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November 2, 2020

Richard L. Snyder, MD
Executive Vice President
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Independence Blue Cross
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Submitted electronically via IBCMedicalPolicy@ibx.com

Subject: Independence Blue Cross Policy 11.14.27d-Spinal Fusion

Dear Dr. Snyder:

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), representing more than 4,000 neurosurgeons in the United States, we appreciate the opportunity to comment on recent changes in the above-referenced policy, Independence Blue Cross Policy #11.14/27d-Spinal Fusion.[1]

This policy now requires that a patient undergoing a spinal fusion operation be seen by a physiatrist to obtain prior authorization for surgery. Specifically, the policy states:

> "Lumbar spinal fusion is considered medically necessary and, therefore, covered when any of the following criteria are met**;** and a physiatry consultation has been completed to confirm the failures of nonsurgical options."

The updated definition of "medically necessary" for lumbar fusion raises serious concerns for our patients. A blanket requirement to first seek a physiatry consultation to "confirm the failures of nonsurgical options" will inevitably lead to delayed access to surgical care, adding further burdensome requirements, providing little benefit to patients.

When patients are evaluated for spinal pathology, consultations with physiatrists may not initially be sought. Low back pain remains one of the most common symptoms tied to disability in the United States, and physiatrists are not the only providers that provide non-surgical management.[2] Due to the numerous associated diagnoses, before a surgical referral, patients may work with primary care physicians, anesthesiologists specializing in pain medicine, neurologists and many others whose care frequently overlaps with physiatrists.

The treatment goals of physiatrists and spinal surgeons are fundamentally different. Surgeons treat specific pathology that is amenable to surgical intervention. In contrast, physiatrists treat symptoms, such as low back pain — which may or may not be more appropriately treated with surgery. Therefore,

[1] Spinal Fusion. Independence Blue Cross Medical Policy Bulletin.11.14.27d (https://medpolicy.ibx.com/ibc/Commercial/Pages/Policy/6C6218B5CEC0F18085258588005C4080.aspx).

[2] Cassidy JD, Cote P, Carroll LJ, Kristman V. Incidence and course of low back pain episodes in the general population. Spine (Phila Pa 1976). 2005;30(24):2817-2823.

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once the patient has failed conservative treatment and has pathology significant enough for a surgeon to recommend a surgical intervention for which prior-authorization is sought, the additional requirement of involving a physiatrist will be of little added benefit and will only delay care.

Further, as explicitly stated in the policy, it appears that the purpose of involving the physiatrist is to "confirm the failures of nonsurgical options." However, the surgeon is already responsible for confirming the failure of conservative treatment, which is one of several indications for intervention that the spinal surgeon will consider in recommending surgical intervention. The spinal surgeon is undoubtedly capable of determining what conservative treatment has been performed successfully without the additional time, cost, and delay of involving yet another non-surgical specialist in the patient's care.

Associated delays will be exacerbated by physiatrists' interventions leading to increased overall costs, as has been shown to occur. Goodman et al. studied the implementation of mandatory physiatry screening in elective lumbar fusion and found increased costs from nonoperative services and only transitory reductions in lumbar fusion rates.[3] One such cost driver might be repetitive epidural steroid injections, which often have very little evidence to demonstrate their efficacy. Despite being very common, interlaminar epidural steroid injections have mixed to poor results as a treatment for axial back pain, regardless of the etiology.[4] Currently, the Food and Drug Administration has not approved the use of steroids in the spine. Therefore, the data that would support continued epidural steroid injections would be far weaker than the data supporting surgical intervention.

Besides delays in care, the current language inappropriately delegates physiatrists as the sole arbiter in the surgical decision-making process for spinal fusions. This complex decision must come from surgeons experienced in performing and recommending fusion procedures and is outside of the scope of physical medicine and rehabilitation (PM&R) medicine.[5] As such, the appropriate declaration of "treatment failure" may not readily occur in patients whose pathology falls outside the scope of PM&R medicine. Further, a potential for disorganized or confused care is inevitable. This requirement inappropriately places the onus of determining indications for surgery in the hands of non-surgeons. In consultation with the patient, the spinal surgeon should make the final determination for surgical care without an unnecessary additional patient visit to a non-surgical physician.

Another significant concern is the availability of physiatrists to the patient population in question. For example, there are a total of 16 "Spine Medicine" physiatrists in the 10-mile area surrounding central Philadelphia, relative to the approximately 1.5 million people in the city of Philadelphia and over 6 million people in the metro area.[6,7] Given this small number of physiatrists, an undue burden is placed on patients seeking fusion surgery and will create a bottleneck that will significantly delay care. Surgeons operating in certain private settings will be particularly affected.

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[3] Goodman RM, Powell CC, Park P. The Impact of Commercial Health Plan Prior Authorization Programs on the Utilization of Services for Low Back Pain. Spine (Phila Pa 1976). 2016;41(9):810-815.

[4] Sharma AK, Vorobeychik Y, Wasserman R, et al. The Effectiveness and Risks of Fluoroscopically Guided Lumbar Interlaminar Epidural Steroid Injections: A Systematic Review with Comprehensive Analysis of the Published Data. Pain Med. 2017;18(2):239-251.

[5] Physiatric Scope of Practice. The American Academy of Physical Medicine and Rehabilitation. 2012 (https://www.aapmr.org/docs/default-source/protected-advocacy/Position-Statements/physiatric-scope-of-practice.pdf).

[6] City and Town Population Totals: 2010-2019. United States Census Bureau. 2019 (https://www.census.gov/data/tables/time-series/demo/popest/2010s-total-cities-and-towns.html)

[7] Find a PM&R Physician. AAPM&R. (https://members.aapmr.org/AAPMR/AAPMR_FINDER.aspx).

The utilization and burdens of the prior authorization process have increased significantly over the last several years. The AANS and the CNS have joined the American Medical Association to contend that prior authorization is overused, presents significant administrative and clinical concerns and the process needs reform.[8]

Combined with the other stringent criteria for lumbar fusion, it is hard to comprehend why this barrier to care is necessary and, more importantly, how it benefits patients, physicians or payors. While we assume that this policy was made in good faith, to provide a collaborative approach to patient care, such a policy will only delay appropriate care, increase costs and decrease patient satisfaction and outcomes.

The AANS, CNS and the DSPN strongly urge you to rescind this new policy. We respectfully request an opportunity to discuss our views and recommendation via a conference call. Catherine Hill in our AANS/CNS Washington Office can help arrange a call and her contact information is below.

We look forward to hearing from you soon.

Thank you.

Sincerely,

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American Association of Neurological Surgeons

Brian L. Hoh, MD, President
Congress of Neurological Surgeons

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[8] AMA Prior Authorization (PA) Physician Survey. 2018. https://www.ama-assn.org/system/files/2020-06/prior-authorization-survey-2019.pdf