



Working together to improve health care quality, outcomes, and affordability in Washington State.

## Lumbar Fusion Bundle and Warranty

2018

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## Introduction

There is broad agreement that lumbar fusion surgery is appropriate to mitigate the immediate threat of spinal instability from major trauma, tumor, infection, or congenital anomalies. In many other circumstances, however, there is less accord concerning the benefit of lumbar fusion. Search and appraisal of scientific, economic and policy literature indicates that lumbar fusion surgery is associated with a substantial complication rate (Brox, *Spine*, 2003), is costly to patients and purchasers (CMS database, 2014), and for many, is of uncertain benefit compared with non-surgical care (Brox, *Spine*, 2003). Despite these concerns, the number of patients undergoing lumbar fusion is increasing rapidly and disproportionately to other spine surgeries. The regional rate for lumbar fusion among CMS patients varies by a factor of 20 (Weinstein, *Spine*, 2006) with a nearly three-fold difference in charges billed to CMS nationwide (CMS database, 2014) for this surgery. Standards for appropriateness, fitness for surgery, best surgical practice, and methods to ensure return to function are rudimentary, fragmented, and inconsistent. When clinical standards for reimbursement for lumbar fusion are relaxed, rates of fusion, complications, and reoperation rates all increase as does inpatient cost (Martin, *Spine*, 2013).

We acknowledge serious deficiencies in the medical literature addressing relative risks and benefits of lumbar fusion and that population-based research may have limitations in individual cases. We support the perspective that provider judgment has an important role in ensuring best care.

Given these constraints and uncertainties we nevertheless believe that much can be accomplished in improving outcomes for patients, performance for providers and affordability. To this end we have created the following community standards for safety and appropriateness to be used as minimum requirements for production, purchasing, and payment of health care for spinal fusion.

### Inclusion Criteria

- Patients with more than 12 weeks of back or lower extremity pain of confirmed spinal origin with neurologic symptoms or signs.

### Exclusion Criteria

- Back pain associated with degenerative joint disease in the absence of structural instability.
- Patients under 18 years of age.
- Use of lumbar fusion in the care of patients with spinal trauma, osteoporotic fracture, tumor, infection, inflammatory conditions, and scoliosis.

Even in the presence of spinal instability, a structured, conservative, non-surgical approach is preferred for patients without neurologic symptoms or signs. Failure of other therapies is likewise not a clear indication for lumbar fusion. Decompression surgery alone should be considered before lumbar fusion when the former is appropriate. We acknowledge that lumbar fusion may be considered in rare and specific situations as detailed in the bundle document.

To improve safety for patients, performance for providers and affordability for purchasers, we are proposing the following four-cycle model as a guide to providers, purchasers, and payers. This model requires documentation of disability despite explicit non-surgical care, meeting fitness requirements for patients prior to surgery, adherence of standards for best practice surgery, and implementation of a structured plan to rapidly return patients to function. The workgroup recommends that payors and purchasers fund elements of this lumbar fusion bundle.

## References

In developing this bundled payment model, we have drawn from existing standards, data and reimbursement policies noted below. Citations related to clinical standards set forth in the bundle are noted in the associated evidence table, available here: [www.breecollaborative.org/wp-content/uploads/Lumbar-Fusion-Evidence-Table-Final.pdf](http://www.breecollaborative.org/wp-content/uploads/Lumbar-Fusion-Evidence-Table-Final.pdf)

BlueCross BlueShield of North Carolina. Corporate medical policy: Lumbar spine fusion surgery. File name: lumbar spine fusion surgery. Origination: 9/2010; Last review: 5/2013.

[http://www.bcbsnc.com/assets/services/public/pdfs/medicalpolicy/lumbar\\_spine\\_fusion\\_surgery.pdf](http://www.bcbsnc.com/assets/services/public/pdfs/medicalpolicy/lumbar_spine_fusion_surgery.pdf)

Deyo RA, Mirza SK, Martin BI, Kreuter W, Goodman DC, Jarvik JG. Trends, major medical complications, and charges associated with surgery for lumbar spinal stenosis in older adults. JAMA. 2010 Apr 7; 303(13):1259-65. PMID: 20371784

<http://jama.jamanetwork.com/article.aspx?articleid=185630>

Centers for Medicare and Medicaid Services. Medicare provider utilization and payment data. Viewed on: 22 April 2014 (page last modified 04/11/2014 10:57am). <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Physician-and-Other-Supplier.html>

Fu KM, et al. Morbidity and mortality in the surgical treatment of 10,329 adults with degenerative lumbar stenosis. Journal of Neurosurgery: Spine 2010 May; 12(5): 443-6. PMID: 20433290

<http://thejns.org/doi/pdf/10.3171/2009.11.SPINE09531>

Goz V, Weinreb JH, McCarthy I, Schwab F, Lafage V, Errico TJ . Perioperative complications and mortality after spinal fusions: Analysis of trends and risk factors. Spine 2013 Oct 15; 38(22): 1970-6. PMID: 23928714.

<http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&AN=00007632-201310150-00022&D=ovft&PDF=y>

Premera Blue Cross. Medical policy: Lumbar fusion. Number 7.01.542. Effective date: April 8, 2013.

[https://www.premera.com/medicalpolicies/cmi\\_125925.htm](https://www.premera.com/medicalpolicies/cmi_125925.htm)

Sansur CA, et al. Morbidity and mortality in the surgical treatment of 10,242 adults with spondylolisthesis. Journal of Neurosurgery: Spine 2010 Nov; 13(5): 589-93. PMID: 21039149

<http://thejns.org/doi/pdf/10.3171/2010.5.SPINE09529>

Washington State Health Care Authority. Health Technology Assessment: Lumbar fusion. Updated 2/15/2008. Number and Coverage Topic: 2001101 - Lumbar fusion.

[http://www.hca.wa.gov/hta/documents/decisions\\_findings\\_lumbar\\_021508.pdf](http://www.hca.wa.gov/hta/documents/decisions_findings_lumbar_021508.pdf)

Washington State Department of Labor & Industries. Medical treatment guidelines; Office of the Medical Director. Surgical guideline for lumbar fusion (arthrodesis). 1 Nov 2009.

<http://www.lni.wa.gov/ClaimsIns/Files/OMD/MedTreat/LumbarFusion.pdf>

## I. Disability Despite Non-Surgical Therapy

**Note: A trial of non-surgical care is not indicated if symptoms, signs and imaging findings reveal objective (i.e., physical exam, imaging), severe, rapidly progressive condition.**

### A) Specification of the patient's degree of functional impairment

1. Clinically:
  - a. Due to back or radicular pain and/or
  - b. Neurologic symptoms or signs
2. With PROMIS-10 and Oswestry Disability Index with additional optional measures including the following patient reported outcome measures :
  - a. Roland-Morris Disability Scale
  - b. EuroQual-5 Dimensions (EQ-5D)
  - c. Short Form 36 (SF-36)
  - d. A similarly peer-reviewed and validated patient-reported outcome
  - e. Therapeutic Associates Outcome Score

### B) Documentation of imaging findings confirming lumbar instability that correlate with the patient's symptoms and signs

1. At least 4mm of a/p translation at L1-5 levels or 5mm of translation at L5-S1 when supine lateral (or cross table lateral) or standing extension lateral lumbar x-rays are compared to standing flexion views OR 11 degrees or greater end plate angular change at a single level, compared to an adjacent level.
2. Neural foraminal stenosis as the result of loss of foraminal height, associated with nerve root compression and concordant radiculopathy.
3. **Proposed** decompressive surgery requiring significant facetectomies for foraminal decompression that are expected to create instability in the spinal segment.

### C) Document at least three months of structured non-surgical therapy delivered by a collaborative team.

The care team should include a physiatrist, a spine surgeon, the primary care provider, physical therapist, care partner, clinical psychologist or pain specialist, and others as needed. A consultation with a physiatrist must be obtained to validate that optimal non-surgical care has occurred and that surgery is indicated. The primary care provider is accountable for leading the team to ensure delivery of comprehensive non-surgical care that includes the following non-surgical measures and medications unless neurologic signs or imaging findings are severe or rapidly progressive. Other appropriate and evidence-based medications, as indicated.

1. Trial of the following non-surgical measures:
  - a. Patient education.
  - b. Risk stratification with the STarT Back tool or similar to inform treatment plan
  - c. Active physical therapy aimed specifically at patients with lumbar segmental instability, with a program of spinal stabilization and hip mobilization.
  - d. Behavioral therapies aimed at improving self-efficacy with an emphasis on effectively addressing important psychosocial elements such as fear avoidance, catastrophizing, and low expectations of recovery. Examples of behavioral therapies might include various methods of cognitive behavioral therapy, such as activity coaching (e.g., a progressive goal attainment program).

- e. Identification and management of associated anxiety and depression.
  2. Time-limited trial of non-steroidal anti-inflammatory drugs or skeletal muscle relaxants if not contraindicated:
  3. Spinal manipulation or other evidence-based non-surgical therapies may be used at the discretion of the collaborative care team.
  4. Use of opioids is discouraged.
  5. If injection therapy is used as an adjunct to non-surgical care it should comply with the determination of the Health Technology Assessment Program or other evidence based guidelines.
- D) Documentation of severe disability unresponsive to non-surgical therapy**
1. Formal consultation with collaborative team led by board certified physiatrist to confirm appropriateness, adequacy, completeness, and active participation in non-surgical therapy and need for lumbar fusion. Need for lumbar fusion should be based on persistent disability and absence of psychosocial barriers. A decision for lumbar fusion requires a meeting of all members of the team and a documented recommendation for fusion by the physiatrist.
  2. Measure severe disability unresponsive to nonsurgical care according to patient reported outcome indicator used at baseline (e.g., PROMIS-10, TAOs)
  3. Confirm that the degree and location of pain and/or physical impairment matches the anatomic location of imaging abnormalities.
  4. Departures from these standards should be reviewed by the collaborative care team.
- E) Patient must participate in shared decision-making validated decision aid such as those approved by Washington State, if available. This requirement is in addition to informed consent**

## II. Fitness for Surgery

### A) Document requirements related to patient safety

1. Patient should meet the following minimum requirements prior to surgery and assist patients in meeting these requirements. Exceptions to these requirements should be discussed in the multidisciplinary conference:
  - a. Body Mass Index less than 40.
  - b. Hemoglobin A1c less than 8% in patients with diabetes.
  - c. Adequate nutritional status to ensure healing.
  - d. Sufficient liver function to ensure healing particularly for high risk patients.
  - e. Pre-operative plan for management of opioid dependency, if patient has taken opioids for more than three preceding months as per Bree Collaborative Supplement to AMDG Guidelines.
  - f. Avoidance of nicotine with confirmation of at least one negative urine screen for a minimum of four weeks pre-operatively.
  - g. Screen for alcohol abuse; manage if screen is positive.
  - h. Absence of severe disability from an unrelated condition that would severely limit the benefits of surgery.
  - i. Absence of dementia that would interfere with recovery – performing surgery for a patient with such dementia requires informed consent of a person with Durable Power of Attorney for Health Care, and a contract with the patient’s care partner.
  - j. Screen for untreated depression, psychiatric disorder, or cognitive dysfunction; manage if screen is positive.
  - k. Screen for anemia and manage as necessary.
2. Complete a pre-operative plan for post-operative return to function.
3. Assess home environment for safety and adequate support (e.g. architectural barriers, availability of assistive devices, availability of care companion etc.).

### B) Document patient engagement

1. Patient must designate a personal care partner.<sup>1</sup> Patient and care partner must actively participate in the following:
  - a. Surgical consultation.
  - b. Pre-operative evaluation.
  - c. Pre-surgical class and/or required surgical and anesthesia educational programs.
  - d. In-hospital care.
  - e. Post-operative care teaching.
  - f. Patient’s home care and exercise program.
2. Patient must participate in end of life planning, including completion of an advance directive and designation of durable power of attorney for health care.
3. Patient agrees to participate in a registry such as Spine COAP and understand that they may be contacted at two years for follow-up data collection.

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<sup>1</sup> A care partner is someone who joins the patient as a supportive lay partner who attends pre- and post-operative informational sessions with providers and provides general assistance to the patient until the patient is able to return to independent function. Instruction to the care partner should include the elements of discharge planning. The care partner must be intellectually, emotionally, and physically qualified to assume this role.

**C) Document optimal preparation for surgery**

1. Perform pre-operative history and physical examination with additional testing as needed. Recommended guidelines include the:
  - a. [2016 guideline from the National Institute for Health and Care Excellence](#) (NICE), and the
  - b. [2014 ACC/AHA Guideline on Perioperative Cardiovascular Evaluation and Management of Patients Undergoing Noncardiac Surgery](#).
2. Treat nasal passages for possible staphylococcal carrier state or culture nasal passages and treat if positive.
3. Ensure A1c less than 8% within last three months in patients with diabetes.
4. Screen for predictors of delirium.
5. Perform relevant imaging as necessary if symptoms have changed.
6. Obtain relevant consultations.
  - a. Dental consultation if patient has poor dental hygiene.
  - b. Anesthesia consultation per [American Society of Anesthesiology Guidelines](#)
  - c. Physical therapy to instruct in improving return to function.
  - d. Other consultations as necessary.

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### III. Spinal Fusion Procedure

#### A) General standards for a surgical team performing surgery

1. The spine surgeon should perform a minimum of twenty lumbar fusion surgeries in the previous twelve months. Neurosurgeons must be board certified or board eligible. Orthopedic surgeons must have successfully completed a spine fellowship.

1. Neurosurgeons must be Board Certified or Board Eligible and credentialed to perform spine surgery by their institution.
2. Orthopedic surgeons must have completed fellowship or specialty training in spine or have > 60% or their practice devoted to spine care and passed subspecialty certification exam.

2. Orthopedic surgeons must have completed fellowship or specialty training in spine or have > 60% or their practice devoted to spine care and passed subspecialty certification exam.
3. Members of the surgical team must have documented credentials, training, and experience. The roster of the surgical team should be consistent.
4. Surgical team may include two attending surgeons to reduce anesthesia time and blood loss particularly in complex cases.
5. Elective spine surgery must be scheduled to begin before 5:00 pm.
6. Surgery must be performed in a facility with sufficient staffing and access to resources to address potential complications.
7. 30 LF/surgeon/yr 60 LF/facility/yr
8. Facilities in which surgery is performed should have policies that align with the American College of Surgeons Statement on Health Care Industry Representatives in the Operating Room.
9. Providers should follow guidelines for concurrent and overlapping surgeries as set forth by the American College of Surgeons.

#### B) Elements of optimal surgical process

1. Optimize pain management and anesthesia:
  - a. Use multimodal pain management format to minimize sedation and encourage early ambulation.
  - b. Minimize use of opioids according to both the [2015 Agency Medical Directors Guideline](#) and the [2018 Bree Collaborative Post-Op Supplement](#).
2. Avoid infection:
  - a. Administer appropriate perioperative course of antibiotics according to guidelines set forth in the Surgical Care Improvement Project (SCIP).
  - b. Restrict use of urinary catheter to the minimum necessary hours.
  - c. Use chlorhexidine skin prep by patient prior to surgery if no contraindication.
3. Avoid bleeding and low blood pressure:
  - a. Employ measures to reduce blood loss and need for transfusion.
  - b. Use standardized IV fluid protocols including those implemented by RNs post-operatively with appropriate supervision and monitoring.
4. Avoid deep venous thrombosis and embolism according to guidelines set forth in the SCIP.
5. Avoid hyperglycemia: use standardized protocol to maintain optimal glucose control.
6. Bone morphogenetic protein: If bone morphogenetic protein is used it must be in accord with Washington Health Technology Program policy: [Bone Morphogenetic Protein for use in Lumbar Fusion](#)

**C) Participation in registries**

1. Hospitals must participate in a registry such as Spine COAP with results available to purchasers.
2. Providers must maintain a registry of patients undergoing lumbar fusion and collect prospective patient reported outcome measures as part of an internal quality improvement program.

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## IV. Post-Operative Care and Return to Function

### A) Standard process for post-operative care

1. Utilize a standardized and rapid recovery track to mobilize patients following surgery:
  - a. Provide accelerated physical therapy and mobilization if regional pain control is acceptable.
  - b. Provide a patient-oriented visual cue to record progress on functional milestones required for discharge.
  - c. Instruct patients in home exercise, use of walking aids, and precautions.
  - d. Instruct Care Partner to assist with home exercise regimen.
2. Patients that meet CMS standards for placement in a skilled nursing facility must have their post-operative nursing and rehabilitative needs addressed.
3. Hospitalists or appropriate medical consultants will be available for consultation to assist with complex or unstable medical problems in the post-operative period.

### B) Use standardized hospital discharge process aligned with Washington State Hospital Association (WSHA) toolkit

1. Arrange follow up with care team according to WSHA toolkit and Bree Collaborative Potentially Avoidable Hospital Readmissions Report and Recommendations.
2. Evaluate social and resource barriers based on WSHA toolkit.
3. Assess home environment for safety and adequate support (e.g. architectural barriers, availability of assistive devices, availability of care companion etc.).
4. Reconcile medications.
5. Provide patient and family/caregiver education with plan of care:
  - a. Signs or symptoms that warrant follow up with provider.
  - b. Guidelines for emergency care and alternatives to emergency care.
  - c. Contact information for the spine surgeon and primary care provider.
6. Ensure post-discharge phone call to patient by care team to check progress, with timing of call aligned with Bree Collaborative [Potentially Avoidable Hospital Readmissions Report and Recommendations](#).
7. Send post-discharge summary to primary care provider or after care provider within three business days of discharge.
8. Pain management to align with [2015 Agency Medical Directors Guideline](#) and the [2018 Bree Collaborative Post-Op Supplement](#)

### C) Arrange home health services

1. Provide the patient and Care Partner with information about medically recommended home exercises.
2. Arrange additional home health services as necessary.

### D) Schedule follow up appointments

1. Schedule return visits as appropriate.
2. Measure patient-reported functional outcomes with standard instruments at 3 months and if possible at 12 months as specified above using the same tools used for initial assessment.
3. Continued smoking cessation three months post-operatively.

## Quality Standards

The provider group performing surgery must maintain or participate in a registry of all patients having first-time, single level lumbar fusion excluding patients with surgery for fracture, infection, cancer, or inflammatory conditions. This registry will be updated quarterly and be available for reporting to current or prospective purchasers and their health plan. It will be made available to quality organizations such as the Washington Health Alliance and the Foundation for Health Care Quality.

During the first year of the bundled contract, providers will be expected to install methods to measure appropriateness, evidence-based surgery, return to function, and the patient care experience according to the standards noted below. Reporting of results will be expected to begin the second year of the contract. The only exception to this reporting requirement is that the measures of patient safety and affordability noted in section 5 below will begin the first year of the contract.

See **Appendix A** for more detailed information on quality standard numerators and denominators.

### 1. Standards for appropriateness

These standards are intended to document patient engagement in medical decision-making and measurement of disability prior to surgery. Report:

- a. Proportion of patients with lumbar fusion (as defined above) receiving formal shared decision-making decision aids pre-operatively.
- b. Proportion of patients with lumbar fusion with documented patient-reported measures of disability and quality of life function prior to surgery using the ODI and PROMIS-10 Global Health tools.
- c. Results of measures from 1b, specifically including ODI score and questions on the PROMIS-10 Global Health survey regarding everyday physical activities (Question 6) and pain (Question 7).

### 2. Standards for evidence-based surgery

These standards are intended to document adherence to evidence-based best practices related to the peri-operative process. Report the proportion of lumbar fusion patients that have received all of the following in the peri-operative period:

- a. Measures to manage pain using multimodal anesthesia.
- b. Measures to reduce risk of venous thromboembolism and pulmonary embolism.
- c. Measures to reduce blood loss and need for transfusion.
- d. Measures to reduce infection such as administration of prophylactic antibiotics.
- e. Measures to maintain optimal blood sugar control.

3. Standards for ensuring rapid and durable return to function

These standards are intended to measure patient recovery. Report:

- a. Proportion of patients with lumbar fusion for which there are documented patient-reported measures of disability and quality of life three months, twelve months, and twenty four months if possible following surgery – the same measures should be used as in standard 1b.
- b. Results of measures from 2b, specifically including responses to the questions identified in standard 1c.

4. Standards for the patient care experience

These standards are intended to measure patient-centered care. Report:

- a. Proportion of patients with lumbar fusion surveyed using HCAHPS.
- b. Results of measures from 4a, specifically including responses to Q6 and Q22-Q25 in HCAHPS survey.
- c. Other validated measures as available pertinent to non-hospital site of service

5. Standards for patient safety and affordability

These standards are intended to measure success in avoiding complications and reducing readmissions. Report:

- a. 30-day all-cause readmission rate for patients with lumbar fusion.
- b. Readmission rate for patients following lumbar fusion surgery with any of the nine complications included under the terms of the warranty.

## Elective Lumbar Fusion Warranty

In developing this warranty for lumbar fusion the Accountable Payment Model (APM) subgroup of the Dr. Robert Bree Collaborative relied most heavily on a similar initiative creating a warranty for total knee replacement (TKR) and total hip replacement (THR). It is our opinion that lumbar fusion and total joint replacement shared sufficient similarities with respect to readmission to the hospital for avoidable complications that the model was transferrable to single level lumbar fusion surgery.

The warranty for TKR and THR was based on a study of complications of these surgeries commissioned by the Centers for Medicare and Medicaid Services (CMS) and subsequently adopted by the High Value Healthcare Collaborative (HVHC), a group of 18 major medical systems from across the country founded by the Dartmouth Institute. To see this report, please visit: [http://www.breecollaborative.org/wp-content/uploads/bree\\_warranty\\_tkr\\_thr.pdf](http://www.breecollaborative.org/wp-content/uploads/bree_warranty_tkr_thr.pdf)

The primary intent of the warranty is to set a high priority on patient safety. It is also intended to balance financial gain for providers and institutions performing lumbar fusion surgery with financial accountability for complications attributable to these procedures. In this warranty the intent is to distribute financial risk across professional and facility components in proportion to the revenue generated by the procedure.

### **Definitions related to a warranty for Lumbar Fusion**

- Diagnostic code for osteoarthritis of the spine - excludes trauma, cancer, inflammatory conditions, and congenital scoliosis.
- Procedural codes for single level lumbar fusion.
- Age limits.
- Definition of complications excluded from additional reimbursement.
- Definition of warranty period.

### **Diagnostic codes**

Diagnostic codes for posterior lumbar fusion with instrumentation 1 level include:

- 722.10 = Herniated disk
- 724.02 = Stenosis without neurogenic claudication
- 724.03 = Stenosis with neurogenic claudication
- 738.4 = Spondylolisthesis
- 722.52 = Degenerative disk disease
- 996.4 = Pseudoarthrosis

### **Procedure Codes**

Procedure codes for posterior lumbar fusion with instrumentation 1 level include:

- 22633 = Includes both posterolateral and posterior interbody arthrodesis (fusion)
- 63047-59 = DLL or
  - 63012 = Gill Procedure for spondylolisthesis or
  - 63042 = Redo laminectomy
- 22853, 22854, 22859 = Application of cages
- 22840 = Posterior non-segmental instrumentation
- 20930 = Cadaver bone chips
- 20936 = Autograft (same incision)
- 38220 = Bone marrow aspiration/draft

### **Including fusions in addition to posterior lumbar fusions and other procedures**

#### **Age limits**

>=18 years old (no upper limit)

### **Complications**

Definition of complications included in warranty:

- As specified by CMS TEP report (*Available in the total knee replacement and total hip replacement warranty*).
- Aligned with ICD-9 codes adopted by HVHC for lumbar fusion.

Complications for warranty are intended to meet the following criteria:

- Represent significant complications attributable to the lumbar fusion procedure.
  - Are identifiable in administrative claims data.
  - Are fair to hospitals and physicians.
1. Death as a result of any of the other complications included in the warranty.
  2. Surgical complications:
    - a. Mechanical complications.
    - b. Periprosthetic joint complications:
      - Incision and drainage.
      - Revision.
      - Removal.
    - c. Wound infection:
      - Incision and drainage.
      - Revision.
      - Removal.
    - d. Surgical site bleeding requiring readmission for incision and drainage.
    - e. Pulmonary embolism.
  3. Medical complications:
    - a. Acute myocardial infarction.
    - b. Pneumonia.
    - c. Sepsis/septicemia.

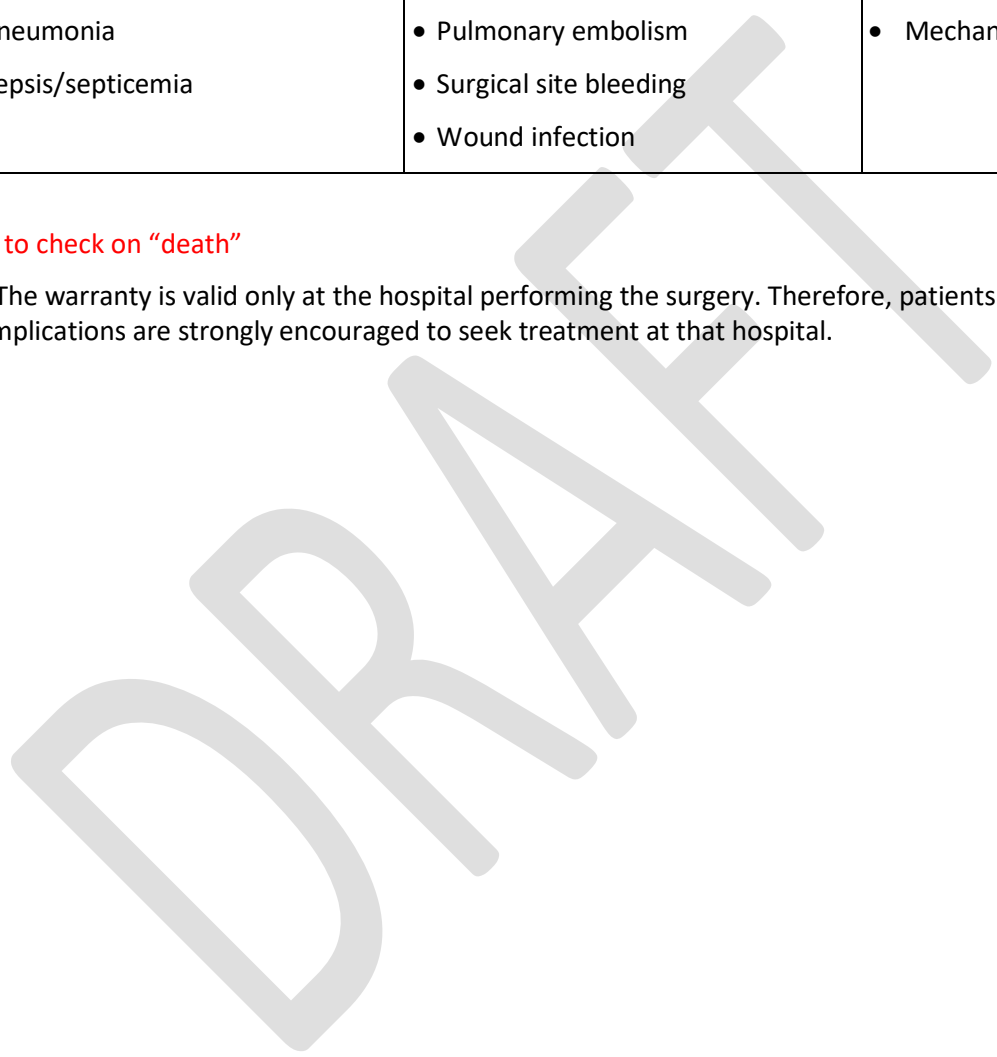
**Warranty period and other terms**

1. Warranty period is complication-specific:

7 days	30 days	90 days
<ul style="list-style-type: none"> <li>• Acute myocardial infarction</li> <li>• Pneumonia</li> <li>• Sepsis/septicemia</li> </ul>	<ul style="list-style-type: none"> <li>• <del>Death</del></li> <li>• Pulmonary embolism</li> <li>• Surgical site bleeding</li> <li>• Wound infection</li> </ul>	<ul style="list-style-type: none"> <li>• Infection involving implant</li> <li>• Mechanical complications</li> </ul>

Meck to check on “death”

2. The warranty is valid only at the hospital performing the surgery. Therefore, patients experiencing complications are strongly encouraged to seek treatment at that hospital.





## Appendix A: Bree Collaborative Members

Member	Title	Organization
Susie Dade, MS	Deputy Director	Washington Health Alliance
Peter Dunbar, MB, ChB, MBA	CEO	Foundation for Health Care Quality
John Espinola, MD, MPH	Executive Vice President, Health Care Services	Premera Blue Cross
Gary Franklin, MD, MPH	Medical Director	Washington State Department of Labor and Industries
Stuart Freed, MD	Chief Medical Officer	Confluence Health
Richard Goss, MD	Medical Director	Harborview Medical Center – University of Washington
Jennifer Graves, RN, MS	Senior Vice President, Patient Safety	Washington State Hospital Association
Christopher Kodama, MD	President, MultiCare Connected Care	MultiCare Health System
Daniel Lessler, MD, MHA	Chief Medical Officer	Washington State Health Care Authority
Wm. Richard Ludwig, MD	Chief Medical Officer, Accountable Care Organization	Providence Health and Services
Greg Marchand	Director, Benefits & Policy and Strategy	The Boeing Company
Robert Mecklenburg, MD	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
Kimberly Moore, MD	Associate Chief Medical Officer	Franciscan Health System
Carl Olden, MD	Family Physician	Pacific Crest Family Medicine, Yakima
Mary Kay O'Neill, MD, MBA	Partner	Mercer
John Robinson, MD, SM	Chief Medical Officer	First Choice Health
Terry Rogers, MD (Vice Chair)	Retired	
Jeanne Rupert, DO, PhD	Medical Director, Community Health Services	Public Health – Seattle and King County
Kerry Schaefer, MS	Strategic Planner for Employee Health	King County
Lani Spencer, RN, MHA	Vice President, Health Care Management Services	Amerigroup
Hugh Straley, MD (Chair)	Retired	Medical Director, Group Health Cooperative; President, Group Health Physicians
Shawn West, MD	Family Physician	Edmonds Family Medicine

## Appendix B: Accountable Payment Models: Lumbar Fusion Workgroup Charter and Roster

### Problem Statement

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Health care in the United States is typically fee-for-service, rewarding providers for volume instead of quality. This misalignment between health care reimbursement and quality does not provide incentive for appropriateness, best outcomes, and affordability.

### Aim

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To recommend reimbursement models including warranties and bundled payments that align with patient safety, appropriateness, evidence-based quality, timeliness, outcomes and the patient care experience.

### Purpose

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To identify conditions of high variability in clinical practice and cost to purchasers, to define evidence-based standards of practice for these conditions and to develop quality measures that align with best practice. The intent of developing such standards and quality measures is to provide a basis for production, payment, and purchasing of health care that should be used by providers, health plans and purchasers as a basis for market-based health care reform.

Methods used by the Accountable Payment Models Workgroup (APM) should themselves be standardized, permitting applicability to a variety of medical conditions.

### Duties and Functions

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The APM workgroup shall:

- Select a series of medical conditions in which variation in practice and price to purchasers is not associated with commensurate quality of outcomes.
- Review existing standards related to each condition, particularly those developed by the Centers for Medicare and Medicaid Services.
- Ensure that appropriate content experts and opinion leaders are recruited to participate in the work associated with each medical condition the APM workgroup selects.
- Consult members of the Washington State Hospital Association, The Washington State Medical Association and other stakeholder organizations and subject matter experts on feedback on content of payment models the APM develops.
- Define scope of work for each medical condition.
- Identify common medical interventions for each condition to create a standardized patient care pathway.
- Use standardized evidence search and appraisal methods to create an evidence table that can be used to assess the value of each intervention.
- Eliminate interventions from the pathway that are not value-added to create a future-state patient care pathway.
- Develop quality metrics that can be used to assess performance as providers to support payment and purchasing of health care.
- Solicit feedback from stakeholders to improve the patient care pathway, evidence table and quality metrics.
- Present the final draft to the Bree Collaborative for approval.

**Structure**

The APM will consist of individuals appointed by the Bree Collaborative Steering Committee. Individuals must have in-depth knowledge and expertise in at least one of the following: payment reform, the health care delivery system, benefit design, and/or quality improvement. There must be at least one representative from each stakeholder group: employer, health plan, hospital, provider (including a specialist), and quality improvement organization.

The chair of the APM workgroup will be appointed by the chair of the Collaborative with advice from the Collaborative steering committee.

The Collaborative project director will staff and provide management and support services for the APM. The CEO of the Foundation for Health Care Quality will also provide staff support and technical assistance.

Less than the full APM may convene to: gather and discuss information; conduct research; analyze relevant issues and facts or draft recommendations for the deliberation of the full APM. A quorum shall be a simple majority and shall be required to accept and approve recommendations to the PAR workgroup and the Collaborative.

**Meetings**

The APM will hold meetings at least once a month and more frequently if necessary.

The APM chair will conduct meetings. The Collaborative project director will arrange for the recording of each meeting, and will distribute meeting agendas and other materials prior to each meeting.

Name	Title	Organization
Robert Mecklenburg, MD (Co-Chair)	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
Kerry Schaefer, MS (Co-Chair)	Strategic Planner for Employee Health	King County
Lydia Bartholomew, MD	Senior Medical Director, Pacific Northwest	Aetna
Arman Dagal, MD	Medical Director	Spine COAP
Sharon Eloranta, MD	Division Director, Clinical Excellence and Quality	CHI Franciscan Health
Farrokh Farrokhi, MD	Neurosurgeon	Virginia Mason Medical Center
Gary Franklin MD, MPH	Medical Director	Washington State Department of Labor and Industries
Andrew Friedman, MD	Physical Medicine and Rehabilitation	Virginia Mason Medical Center
Michael Hatzakis, MD	Physiatrist	Overlake Medical Center
Sara Groves-Rupp	Asst Administrator, Performance Improvement	University of Washington Medicine
Marcia Peterson	Manager of Benefits Strategy and Design	Washington State Health Care Authority
Linda Radach	Patient Advocate	
Jason Thompson, MD	Spine Surgeon	Proliance Surgeons
Mia Wise, DO	Medical Director, Provider & Customer Engagement	Premera Blue Cross

## Appendix C: Detailed Quality Standards

For all of the following, lumbar fusion patients refers to first-time, single-level lumbar fusion, excluding patients with fusion for trauma, cancer, or inflammatory arthritis. Please note that three of the quality measures refer to specific results or scores and therefore have no numerator or denominator.

	Numerator	Denominator
<b>1: Standards for appropriateness</b>		
a	Number of patients with lumbar fusion receiving formal shared decision-making decision aids pre-operatively.	Total number of patients with lumbar fusion.
b	Number of patients with lumbar fusion with documented patient-reported measures of disability and quality of life function prior to surgery using the ODI and PROMIS-10 Global Health tools.	Total number of patients with lumbar fusion.
c	Results of measures from 1b, specifically including score for the Oswestry Disability Index and questions regarding everyday physical activities (Question 6) and pain (Question 7) on the PROMIS-10 Global Health survey.	
<b>2: Standards for evidence-based surgery</b>		
a	Number of patients with lumbar fusion receiving measures to manage pain using multimodal anesthesia in the peri-operative period.	Total number of patients with lumbar fusion.
b	Number of patients with lumbar fusion receiving measures to reduce risk of venous thromboembolism and pulmonary embolism in the peri-operative period.	Total number of patients with lumbar fusion.
c	Number of patients with lumbar fusion receiving measures to reduce blood loss in the peri-operative period.	Total number of patients with lumbar fusion.
d	Number of patients with lumbar fusion receiving measures to reduce infection such as administration of prophylactic antibiotics in the peri-operative period.	Total number of patients with lumbar fusion.
e	Number of patients with lumbar fusion receiving measures to maintain optimal blood sugar control in the peri-operative period.	Total number of patients with lumbar fusion.
<b>3: Standards for ensuring rapid and durable return to function</b>		
a	Number of patients with lumbar fusion for which there are documented patient-reported measures of disability and quality of life six months following surgery (the same measures should be used as in standard 1b).	Total number of patients with lumbar fusion.
b	Number of patients with lumbar fusion for which there are documented patient-reported measures of disability and quality of life two years following surgery (the same measures should be used as in standard 1b).	Total number of patients with lumbar fusion.
c	Results of measures from 2b, specifically the score from the Oswestry Disability Index and questions regarding everyday physical activities (Question 6) and pain (Question 7) on the PROMIS-10 Global Health survey).	

<b>4: Standards for the patient care experience</b>		
a	Number of patients with lumbar fusion surveyed using HCAHPS.	Total number of patients with lumbar fusion.
b	Results of measures from 4a, specifically responses to Q6 and Q22-Q25 if HCAHPS is used.	
<b>5: Standards for patient safety and affordability</b>		
a	Number of patients with lumbar fusion readmitted to the hospital within 30 days of discharge, all causes.	Total number of patients with lumbar fusion.
b	Number of patients with lumbar fusion readmitted to the hospital within 30 days of discharge for any of the nine complications and intervals included under the terms of the warranty.	Total number of patients with lumbar fusion.

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