison,” because CPT code 36832 is similar in total time, work intensity and number of visits, had a higher service utilization, and was reviewed more recently.

In fact, CMS argued that its crosswalk of CPT 36832 “is supported by the ratio between total time and work in the key reference service, **CPT code 63047**” -- the very code we recommend that CMS use as a crosswalk.

³ Koksoy C, Brachiobasilic versus brachiocephalic arteriovenous fistula: A randomized prospective study. J Vasc Surg 2009;49:271 available at [https://www.jvascsurg.org/article/S0741-5214\(08\)02085-5/pdf](https://www.jvascsurg.org/article/S0741-5214(08)02085-5/pdf).

In short, CPT code 36832 fails to appropriately reflect the work based on the totality of the evidence. Therefore, due to confusion regarding the two surveyed procedures, which ultimately led to incorrect and flawed crosswalk assumptions, we urge CMS to declare CPT 22867 as a misvalued code and revalue this code.

E. Add Work RVUs for Insertion of Interlaminar/Interspinous Process Stabilization/Distracton Device

As noted above, while both CPT 22867 and CPT 63047 involve the common procedural steps of a laminectomy followed by an open decompression procedure, CPT 22867 also requires the surgeon to implant the interspinous stabilization distraction device. The work RVUs must reflect this additional surgical step. The work value of the insertion procedure compared to a laminectomy can be approximated with the work value of CPT 22868, Insertion of interlaminar/interspinous process stabilization/distracton device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure) – which is 4.0 work RVUs.

We therefore recommend that CMS add work RVUs in the range of 4.0 to CPT 22867 based on CPT code 22868.

F. Crosswalk CPT 22867 to CPT 67108 = 17.13 Work RVUs

We believe CPT 67108⁴ represents the best crosswalk to value CPT 22867 appropriately. CPT 67108 was valued by the RUC and CMS in 2015 with 90 minutes intra-service time, which is equal to the survey time for 22867. In addition, both procedures are primarily outpatient with no inpatient visits and have similar total times (271 total minutes for CPT 22867 and 295 for CPT 67108). These similarities make CPT 67108 a more appropriate crosswalk for 22867 than the CMS referenced crosswalk code of CPT 36832.

CPT 67108 is valued at 17.13 work RVUs. This is less than the combined work values of CPT 63047 (15.37) plus CPT 22868 (4.0) and the survey data presented above, and slightly less than the combined values of CPT 22868 (currently 13.50) plus CPT 22868 (4.0).

We therefore recommend that CMS propose adoption of 17.13 work RVUs for CPT 22867 in the proposed 2021 Medicare physician fee schedule rule.

⁴ CPT 67108, Repair of retinal detachment; 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.



II. CPT 22867 Malpractice RVU is Misvalued

A. Increase MP RVUs to at least 4.51 for CPT 22867

ISASS recommends that CMS increase the MP RVUs for CPT 22867 from 3.88 in 2020 to at least 4.51. This would align the MP RVUs for CPT 22867 with CPT 63047 and other similar spine procedures in terms of specialty-level and service-level risk factors as well as intensity and complexity of the service.

In the final 2020 PFS rule, CMS reduced the MP RVUs for CPT 22867 from 3.97 to 3.88. We understand that CMS views the MP RVUs for CPT code 22867 to be the result of recent malpractice premium data and the current specialty mix that furnishes these services. However, the specialty mix for CPT codes 22867 and CPT 63047 are identical. Thus, the two values should be similar.

Furthermore, it is important to note that the laminectomy and decompression portion of the procedure included in CPT 22867 and CPT 63047 are the same. The only difference is that CPT 22867 involves the *additional* work involved with implanting the motion preserving interlaminar/interspinous stabilization device which, in turn, results in additional work of implanting an implant that should increase the malpractice RVUs. Thus, there is no logical reason why the malpractice RVUs for CPT 22867 should be lower than that of CPT 63047. We believe that correction of the *work* RVUs for 22867 to reflect the intensity/complexity of this procedure, as recommended above, would provide additional support for revising the *malpractice* RVU for CPT 22867.

We therefore request that the CMS correct the MP RVUs for CPT 22867 in the proposed 2021 PFS rule. We believe that the level of at least 4.51 is most appropriate given the similarities to CPT 63047. It would be more accurate, however, for CMS to provide an additional 1.18 MP RVUs – which reflects the MP RVUs in CPT 22868, which isolates the insertion procedure, for a total of 5.69 MP RVUs.

* * *

In summary, we request that CMS consider CPT 22867 as a potentially misvalued code for 2021 because the current physician work and malpractice RVUs that CMS has assigned to CPT 22867 significantly undervalue this procedure. We will be contacting your staff separately to request a meeting to discuss resolution of this important issue. In the meantime, please let me know if you have any questions or if you need additional information.

Thank you for your time and consideration of ISASS's comments. We greatly appreciate the opportunity to participate in efforts to more efficiently and accurately capture current care delivery. We commend CMS on its continued efforts to improve care quality and access. If you have any questions on our comments, please do not hesitate to contact Morgan Lorio, MD, Chair ISASS Coding and Reimbursement Taskforce at mloriomd@gmail.com.

Sincerely,



Morgan Lorio, MD, FACS
Chair, ISASS Coding and Reimbursement Taskforce