April 1, 2011

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RE: **Physician Consultant Input from American Association of Neurological Surgeons to Medical Policy Sent by WellPoint, Inc.**

Dear Ms. Orrico, Ms. Hill and Mr. Marshall:

Thank you for the input your organization has facilitated or directly provided regarding WellPoint, Inc. medical policy as well as the medical policy for a national association and its member health plans (collectively, "Association"). We value the contributions of the physicians identified through the American Association of Neurological Surgeons. The collective input is taken into consideration as WellPoint and an Association creates or updates policy positions, which impact the health care benefits provided to WellPoint's more than 33 million enrollees and the additional millions of Americans whose health care benefits are provided through the Association member plans.

We want to take this opportunity to share some feedback with you regarding your participation in our policy process. This report provides feedback on dimensions of value and benchmarking, evaluating various aspects of the process. This report also includes case-specific detail with a spotlight on input from physicians identified through physician specialty medical societies or academic medical centers that impacted WellPoint's final policy position.

Physician Consultant Input Metrics

There are many ways to objectively assess this program, your society's participation and the value of the reviews your members provide. We offer the following data not as a critique, but rather to identify opportunities to improve the overall program. In particular, we measure ***responsiveness (response rate and timeliness), review quality, agreement with policy position, and incorporation of input to change final policy position.***

Another domain which we would ideally measure and report, but often do not have the detail, is the reason reviews are not returned. For example, was the review not returned because the reviewer agreed with the policy position or does not provide the specific service under review, or was the applicable specialist not available or willing to complete the review, or other reason(s)? We welcome your feedback when reviews are not returned on any specific reason so we can fully capture this dimension.

We hope this report encourages you to encourage your society to respond to all the surveys so that we have a more complete picture regarding the opinions of specialty medical societies or their members throughout the country. We appreciate knowing when reviewers ***agree and disagree*** with our policy positions. We are also keenly interested in knowing when a service is only being provided in very limited circumstances, given the implications to assessment of whether it has been generally accepted in the community.

Responsiveness

Response Rate
Ideally, the response rate approaches 100% to maximize the value of the input we receive by including both agreement and disagreement, as well as any special circumstances which may exist.

We may request more than one physician specialty medical society provide input on a medical policy. For example, for some medical policies we may ask for input from family practice physicians or internal medicine physicians as well as surgeons or other specialists. We are interested in hearing from those involved in all aspects of care. In other cases, a particular policy may have multiple indications that cross over to various specialty physicians. Only certain aspects of the medical policy may be applicable to certain physicians. We will generally include the complete medical policy and welcome input from various physician specialties, again looking for a broad range of input, not only from those that directly provide the service but from others involved in aspects of care.

We have been preparing and sending our annual review reports to the various specialty medical societies who participate in this process. There are thirty-two (32) SMS's which have participated in the past year. Table 1 shows the number of medical policy reviews requested and reviews completed from the participating SMS's based on the unique request sent. Reviews completed for requests sent in the fourth quarter 2010 is subject to change as additional responses may be received for requests sent near the end of 2010.

Table 1 Overall SMS Response Rate*

*Data includes requests for WellPoint and the Association.

2010	Reviews Completed †	Reviews Requested	Response Rate ‡
Quarter 1	20	57	35%
Quarter 2	24	70	34%
Quarter 3	34	88	39%
Quarter 4	29	88	33%
Annual	107	303	35%

† If input was received from more than one reviewer for a given request, the count for this measure equals one.
‡ Response rate is based on reviews received through 3/03/2011.

Table 2 shows the number of medical policy reviews requested and reviews completed from the American Association of Neurological Surgeons based on the unique request sent.

Table 2 American Association of Neurological Surgeons Response Rate*

*Data includes requests for WellPoint and the Association.

2010	Reviews Completed §	Reviews Requested	Response Rate **
Quarter 1			
Quarter 2			
Quarter 3	3	4	75%
Quarter 4	2	2	100%
Annual	5	6	83%

§ If input was received from more than one reviewer for a given request, the count for this measure equals one.
** Response rate is based on reviews received through 3/03/2011.

Table 3 shows the specific policies requested and completed reviews received from the American Association of Neurological Surgeons.

Table 3

Policy Number & Title	Request Date	Review Date	Number of Reviews Received
SURG.00001 Carotid, Vertebral and Intracranial Artery Angioplasty with or without Stent Placement	7/16/10	9/8/10	1
DME.00004 Electrical Bone Growth Stimulation	7/16/10	7/29/10	1
7.01.116 Radiofrequency Facet Joint Denervation and SURG.00066 Percutaneous Neurolysis for Chronic Back Pain	7/19/10		*see footnote
SURG.00017 Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy	9/28/10	11/11/10	1

Policy Number & Title	Request Date	Review Date	Number of Reviews Received
7.01.85 Electrical Stimulation of the Spine as an Adjunct to Spinal Fusion Procedures	10/25/10	11/22/10	1
2.01.54 Endovascular Procedures for Intracranial Arterial Disease (Atherosclerosis and Aneurysms)	11/5/10	12/13/10	1

* For 7.01.116 Radiofrequency Facet Joint Denervation and SURG.00066 Percutaneous Neurolysis for Chronic Back Pain, response received indicated, "We circulated your request for input regarding Radiofrequency Facet Joint Denervation to the leaders of our AANS/CNS Joint Section on Pain and our Coding and Reimbursement Committee. The consensus was that these procedures are not frequently performed by neurosurgeons. Therefore, we will not be providing a response on this particular procedure."

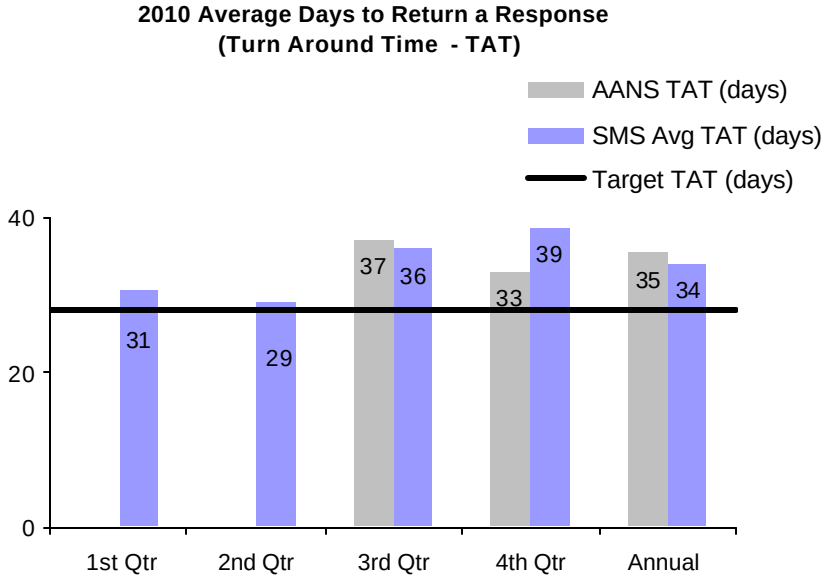
Timeliness

The ideal ***turnaround time,*** the time taken by the SMS to reply, is ***4 weeks or less*** on average. This will maximize the impact of the review on our policy formation process by synching up presentation of your review with the Committee meeting at which the topic will be most actively discussed.

Chart 1 shows the American Association of Neurological Surgeons timeliness relative to other participating SMS's. Timeliness for the fourth quarter 2010 is subject to change as additional responses may be received for requests sent near the end of 2010.

Chart 1*

* Data includes requests for WellPoint and the Association



Evaluation of Physician Consultant Reviews Received
We also evaluate the quality of review, whether the reviewer agrees with the medical policy position, and whether there was a change in medical policy associated with the reviewer input.

Measure of Quality of Physician Consultant Review
The quality of the physician consultant review is categorized as follows:

- Excellent
- Good
- Fair

Factors considered in evaluating quality of reviews received include completion of entire questionnaire including conflict of interest and thoroughness of response including providing comments and listing reference(s) when disagreeing with policy position or providing additional feedback such as patient selection criteria, contraindications, and so forth. A fair review might be incomplete or indicate disagreement but not provide a citation or other basis. An excellent review is complete and provides both the reviewer's comments as well as relevant citations in support.

Measure of Physician Consultant Agreement with Proposed Medical Policy
The physician consultant agreement with the medical policy is categorized as follows:

- Agrees completely
- Agrees to some questions, disagrees with others
- Disagrees completely
- Agreement not specified

Measure of Incorporation of Physician Consultant Input into a Change in Final Medical Policy
Policies reviewed at quarterly Committee meetings, may or may not be changed, based on a variety of inputs including the individual consultant feedback. Input from consultant feedback, particularly when feedback from multiple consultants is concordant, can be an important contributor to policy position revision. When changes are made, and the consultant input played a role in that change, we categorize that as follows:

- Yes (consultant disagreed, and policy was changed)
- No (consultant disagreed, but policy was not changed)
- Tabled (policy was not finalized at the meeting)
- Agreed (consultant agreed, therefore no change expected)

Table 4 shows measures for evaluation of individual physician consultant reviews received from the thirty-two (32) participating SMS's. Measures for (a) physician consultant agreement with draft medical policy and (b) quality of consultant review are completed for all reviews received for both WellPoint and Association policies, including those consultant reviews pending presentation at Committee meeting(s). Measure for physician consultant review contributed to policy revision is specific to reviews for WellPoint policy presented at the Medical Policy & Technology Assessment Committee (MPTAC) meeting. Therefore, the overall total for agreement with draft policy and quality will not match that of contribution to policy revision. The contribution to policy revision is completed specific to WellPoint policy and after WellPoint policy is presented at MPTAC meeting.

Table 4: Individual Physician Consultant Review Measures for Participating SMS's

	Agreement with Draft				Quality			Physician Review Contributed to Policy Revision			
2010	Complete	Partial	Does Not Agree	Not Specified	Excellent	Good	Fair	Yes	No	Tabled	Agreed
Quarter 1	11	14	6		10	19	2	1	8		4
Quarter 2	14	8	10	2	9	23	2		3		4
Quarter 3	7	27	4	6	15	17	9	8	20		2
Quarter 4	6	26	8		12	19	9		8		2
Overall	38	75	28	8	46	78	22	9	39		12

Table 5 shows measures for evaluation of individual physician consultant reviews received from the American Association of Neurological Surgeons. Measures for (a) physician consultant agreement with draft medical policy and (b) quality of consultant review are completed for all reviews received for both WellPoint and Association policies, including those consultant reviews pending presentation at Committee meeting(s). Measure for physician consultant review contributed to policy revision is specific to reviews for WellPoint policy presented at the Medical Policy & Technology Assessment Committee (MPTAC) meeting. Therefore, the overall total for agreement with draft policy and quality will not match that of contribution to policy revision. The contribution to policy revision is completed specific to WellPoint policy and after WellPoint policy is presented at MPTAC meeting.

Table 5: Individual Physician Consultant Review Measures for American Association of Neurological Surgeons

	Agreement with Draft				Quality			Physician Review Contributed to Policy Revision			
2010	Complete	Partial	Does Not Agree	Not Specified	Excellent	Good	Fair	Yes	No	Tabled	Agreed
Quarter 1											
Quarter 2											
Quarter 3	2	1			3			1	1		1
Quarter 4		2			2						
Overall	2	3			5			1	1		1

The metrics for physician review contributed to policy revision does not fully capture the entire impact of physician consultant reviews received. The consultant reviews received may have contributed to other changes to policy such as partial position changes, other rationale or criterion updates, bibliography or rationale revision, further discussion at a subsequent Committee meeting and so forth. Furthermore, a response which is in agreement with a policy confirms our policy position review process. We appreciate your time and value the input received through the American Association of Neurological Surgeons. We are interested in having a complete picture regarding the opinions of specialists throughout the country, including that of your society or of individual physicians identified through the AANS.

Examples of Physician Consultant Reviews Impacting WellPoint Medical Policy
The following examples of physician consultant reviews received from American Association of Neurological Surgeons (Case #1) and another physician specialty medical society (Case #2) demonstrate the value of consultant input to the medical policy development process.

Case #1
Medical Policy: DME.0004 Electrical Bone Growth Stimulation
Date Received: 08/11/2010
Excerpt of Response Received:

Specific questions regarding the policy determination	**Yes**	**No**	**Comments**
Noninvasive **Electrical Stimulation of the Spine for Spinal Fusion Surgery:** Applied at any time between the time of surgery and 6 months after surgery	**Yes**	**No**	**Comments**
For spinal fusion surgery, the policy indicates that noninvasive electrical bone growth stimulation may be applied as an adjunct to surgery (from the time of surgery to 30 days later) for individuals with risk factors for developing pseudoarthroses. If, for some reason, such an individual has not yet received noninvasive electrical bone growth stimulation during the first 30 days post-operatively, is it still appropriate to add this therapy during the period beginning 30 days postoperatively to as long as 6 months postoperatively? Please provide additional comments and references if possible, with your answer.	X		Electrical bone growth stimulation is thought to mimic the physiological processes through which mechanical stimuli trigger bone formation. This technology has been shown to be effective not only for patients at high risk for non-union after spinal surgery but is also used for the treatment of established nonunion of the spine as well as non-union of long bone fractures and congenital pseudarthroses. The effectiveness of electrical bone growth stimulation in these circumstances indicates that the therapeutic window does not close after 30 days. Therefore, it may be appropriate to add noninvasive electrical bone growth stimulation between 30 days and up to 6 months postoperatively. The role of bone growth stimulating devices and orthobiologics in healing nonunion fractures. Technology Assessment, AHRQ, 21 September 2005.
Noninvasive **Electrical Stimulation for Failed Spinal Fusion:** Applied a minimum of 6 months after the original surgery	**Yes**	**No**	**Comments**
For individuals with failed spinal fusion surgery	X		Given that the accepted definition of failed

Specific questions regarding the policy determination	Yes	No	Comments
(nonunion), the policy states that ***noninvasive* electrical bone growth stimulation** may be applied. Failed spinal fusion is defined as a spinal fusion that has not healed at a minimum of 6 months after the original surgery, as evidenced by serial x-rays over a course of 3 months during the latter portion of the 6 month period. Do you feel that failed spinal fusion surgery may be confirmed **prior** to 6 months after surgery, and if so, what are the criteria for determining this? Please provide additional comments and references if possible, with your answer.			spinal fusion is 3 months of documented non-healing 6 months after surgery, confirmation of failed fusion cannot, strictly speaking, occur until those criteria are met. However, it is certainly possible to have a high degree of suspicion of failed spinal fusion prior to the 6-month time point that is subsequently confirmed. Signs that may indicate an impending failed spinal fusion include increasing axial back pain, peri-implant lucencies, progression of deformity, and bone resorption surrounding interbody grafts or devices. Kim YJ, Bridwell KH, et al. Pseudarthrosis in long adult spinal deformity instrumentation and fusion to the sacrum: prevalence and risk factor analysis of 144 cases. Spine 32(20):2329-36, 2006.

Notes: The physician review (above) was presented at the Medical Policy and Technology Assessment Committee (MPTAC) meeting in August 2010. In addition to this specific input, the MPTAC reviewed additional consultant input, relevant peer-reviewed publications and other evidence-based sources. The MPTAC revised the policy position on DME.00004 based on this review. The revised medical policy became effective on August 19, 2010 and is available for public viewing on our Plan web sites.

Case #2
Medical Policy: SURG.00033 Implantable Cardioverter-Defibrillator (ICD)
Date Received: 10/25/2010
Excerpt of Response Received:

Specific questions regarding the Policy determination	Yes	No	Comments
Focused Questions: - Do you consider the following as a medically appropriate indication for ICD placement: **primary prevention** of sudden cardiac death (SCD) in the setting of hypertrophic cardiomyopathy, WITH or WITHOUT the presence of additional risk factors for SCD? - If yes, please comment on specific risk factors (or criteria or other clinical features), if any, that would be required to be present, in order to consider this scenario a medically necessary indication for ICD. - Please cite literature to support	X		I consider the following a medically appropriate indication for ICD implantation: Primary prevention of SCD in the setting of hypertrophic cardiomyopathy WITH the presence of additional risk factors for SCD (not WITHOUT). These risk factors include: 1) Syncope 2) Family history of SCT 3) Non-sustained VT 4) LV wall thickness of = 3 cms 5) A blunted blood pressure response to exercise Many experts argue that the presence of 1 of these factors should be enough. **References**: Maron BJ. Contemporary Insights and Strategies for Risk Stratification and Prevention of Sudden Death in Hypertrophic Cardiomyopathy.

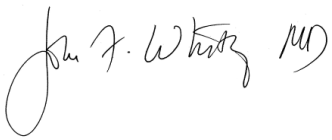
Specific questions regarding the Policy determination	Yes	No	Comments
your comments.			Circulation 2010; 121:445-456. Many important citations are included in this review article. of High Risk Patients Perry M. Elliott, et al, J Am Coll Cardiol 2000;36:2212– 8. Spirito P, Bellone P, Harris KM, et al. Magnitude of left ventricular hypertrophy and risk of sudden death in hypertrophic cardiomyopathy. N Engl J Med 2000; 342:1778–85.

Notes: The physician review (above) was presented at the Medical Policy and Technology Assessment Committee (MPTAC) meeting November 2010. In addition to this specific input, the MPTAC reviewed additional consultant input, relevant peer-reviewed publications and other evidence-based sources. The MPTAC revised the policy position on SURG.00033 based on this review. The revised medical policy became effective on December 1, 2010 and is available for public viewing on our Plan web sites.

We would like your thoughts on any opportunities to enhance this process. In particular, we would be interested in your input on how to improve response rates, turnaround time and the quality of the reviews so that all could be as informative as the examples cited. We will be reaching out to you to offer a meeting to review this report and discuss any of your ideas on how the process could be enhanced.

In closing, we hope you find this information helpful and look forward to continuing our relationship with the American Association of Neurological Surgeons. Thank you for your participation in this important process to provide clinical input into our review and to support the principles of evidence-based medicine.

Sincerely,



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