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Payment for Insertion of Interlaminar/Interspinous Process Stabilization/Distraction Device Without Open Decompression or Fusion

Advisory Panel on Hospital Outpatient Payment Meeting

August 19, 2019

Participants and Disclosures

- Maria Stewart, Vice President, Global Health Economics and Market Access, Boston Scientific Corporation
  - Ms. Stewart is an employee of Boston Scientific Corporation
- Toni Harp, Director, Health Economics and Market Access, Neuromodulation Division, Boston Scientific Corporation
  - Ms. Harp is an employee of Boston Scientific Corporation
- Sean Patrick, Chief Marketing Officer, Vertiflex, Inc., a Boston Scientific Corporation Company
  - Mr. Patrick is an employee of Vertiflex, Inc., a Boston Scientific Corporation Company

Agenda

- Review of Issue and Requested Action
- Lumbar Spinal Stenosis:
  High Prevalence in the Medicare Population
- Procedure Overview
- Impact of Interspinous Process Decompression on Opioid Use
- Review of 2020 (P) Data for CPT 22869 (formerly 0171T)
  - Hospital Level Review of 2020 (P) Data for CPT 22869
  - Impact of Hospital A on GM Costs, APC Assignment
- Anticipated Impact of CMS Proposal and Boston Scientific Request
- Summary

Review of Issue and Requested Action

- Issue: Medicare proposal to reassign CPT code 22869, Insertion of interlaminar/interspinous process stabilization/distraction device without open decompression or fusion, including image guidance when performed, lumbar; single level to C-APC 5115 from C-APC 5116 in CY 2020
  - Change would result in 22% reduction in outpatient hospital payments ($15,402 in 2019 to $11,960 in 2020) and a corresponding 22% payment reduction in the Ambulatory Surgery Center (ASC) setting ($12,598 in 2019 to $9,780 in 2020)

- Requested Action: Leave CPT Code 22869 in C-APC 5116 for CY 2020
  - It appears that one hospital's incorrect charge methodology is driving the reductions proposed for outpatient hospital and ASC payments
    - Once charges are reduced to cost for "Hospital A," the costs reported for the device are approximately 22% of the true (invoice) cost of the device
    - Removal of this hospital's incorrect claims from analysis results in a GM cost aligned with previous years and supports leaving CPT code 22869 in APC 5116
    - Proposed reductions in hospital outpatient department and ASC payments would cause a deterrent to an opioid alternative for chronic pain relief

Lumbar Spinal Stenosis: High Prevalence in the Medicare Population

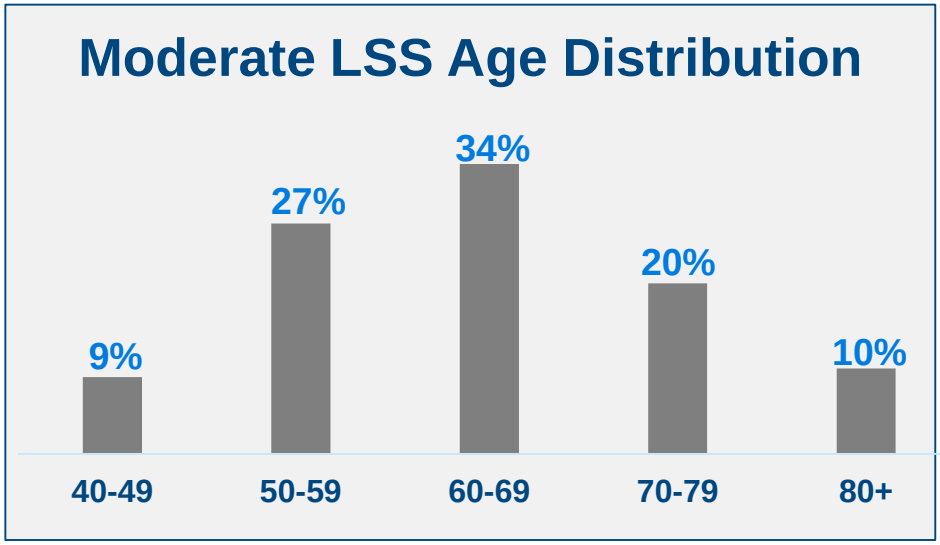
The natural degenerative process of the spine creates a growing and increasingly symptomatic elderly patient population

1.8 M

US patients Suffering with LSS meet the FDA indications for Use of Superion

109 K

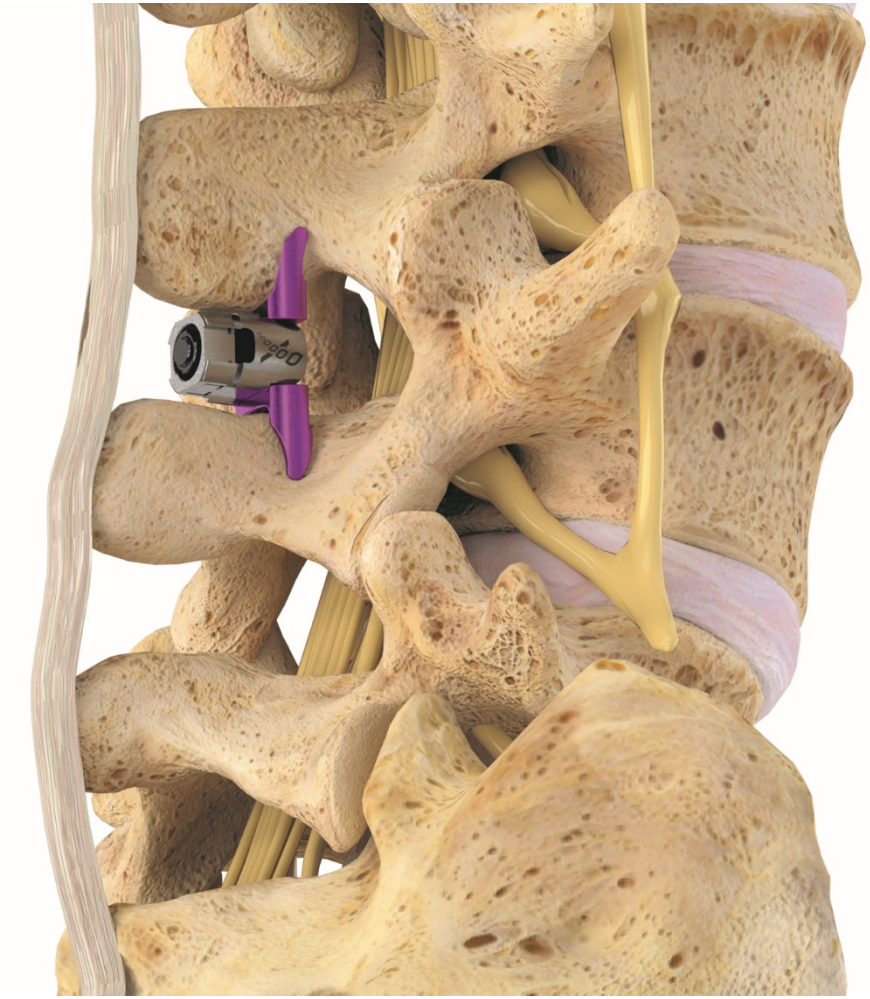
109k newly indicated patients annually



Comorbidities often limit treatment choices for this rapidly growing population

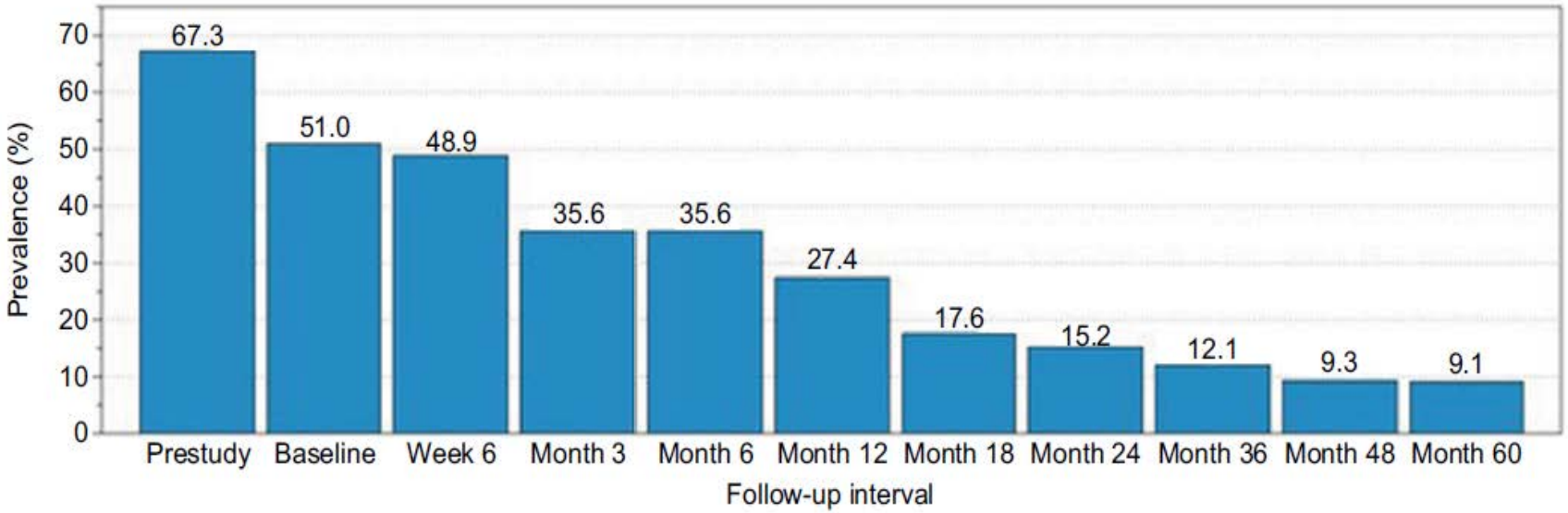
*Navigant Consulting Strategic Market Assessment Research 2018.

Procedure Overview



Impact of Interspinous Process Decompression on Opioid Use

Stand-alone IPD is associated with a marked decrease in the need for opioid medications to manage symptoms related to LSS.[1]



Opioid-medication prevalence (%) by follow-up interval for study subjects with opioid history (n=98)

"Defeating our country's epidemic of opioid addiction requires identifying all possible ways to treat the very real problem of chronic pain." HHS Secretary Alex Azar

[1] Nunley et al. *Journal of Pain Research downloaded from https://www.dovepress.com/ by 104.129.198.96 on 20-Dec-2018.*

Review of 2020 (P) Data for CPT 22869 (formerly 0171T)

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Costs are consistent for all claims years except 2018, which is driving 2020 proposed payment

Year	HCPCS	APC	Payment Rate	Single Freq.	Total Freq.	Min. Cost	Max. Cost	Median Cost	GM Cost
2017	0171T	5116	$14,704	315	317	$4,191	$28,284	$12,988	$12,966
2018	0171T	5116	$15,371	455	457	$5,830	$31,938	$12,978	$13,657
2019	22869	5116	$15,402	114	117	$5,010	$34,187	$13,912	$13,629
2020 P	22869	5115	$11,960	353	353	$994	$39,447	$13,592	$9,920

Geometric mean costs for CPT code 22869 are not in violation of the 2 Times Rule if the code remains assigned to APC 5116 – Level 6 Musculoskeletal Px

HCPCS*	Total Frequency	GM Cost	2 Times Violation?
22869 (Lowest)	353	$9,919.80	No: GM Cost for CPT code 24363 is 1.87 times higher than 22869
24363 (Highest)	291	$18,586.88	

* Only significant codes per CMS definition considered.

Hospital Level Review of 2020 (P) Data for CPT 22869

- Hospital 51003X new provider in 2017; claims trimmed from OPSAF file

Provider #	Total Counts	Total Claim GM Charge	Total Claim GM Cost	Device GM Charge	Device GM Cost
All Hospitals providing 22869	137	$57,333	$13,894	$27,488	$9,190

Source: 2017 OPSAF Files, 100% Sample; 51003X claims trimmed since +/- 3 standard deviations away from geometric mean cost.

- Hospital 51003X's claims accounted for 22% of all claims in 2018

Provider #	Total Counts	Total Claim GM Charge	Total Claim GM Cost	Device GM Charge	Device GM Cost
51003X	112	$21,415	$2,488	$14,524	$1,437
All Hospitals except 51003X	376*	$56,168	$15,252	$27,434	$10,429
All Hospitals providing 22869	499	$43,648	$9,717	$23,574	$6,556

Source: 2018 OPSAF Files, 100% Sample;
* When Hospital 51003X is removed, a different set of claims is lost to trimming.

One hospital's data for 22869 is driving GM cost and CMS's proposal to move the procedure from APC 5116 to APC 5115.

Impact of Hospital A on GM Costs, APC Assignment

Year	HCPCS	APC	Payment Rate	Single Freq.	Px Min. Cost	Px Max. Cost	Px Median Cost	Px GM Cost
2017	0171T	5116	$14,704	315	$4,191	$28,284	$12,988	$12,966
2018	0171T	5116	$15,371	455	$5,830	$31,938	$12,978	$13,657
2019*	22869	5116	$15,402	114	$5,010	$34,187	$13,912	$13,629
2020 P (a)	22869	5115	$11,960	353	$994	$39,447	$13,592	$9,920
2020 P (b)	22869	5115	$11,960	499	$1,260	$43,412	$12,888	$9,717
2020 P (b)** (Adjusted)	22869	5116	$16,139	376	$5,244	$43,412	$14,965	$15,252

- We believe if claims from Hospital A are removed from the 2020 (P) data (2020 P [Adjusted]), costs associated with remaining claims mirror those of prior years and would support maintaining assignment to APC 5116

* Note: Claims submitted by Hospital A were trimmed from the data used to set 2019 payment rates, however due to an increase in volume, they were not trimmed for ratesetting for 2020.
** Data shown represent estimated payment, volumes and costs once claims from Hospital A are removed.

Source: 2017 / 2018 / 2019 / 2020 P (a) rows: HOPPS Cost Statistics Files; 2020 P (b) / 2020 P (Adjusted) rows: 2018 OPSAF File

Anticipated Impact of CMS Proposal and Boston Scientific Request

- Leaving CPT code 22869 will not impact proposed payments for either C-APC 5115 or C-APC 5116
  - Geometric mean costs and estimated payment rates for each APC do not change significantly

CMS Proposed APC Alignment				
APC	Descriptor	Total Frequency	GM Cost	Proposed Payment
5115	Level 5 Musculoskeletal Procedures	112,678	$11,675	$11,960
5116	Level 6 Musculoskeletal Procedures	3,748	$15,754	$16,139
Boston Scientific Proposed APC Alignment				
APC	Descriptor	Total Frequency	GM Cost	Est. Payment
5115	Level 5 Musculoskeletal Procedures	112,325	$11,681	$11,966
5116	Level 6 Musculoskeletal Procedures	4,101	$15,606	$15,987

Summary

- Requested Action: Leave CPT Code 22869 in C-APC 5116
  - It appears that one hospital's incorrect charge methodology is driving the reductions proposed for outpatient hospital and ASC payments
    - Once charges are reduced to cost for "Hospital A," the costs reported for the device are approximately 22% of the true (invoice) cost of the device
    - Removal of this hospital's incorrect claims from analysis results in a GM cost aligned with previous years and supports leaving CPT code 22869 in APC 5116
    - Proposed reductions in hospital outpatient department and ASC payments would cause a deterrent to an opioid alternative for chronic pain relief

THANK YOU

Endnotes