

Intraoperative Neurophysiologic Testing Proposed Local Coverage Determination DL 32605

Many physicians feel their ability to provide the best possible care to their patients is being threatened by trends in reimbursement. Recent proposed changes in CMS Local Coverage Determinations for Intraoperative Neurophysiologic Testing (LCD-DL 32605) could have adverse effects on patient care. Comments on this proposed LCD were submitted to CMS in early November on behalf of TNS membership.

DL 32605 was based on outdated research (Nuwer MR, 1995) and does not accurately depict the current methods used in intraoperative neurophysiologic testing. DL 32605 does not allow for significant modern developments that facilitate observation of multiple cases and communication between intraoperative neurophysiologic monitoring technicians, surgeons and anesthesiologists. The current standard of practice includes monitoring several overlapping surgical cases, using modern computer equipment, high speed DSL and satellite communications, and sophisticated and effective electronic texting and voice communications. The core conclusion CMS draws from the 1995 trial is that only “undivided attention to a unique patient” could reduce patient risk. This conclusion, however, was not addressed by this trial, as it made no comparison between supervising physicians monitoring single cases and those physicians monitoring 2, 3 or 4 cases. Thus, CMS cannot claim this proposal is evidence-based.

It does not appear that CMS considered a more recent assessment of intraoperative monitoring, and recommendations for practice guidelines published by The American Academy of Neurology when drafting the proposed coverage guidelines. This evidence-based guideline update published in 2012 does not require “undivided attention to a single case,” but places the emphasis more appropriately on concurrent use of both somatosensory evoked responses and motor evoked responses (M.R. Nuwer, 2012). The combination is much more routine now compared to the 1995 benchmark, which was inexplicably chosen by CMS.

From a practical standpoint, this policy ignores the reality of how hospitals manage their available staff and infrastructure resources. The bulk of surgical cases begin early in the morning, and most are completed by mid-day. Thus, monitoring of concurrent cases is the norm, and arranging these cases sequentially in order to afford “undivided attention” from the monitoring physician is not economically possible. The actual effect of this policy on patient safety is likely to be negative, as this service is rendered economically unfeasible and will inevitably become unavailable to Medicare beneficiaries.

Further, CMS’s responsibility to manage limited healthcare resources is not necessarily served by requiring 3 or 4 supervising physicians to perform the job normally accomplished by a single physician. This policy will also have a significant long term impact on the availability of supervising physicians. Under current circumstances, monitoring companies are unable to find qualified physicians who have neurophysiology fellowship training and can meet the requirements for hospital privileges. The alternatives for more productive employment will drive qualified men and women elsewhere, leading to an even greater shortage of qualified physicians.

While CMS may find this proposed cost-cutting method attractive, peer review medical literature indicates that the short term financial gains of this proposal would likely be more than offset by the direct expense of caring for patients with surgically induced neurologic injury. Further consideration by CMS should be given to the pain and suffering of these patients. While the value of this pain and suffering may be difficult to calculate, it can be approximated by the compensation awarded to these patients in our courts. (Francesco Sala, 2007). If the issues mentioned above are not enough to satisfy CMS, surely the long term result of a trend of physicians and hospitals avoiding involvement with Medicare/Medicaid patients should stimulate some reflection on CMS's mission.

Nuwer, MR, Dawson EG, Carlson LG, Kanim LEA, et al. Somatosensory evoked potential spinal cord monitoring reduces neurologic deficits after scoliosis surgery: Results of a large multicenter survey. *Electroencephalography and Clinical Neurophysiology* 1995; 96:6-11.

Nuwer MR, Emerson RG, Galloway G, Legatt AD, Lopez J, Minahan R, Yamada T, Goodin DS, Armon C, Chaudhry V, Gronseth GS, Harden CL. Evidence-based guideline update: intraoperative spinal monitoring with somatosensory and transcranial electrical motor evoked potentials: report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology and [trunc]. *Neurology*. 2012 Feb 21;78(8):585-9.

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