

Jumping Prior Authorization Hurdles: A Step-by-Step Guide for How to Win Spine Surgery Approval



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University of South Alabama



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Disclosures

- No relevant financial relationships that are relevant
- Institution research funding PAULA study, SI-Bone
- Consultant: Stryker
- Chief Medical Officer MS Logger
- Co-founder Neurosurgical Advancement Foundation
- Faculty network member *Foundation for Economic Education*
- Does not represent views of the United States Navy, Department of Defense, or the United States Government

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**WSJ** OPINION

OPINION COMMENTARY Follow

*The Insurer Will See You Now*  
With preauthorization, financiers of care delay needed treatments.

By Richard Menger

**THE HILL**

**Streamlining the process of prior authorization for medical and surgical procedures**

BY RICHARD MENGER, OPINION CONTRIBUTOR - 01/14/21 7:00 PM ET

SHARE POST

**Neurosurgery Podcast**  
Episode 185: Prior Authorization by Neurosurgery Podcast

**1819 NEWS**

**Dr. Richard Menger: Ending the health insurance monopoly will make life healthier for Alabamians**

Richard Menger | 06/27/24

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### Review

- **State** the Problem
- **Understand** the conceptual framework for why prior authorization exist
- **Tactical approach** to take care of patients
- What about the **future?**

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### Take Home

- **Prior Authorization is the Consequence of Central Planning in Healthcare and Moral Hazard perpetuated market failures in healthcare buoyed by lobbying interests.**

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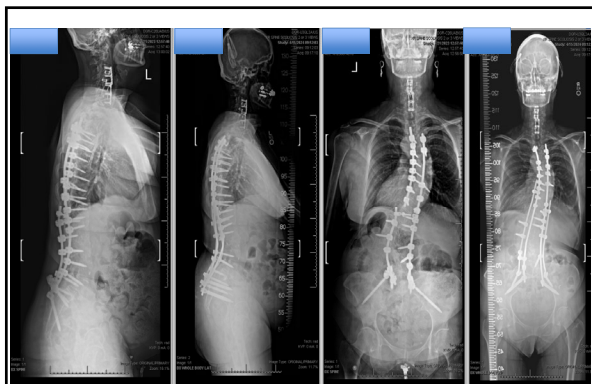
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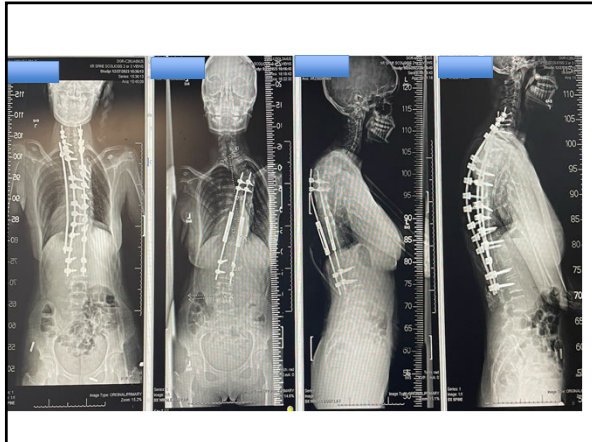
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### Prior Authorization

- Before the insurance company will approve to pay for a test or a procedure it will have to authorize it first.
- Culminates with the “peer-to-peer”

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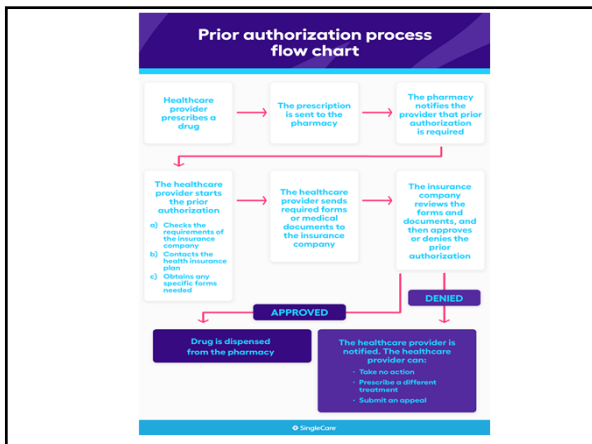
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### Who benefits?

- Prior authorization negatively impacts patients, physicians, and staff.
- Insurance company?
- *"In 2022, United Health Group posted a \$20.6 billion national total net earnings. That same year, insurance giant Cigna posted a national total net income of \$6.7 billion. In 2012, BCBS operated a \$1 billion surplus with over \$2.8 billion in assets just in Alabama. In 2013, The CEO of BCBS Alabama made \$4.84 million. I had trouble finding more current data as a law was passed in 2015 making the salary of Alabama's top health insurance executives confidential."*

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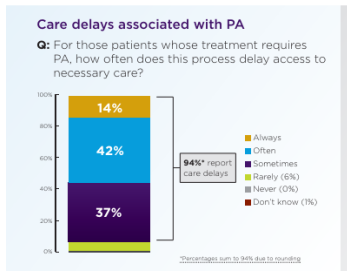
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### Prior Authorization is a Problem for Patients




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### Prior Authorization is a Problem for Patients

**PA and patient harm**

**33% of physicians** report that PA has led to a serious adverse event for a patient in their care.

**25%** of physicians report that PA has led to a patient's hospitalization.

**19%** of physicians report that PA has led to a life-threatening event or required intervention to prevent permanent impairment or damage.

**9%** of physicians report that PA has led to a patient's disability, permanent bodily damage, congenital anomaly/birth defect or death.

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## Prior Authorization is a Problem for Physicians




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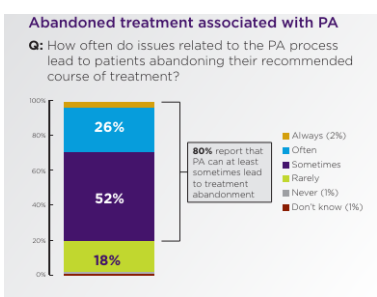
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## It's a tactic




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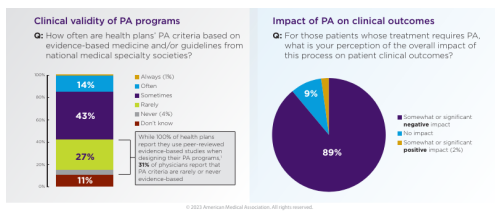
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## Does it work?




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### Prior Authorization is not peer-to-peer review

- The large majority of what we do is NOT surgeon to surgeon.
- This frustrates, leads to time, and deters.

ANOTHER PERSPECTIVE

#### Insurance Companies Use Stalling Tactics to Save Themselves Money

*Our nurses have to spend time regurgitating what is already in the chart to an insurance representative.*

© RICHARD MENDER AND JESSICA MURPHY AND ERIN ROBERTS Journal of Neurosurgery

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**JNS** JOURNAL OF NEUROSURGERY  
OFFICIAL JOURNALS OF THE AANS SINCE 1944


#### Impact of insurance precertification on neurosurgery practice and health care delivery

Richard P. Menger MD, MPA, Jai Deep Thakur MD, Gary Jain MD, and Anil Nanda MD, MPH [View Less](#)

Publication Date: 09 Sep 2016  
Page Range: 332-337  
Volume / Issue: Volume 127, Issue 2  
DOI link: <https://doi.org/10.3171/2016.5.JNS152135>

**Cigna whistleblower says a policy of 'deny, deny, deny' left patients without life-saving care**

Chad Van Allen | May 02, 2024 | Health Exec | Patient Care



A former medical director at Cigna is blowing the whistle about a policy to 'deny, deny, deny' claims. In an effort to hit performance metrics even if it meant patients would be unable to receive necessary care.

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**PROPUBLICA**

**Health Care**

### A Doctor at Cigna Said Her Bosses Pressured Her to Review Patients' Cases Too Quickly. Cigna Threatened to Fire Her.

Cigna tracks every minute that its staff doctors spend deciding whether to pay for health care. Dr. Debby Day said her bosses cared more about being fast than being right: "Deny, deny, deny. That's how you hit your numbers," Day said.

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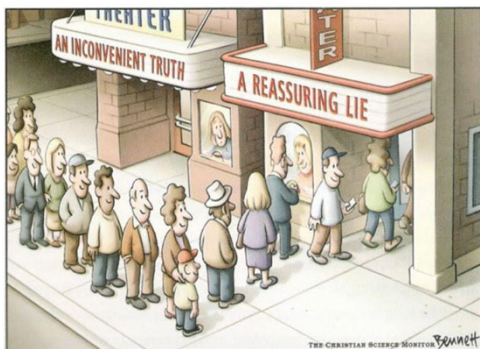
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### Why does this exist?



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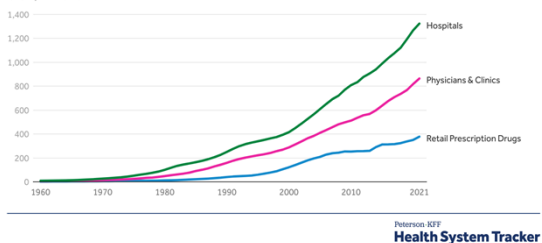
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### Costs are high

Health Expenditures 1960 - 2021  
U.S. \$ Billions



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### Structure

- **Prior Authorization is the Consequence of Central Planning in Healthcare and Moral Hazard perpetuated market failures in healthcare buoyed by lobbying interests.**
- There is too much distance between those receiving healthcare, those providing it, and those paying for it.

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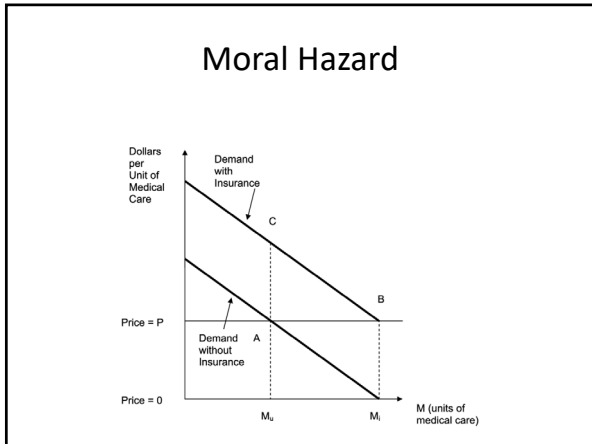
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### Moral Hazard

- Surgeons and patients alter behavior when they are not as directly financially liable.
- This is the nidus behind the 2008 financial crisis.

FREE FOR ALL?  
Insurance, the RAND Health Insurance Experiment  
Joseph P. Newhouse and the Insurance Experiment Group

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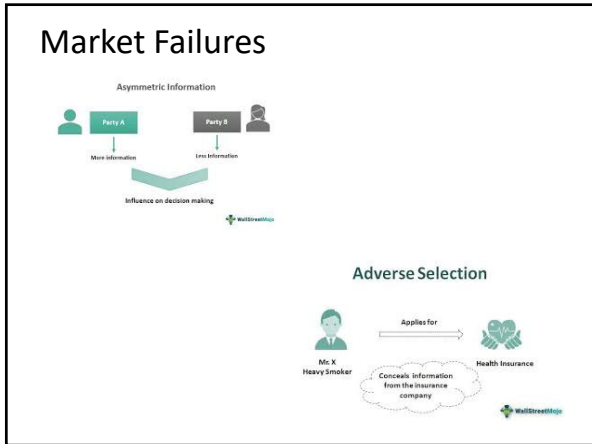
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### Central Planning

- There is too much spine surgery
- wRVU
- Growth of the employed physician

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### Non-surgeons doing spine surgery?

- AANS 2024 Dada et al

*"While neurosurgeon and orthopedic surgeon fusion utilization grew by < 3% and Medicare spending for both declined by 1%, non-surgeon providers utilization grew 26% and non-surgeon Medicare spending for spine fusions grew 62%."*

*"SI-fusions were performed by neurosurgeons (24.8%), orthopedic surgeons (50.7%), and non-surgical interventionalists (24.5%), from 2018-2021. Non-surgeon providers utilization of SI-joint fusions grew 415% and payments grew 435%"*

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### Position Statement on Spine Fusion Surgery



Position Statement  
on  
Arthrodesis of the Spine by the Non-Spine Surgeon

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STATE WATCH

## Perverse Health-Care Incentives Endanger Spine Patients

*It's proof of a lack of free-market forces in the health-care system.*

by ANTHONY DISSORBO AND RICHARD MENGER      May 21, 2012, 12:14 AM



January 29, 2022  
**If you're getting spine surgery, wouldn't it be good to have a spine surgeon?**  
 By Richard Menger, M.D.

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Interventional Pain | Anesthesiology      2y ...

All good points. Rich! Curious about managing complications, would ortho spine call neurosurgery for an iatrogenic dural tear? If so, your points may apply even to properly trained spine surgeons.

Like 4 | Reply 3 Replies

Libbox      2y (edited) ...

These statements from these societies, have more economic motivations than other thing.  
 Should a gastroenterologist do colonoscopies since he can not manage the colonic perforations?  
 Should a cardiologist do interventions since he ...see more

Editorial Board Member at Journal of Pain Research Official Journ...      2y ...

Great piece.Sa should interventional cardiology stop putting stents, interventional neurologist stop doing clips and interventional radiology stop doing procedures too? Do spine surgeons manage their own complications, for instance do they prescribe chronic opioids for failed back, and botched surgeries?

Like 16 | Reply 5 Replies

Load previous replies

D. MBA CEO Spine Surgeon...      2y ...

NYC Harvard Medical Sch Hamar...

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How do you define CPT code 22612 ?

Is there a difference between Ortho/Neuro Spine and Interventional Pain on this question ?

Unfortunately there is !

There are IPM doctors being taught that placing bone graft inside the implant between the spinous processes qualifies as 22612.

Ortho/neuro spine surgeons know you need to place bone graft posterior along the lamina and facets or posterolaterally to the facets between the transverse processes (22612). Note no mention of interspinous. The other option is within the interbody space (22630).

Hope this posts helps to define 22612 versus 22630.

#22612 #22640 #fusion #posterior #spinousprocess #interspinous #posterolateral KIC Ventures NANISX Dr. Soubrata V. Raikar, Matthias H. Wiederholz, MD, MS #ortho #neuro #surgeons #spine

**22667: Insertion of interlaminar/interspinous process device**

13.5 wRVU

**22612: posterior-lateral fusion**

23.5 wVU

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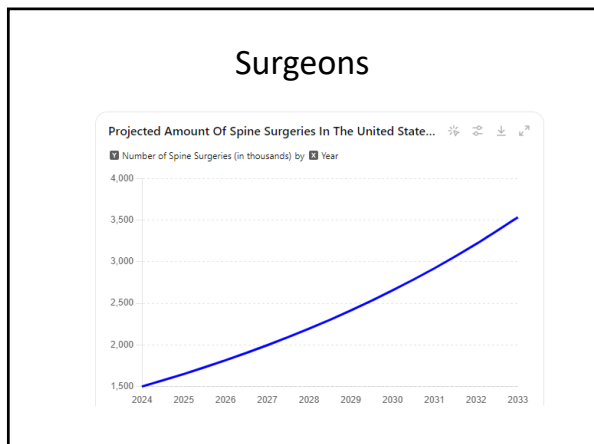
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### Surgeons

We have surgeons in our community who do staged surgeries on just about every lumbar fusion. Stage 1 ALIF, 2 days later Stage 2 XLF, 2 days later Stage 3 posterior decompression and fusion. Amazing how you can milk the cow 3 times for one diagnosis. The hospitals haven't woken up to it. Doubles or triples your volume of surgeries. This article is for them.

#### Staged Versus Same-Day Surgery in Circumferential Minimally Invasive Defectory Correction

**Abstract**  
The purpose of this study was to compare the outcomes of staged versus same-day surgery in circumferential minimally invasive defectory correction. The study included 100 patients who underwent either staged or same-day surgery. The results showed that staged surgery resulted in significantly better outcomes compared to same-day surgery.

**Keywords:** Staged surgery, Same-day surgery, Circumferential minimally invasive defectory correction.

**How do staged procedures benefit Adult Spinal Defo...**

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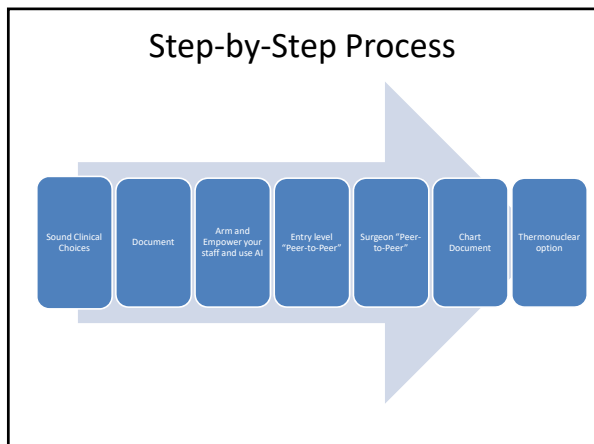
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### Step 1:

- Make good choices
- Don't do stupid things
- If you are deviating from normal practice patterns have extra concern and documentation

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### Step 2

- Document and help your team out
- Follow the best practice guidelines
- NASS and the AANS/CNS Guidelines and document that you are doing that based on those guidelines or consensus in the note

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### Good

**ASSESSMENT AND PLAN:** Patient is seen and examined. She remains a surgical candidate for L1 to the pelvis. The patient was sent to us secondary to needing advanced care. She was seen by an excellent board-certified fellowship trained orthopedic spinal surgeon, but due to the significance of her surgery sent her to our tertiary referral center. This patient needs a lumbopelvic extension fusion. She has significant spinal deformity. She has a coronal plane deformity. She has a coronal plane deformity. This is significant. It is disrupting activities of daily living and her quality of life. We have seen and evaluated her. I am concerned about her overall decrease in her quality of life. She has had a previous lumbopelvic fusion. She needs to get more stability. This curve is progressive as well. On the August x-ray, this curve is worse than it was in the March x-ray. In short, we have a patient referred to us for tertiary referral surgery that needs this surgery. It is medically indicated and safe as necessary. This patient has significant pain. She has worsening activities of daily living and the curve is worse on the x-ray progression.

**IMAGING:** Directly discussed and reviewed again with the patient.

It is clear that this patient needs extension of her fusion. This is a complex surgery and has required tertiary referral center necessity for surgery. The very direct indication for surgery in this patient is advanced segment disease, worsening coronal deformity, as well as pseudoarthrosis. CT myelogram read also indicates disk space and facet hypertrophy with moderate and severe foraminal stenosis. It is in the patient's best interest to proceed with surgery. This is medically necessary and indicated.

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### Better

Surgeon: Richard Meagan, MD  
 Patient: Burzomano, Leahy  
 Signal: Responder System

View: RSP T10-P7 (FLUOR LK51, PCD 1-1-13)  
 Date: 05/30/2024

Global Movement Summary

CTPL	-20.37 mm
Pelvic Obliquity	-14.12°
Clavicle Angle	-6.80°
Sacral Obliquity	1.70°
T11 R/L	1.31°
MC Cobb	-33.60°
MC Type	L
MC Apex	L3-L3
MC Apex Deviation	-44.81 mm
MC Upper/Lower	L5sup-L4inf
SC Cobb	25.90°
SC Type	L
SC Apex	L6-S1
SC Apex Deviation	6.27 mm
SC Upper/Lower	L6sup-S1sup
TC Cobb	14.40°
TC Type	T/L
TC Apex	T10-T11
TC Apex Deviation	21.45 mm
TC Upper/Lower	T6sup-T2inf
C3/6 Offset 1	22.38 mm
L4 sup width	48.84 mm

MEASURE	PRE-OP	POST_OP	NORM
UV	T10	T16	
UV P1	26.39°	14.89°	16.9 to 21.1
UV P2	55.62°	53.42°	53.42°
UV P3	33.92°	34.52°	32.2 to 44.4
UV P4	48.32°	42.58°	40.2 to 44.2
UV P5	3.59°	4.32°	2.2 to 6.2
UV P6	46.30°	41.52°	28.2 to 38.2
UV P7	13.90°	11.12°	6.8 to 17.2
L1-L5 100.02 mm 176.17 mm			
UV T6	6.50°	-0.90°	-4.3 to 16.1
UV T6	20.23°	20.23°	20.2 to 20.2
UV T9-T12	20.01°	20.01°	
UV T9-T12	15.83°	15.83°	
UV T9-S0	-12.90°	-6.50°	-14.9 to 8.2
UV T11-S0	-4.24°	-2.40°	-7.2 to 1.8
UV T11-S0	23.32°	24.90°	20.2 to 25.8
UV T9A	14.70°	14.41°	7.1 to 18.7
T1-L1 311.91 mm 311.91 mm			
T1-S1 485.94 mm 485.98 mm			
UV (C7/S1)	0.51 mm	30.57 mm	-19.3 to 45.2
UV T9	0.00°	0.00°	

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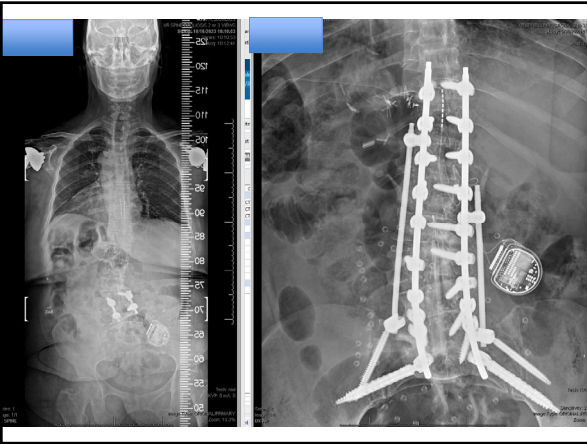
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### Step 3

- Arm your staff with the right information
- Educational series as part of our spine curriculum
- We discuss spinal deformity and the work up and the necessary information
  - Pelvic incidence, global balance, pseudoarthrosis
- Use AI

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### ChatGPT

**You**  
Please create a prior authorization template for getting spine surgery approval for blue cross blue shield in alabama

**ChatGPT**  
Blue Cross Blue Shield of Alabama Prior Authorization Request for Spine Surgery  
Patient Information:

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### ChatGPT

- Location of Surgery:
  - Inpatient
  - Outpatient
  - Ambulatory Surgery Center
- Clinical Information:
  - History and Physical Exam Findings:
    - (Include relevant medical history, physical exam findings, and any conservative treatment attempted and duration)
  - Imaging and Diagnostic Results:
    - (Attach copies of X-rays, MRI, CT scans, etc.)
  - Previous Treatments:
    - (List any medications, physical therapy, injections, or other treatments)
  - Reason for Surgery:
    - (Specify the primary reason for surgery and expected outcome)

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### Step 4

- Entry level “peer-to-peer”
- MA and our APP team
- Optics on this\*\*

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### Step 5

- Surgeon involvement
- Often difficult timing in the reality of a busy practice
  - That’s the point
- Usually approved as you jump the hurdle

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### Step 6

- I will then get the physician working for the insurance company’s name and NPI number.
- I will then write that name in the chart that this physician is making decisions on behalf of the insurance company that are **dictating this** patient’s care.
- I will tell the person on the phone we are doing this.

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### Step 7

- I have only do this once.
- I will directly write in the note that the insurance company is violating best practice and this is hurting this patient and this is unethical and wrong.

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### Patient X

- She was referred to me in Jan 2023
- She was seen in March 2023
- She was seen April 30 2023
- We agreed upon surgery in August 2023
- She had surgery in May 2024

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I called the patient  
Patient was sent to another excellent community surgeon who cannot take on the advanced deformity surgery  
This delay in care from the insurance company is hurting the patient.  
At the end, I told her I am apologetic to doing the surgery she just needs to be taken care of  
She needs treatment by any surgeon/system comfortable in spinal deformity surgery

She has gone to the emergency room with a fair up of back pain and leg pain  
She is depressed from this now. No SI

Very directly, insurance delay has hurt this patient further and caused more suffering.

She was referred to me from an excellent board-certified fellowship trained spine surgeon who diagnosed the problem but does not do spinal deformity surgery and his system is not equipped for that. She saw me and together we agreed on a surgery plan. Insurance denied that after significant back and forth patient was referred to another community spine surgeon who, per report, also recommended she see me.

This patient just needs to be taken care of timely and ethically by whomever is qualified for spinal deformity.

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**Surgeon: Richard Menger, MD**

**Local Measurement Summary**

CPPL	-45.27 mm
Pelvic Obliquity	-3.59°
Clavicle Angle	-4.39°
Sacral Obliquity	-8.90°
T1 Tilt	-2.54°
MC Cobb	38.53°
MC Type	T1L
MC Apex	T10-T11
MC Apex Deviation	21.80 mm
MC Upper/Lower	T5Sup-L2Inf
SC Cobb	-23.68°
SC Type	L
SC Apex	L3-L4
SC Apex Deviation	-10.11 mm
SC Upper/Lower	L2Sup-L4Inf
TC Cobb	-21.62°
TC Type	PT
TC Apex	T9-T4
TC Apex Deviation	8.01 mm
TC Upper/Lower	T5Sup-T8Inf
CPA offset to C	-15.74 mm

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**Surgeon: Richard Menger, MD**

**Spinal Measurement Summary**

MEASURE	PRE-OP	POST_OP	NORM
PT	18.83°	18.83°	14.8 to 25.6
PI	65.35°	65.35°	60.30°
SI	46.51°	46.51°	36.5 to 51.7
LI	-56.35°	-65.18°	-65.1 to -52.2
L1-L4	-30.30°	-30.30°	-25.2 to -24.6
L4-S1	-28.08°	-31.80°	-41.8 to -29.8
P1-L1	8.89°	5.17°	3.8 to 12.8
L1-S1	168.87 mm	169.75 mm	
TL	-11.09°	-11.09°	-8.3 to 1.7
TK	29.30°	29.30°	23.0 to 47.6
T2-T5	13.48°	13.48°	
T5-T12	26.50°	26.50°	
T9-S1	-5.88°	-8.33°	-14.3 to 8.1
T11-S1	-4.45°	-3.34°	-8.3 to -1.1
T11 Slope	24.49°	25.03°	19.3 to 34.3
T12	18.38°	15.40°	8.8 to 21.4
T1-L1	275.26 mm	275.26 mm	
T1-S1	446.12 mm	445.00 mm	
S1A (C7/S1)	50.94 mm	23.15 mm	-10.3 to 52.3
L1PA	-16.73°	-14.82°	
T4PA	-15.72°	-12.95°	
T10 slope 3L2*			

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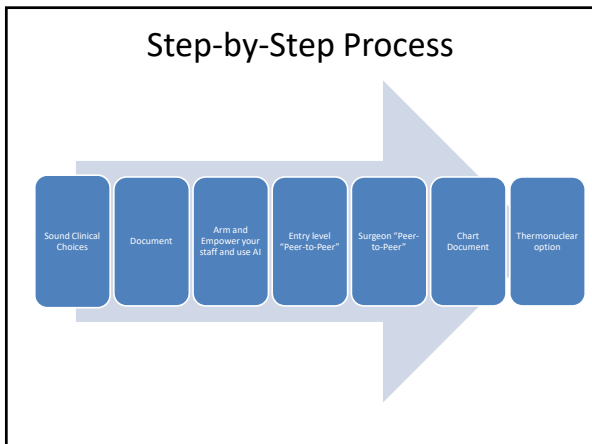
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## Future is brighter

- Patients are angry

The  
New York  
Times

THE NEW OLD AGE

**When 'Prior Authorization' Becomes a Medical Roadblock**

Medicare Advantage plans say it reduces waste and inappropriate care. Critics say it often restricts coverage unnecessarily.

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PRIOR AUTHORIZATION

### 9 states pass bills to fix prior authorization

MAY 8, 2024 • 4:40 PM EDT By Thomas Kilgus, News, Contributions, Newsletter

CMS.gov Centers for Medicare & Medicaid Services

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#### Advancing Interoperability and Improving Prior Authorization Processes Proposed Rule CMS-0057-P:

SPECIAL REPORT: Nominations for Fierce Healthcare's 2024 Most Influential Minority Executives now open

NEWS

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A CPT code for prior authorization? Here's how it could happen

By Noah Ding May 9, 2024 10:33am

[American Medical Association](#)
[Prior Authorization](#)
[Policies](#)
[Administrative Code](#)

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## Conclusion

- Make good clinical choices
- Bend the arc of reform
- Document and empower your team
- Fight for your patients
- Donate to the NeurosurgeryPAC

**Lobbying for health care in 2019**

INDUSTRY	AMOUNT SPENT
Makers of drugs and health products	\$154,458,183
Hospitals and nursing homes	\$50,330,605
Doctors and health professionals	\$39,408,583
Health services and IMCs	\$34,646,637
Miscellaneous health	\$4,582,251
Health insurers	\$16,315,247
<b>TOTAL</b>	<b>\$279,741,496</b>

SOURCE: CENTER FOR RESPONSIVE POLICY

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