

Spinal Endoscope: A Case Study

Patients currently suffering from chronic lower back pain might never gain access to this device if HCFA succeeds in eliminating "local" procedure codes.

Summary

Patient access to this device is threatened because Health Care Financing Administration (HCFA) has proposed eliminating local procedure codes, which are one of the primary avenues currently available to bill for this device. Neither of the national procedure coding systems includes a specific procedure code for the spinal endoscope, which means that if physicians use national codes, they must submit their bills using those existing national codes that they believe most closely resemble the procedure. These, however, lead to inadequate reimbursement. As a result, the company has begun to meet with local Medicare carrier medical directors to ask them to approve "local" codes for the device. These codes are often created by local carriers to integrate newly-available technologies promptly into the services they provide beneficiaries. Unfortunately, HCFA has proposed eliminating local codes beginning in 2000 and replacing them with a solely national process.

Product

Spinal endoscopy is a targeted, minimally invasive method of diagnosing and treating chronic lower back pain. It involves a miniature catheter with a fiberoptic endoscope that provides a three-dimensional view—displayed on a video monitor, in full color and in real time—of the anatomy of the epidural space surrounding the spinal column.

- The endoscope is inserted through a small incision at the base of the tailbone, away from the injury. The patient directs the physician to the nerves that are causing pain.
- Once the precise location is identified, the physician gently pushes the scar tissue away from the nerve root, thereby releasing tension on the nerve, and injects medication directly into the inflamed area.
- Because this is a minimally invasive technique, there is less trauma to the patient than with open surgery and the patient is not subjected to the risks of general anesthesia.

Case History

In August 1998, the Food and Drug Administration cleared the device for use in diagnosing and treating chronic low back pain. However, neither of the national coding systems includes a unique procedure code for spinal endoscopy or arthroscopy, the medical procedures in which this device is used. Therefore, providers and payers have used existing national codes—themselves very limited in number—that they believe most closely resemble the procedure.

In virtually all of these cases, reimbursement is lower than the company believes is appropriate—often not covering the costs of the product or not providing physicians with any reimbursement at all. The company believes that these low reimbursement levels are creating clear incentives for physicians to avoid use of the product altogether.

Because a unique national procedure code does not exist for the spinal endoscope and because the existing codes lead to underpayment, the company is seeking to meet with local Medicare carrier medical directors to ask them to approve "local" codes for the device. These device-specific local codes are often used by local Medicare carriers to promptly cover newly-developed technologies—primarily to avoid delaying such products while they work their way through the slower national coding process. These local codes are then available for use by physicians in a particular region to bill for the device.

Such codes are also useful to device manufacturers because they permit a medical technology which has recently cleared FDA to be used locally while the company seeks a national procedure code. Such use by local Medicare contractors helps the local plan and local medical professionals gain experience and data about the technology. In 1998, however, HCFA made a proposal to eliminate local codes and replace them with a solely national process.

Recommendations

HIMA supports legislation designed to reduce the length of time from FDA clearance to the time when the product is appropriately reimbursed by HCFA and available to patients who need it. The following recommendations help achieve that goal and address specifically some of the challenges described in this case study.

- HCFA should be directed to continue to maintain and use local procedure codes because these codes are most responsive to changes in medical technology. HIMA is opposed to HCFA's proposal to eliminate such codes beginning in 2000 and replace them with a solely national process.
- HCFA should be directed to utilize an advisory committee that examines Medicare coding and payment. This panel would examine how payment, coding, and coverage systems interact and would recommend steps to correct any problems that impede the smooth integration of medical technology into Medicare. This includes monitoring of HCFA's performance in administering coding issues.