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Thank you for your patience.

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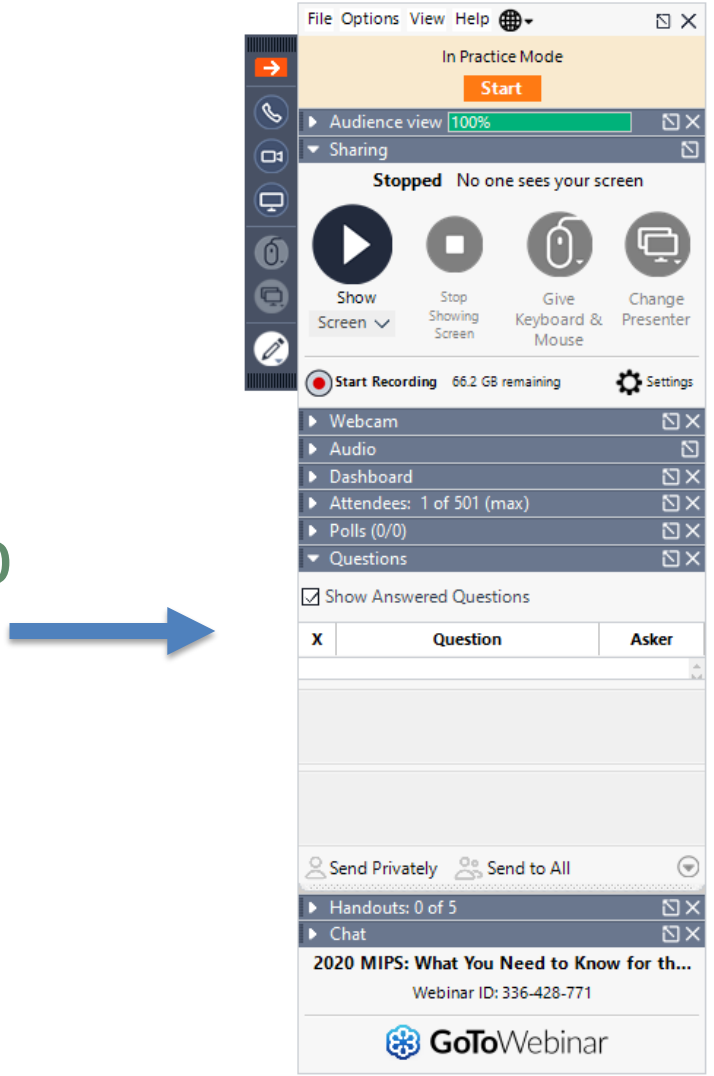
- Please use the “Questions” feature to ask a question. We will get to all questions at the end of the webinar.
- Please note: this webinar is being recorded and will be posted online.



Today’s Speaker: Cindy Moon, MPP, MPH

Cindy H. Moon is Vice President of Health Care Payment and Delivery Reform with Hart Health Strategies Inc. Prior to joining Hart Health Strategies Inc., Ms. Moon worked at the White House Office of Management and Budget (OMB) where she advised on policy solutions affecting the Medicare program. In this role, Ms. Moon collaborated with federal stakeholders across the Executive Office of the President, the Department of Health and Human Services Office of the Secretary, and the Centers for Medicare and Medicaid Services (CMS) to oversee implementation of major payment and programmatic changes to the Medicare program. These efforts included implementation of statutory requirements included in the Affordable Care Act, the Protecting Access to Medicare Act and, most recently, the Medicare Access and CHIP Reauthorization Act (MACRA), which fundamentally transforms Medicare payment for physician and other clinician services. Ms. Moon also oversaw the design and implementation of several innovative models to test payment and health care delivery reforms operated by the Center for Medicare and Medicaid Innovation within CMS.

Prior to joining OMB, Ms. Moon held successively increasing leadership positions within the Health Plan of San Mateo (HPSM), a quasi-public health plan offering publicly-sponsored health coverage for qualifying residents of San Mateo County, California. There, Ms. Moon led HPSM's policy analysis, strategic planning, and business planning related to Medicare Advantage, Medicaid long-term care integration, and indigent care. Ms. Moon also oversaw operations of HPSM's Medicare Advantage and Part D Special Needs Plan for dual eligible beneficiaries, maintaining a particular focus on Medicare compliance and revenue maximization. Additionally, Ms. Moon managed the end-to-end implementation of a new line of business for HPSM to provide third-party administration services for San Mateo County's indigent care program.

Ms. Moon earned her Master of Public Policy and Master of Public Health from the University of California at Berkeley and her Bachelor of Arts from Harvard University.

2020 Quality Payment Program (QPP) Merit-based Incentive Payment System (MIPS) Reporting

American Academy of Physical Medicine & Rehabilitation
December 12, 2019

Cindy Moon, MPP, MPH
VP, Health Care Payment and Delivery Reform
Hart Health Strategies, Inc.

HHS | Hart Health Strategies Inc.

Quality Payment Program (QPP)

MIPS

Provides payment adjustments based on a composite score across four categories:

- Quality
- Cost
- Promoting Interoperability (PI; formerly Advancing Care Information)
- Improvement Activities

- Maximum negative adjustments growing from 4% for 2019 payment up to 9% for 2022 onward
- Annual payment updates of 0.25% starting in 2026

Advanced APMs

Provides a 5% lump sum incentive payment for clinicians who have significant participation in ***risk-based*** APMs that rely on certified EHR technology and MIPS-like quality measures (aka "Advanced APMs").

- Exempt from MIPS reporting requirements and payment adjustments
- Annual payment updates of 0.75% starting in 2026

MIPS Current Status

- 2020 will be the 4th year of the QPP.
- CMS is continuing to transition to full MIPS implementation, which is required by the 6th year of the program.
- CMS is continuing to modify the program in an effort to make it more meaningful and less burdensome to providers, with mixed results.

MIPS for 2020: Overview

- Final rule released November 1, 2019
- Generally finalizes policies for 2020 that affect payment in 2022
- Largely maintains policies from 2019 for 2020, e.g.:
  - Low-volume threshold
  - Facility-based scoring
  - Reporting options
- Updates key parameters for 2020 as part of transition towards full implementation:
  - MIPS performance threshold: Increase to 45 points (up from 30 points for 2019)
    - Increase to 60 points for 2021 performance
  - Exceptional performance threshold: Increase to 85 points (up from 75 points for 2019; also applies to 2021 performance)
  - Maximum negative adjustment: Increase to 9% (up from 7% for 2019)

MIPS Eligible Clinicians

- For 2020, MIPS Eligible Clinicians defined as:
  - Physicians
  - PAs
  - NPs
  - CNS/CRNAs
  - Additional clinicians added starting in 2019:
    - Physical therapists
    - Occupational therapists
    - Qualified speech-language pathologists
    - Qualified audiologists
    - Clinical psychologists
    - Registered dieticians or nutrition professionals
- Each MIPS Eligible Clinician is defined at the TIN/NPI level
  - If you practice with more than one TIN, participation (or exclusion) rules will apply for each TIN/NPI combination.

MIPS Eligible Clinicians

- Exclusions:
  - Newly enrolled in Medicare
  - Significantly participating in advanced APMs
    - Determined to be a Qualifying APM Participant (QP)
  - Below the low-volume threshold
    - $90,000 or less in Part B allowed charges
    - 200 or fewer Part-B enrolled Medicare patients
    - 200 or fewer covered professional services under the Physician Fee Schedule
  - As of 2019: Opportunity to opt-in if you meet one or two of the low-volume criteria, but not all three

Specialty	Newly-Enrolled	QP Status	Low-Volume	Total Exclusions	Total Inclusions
Physical Medicine	501 (5.1%)	79 (0.8%)	2,756 (28.0%)	3,336 (33.8%)	6,520 (66.2%)

2018 through 2020: This number should have increased significantly as the threshold moved from **$30,000 or 100 patients** to **$90,000 to 200 patients**

**Data from October 2016 CY 2017 QPP final rule*

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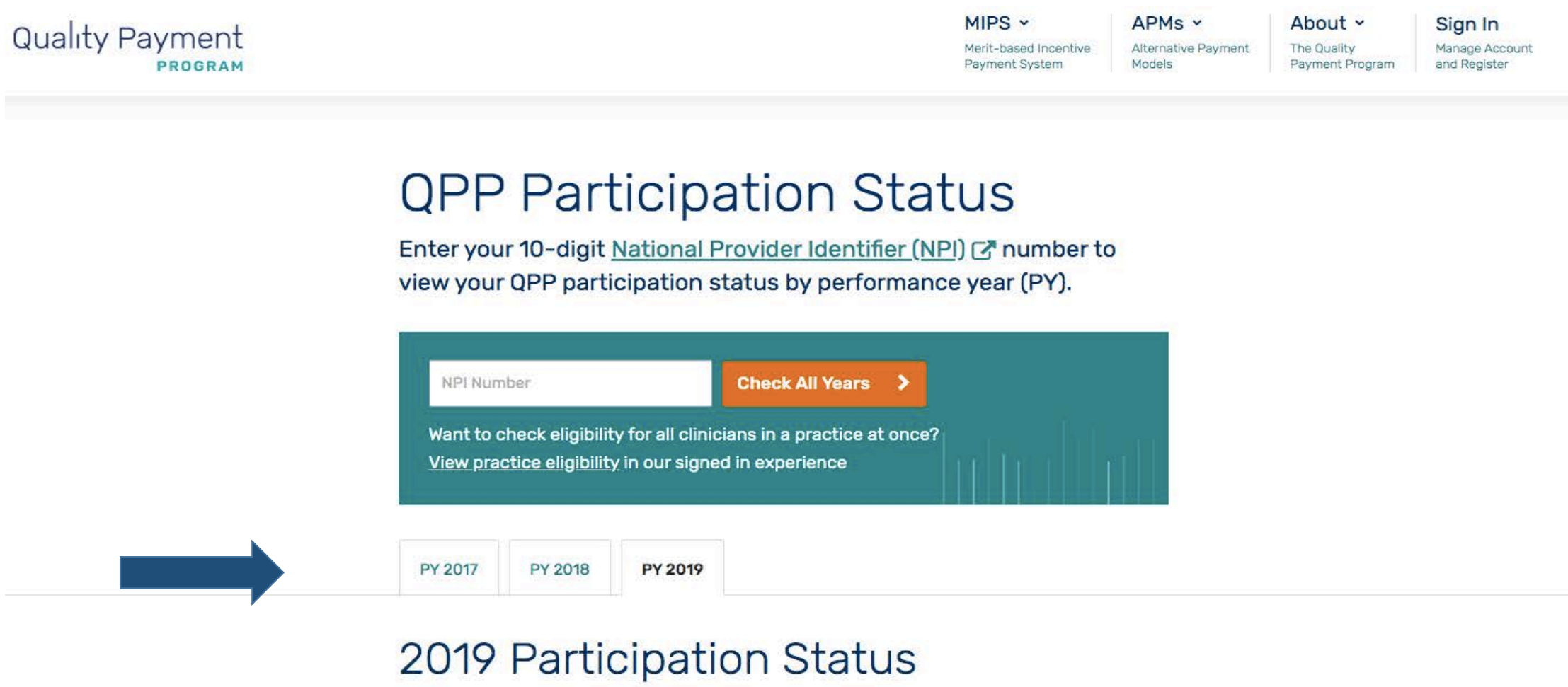
QPP NPI Look-up: **qpp.cms.gov/participation-lookup**



MIPS NPI Look-up

MIPS participation

MIPS Exempt as an Individual

Eligible provider type	Yes
Enrolled in Medicare before January 1, 2018	Yes
Medicare patients for this clinician	Does not exceed 200
Allowed charges for this clinician	Does not exceed $90,000

MIPS Included as a Group

At least one eligible provider type at this practice	Yes
Medicare patients at this practice	Exceeds 200
Allowed charges at this practice	Exceeds $90,000

Learn more About MIPS Participation

MIPS NPI Lookup

Other Factors

These may be automatically received or may be applied for. Learn more about special statuses and exception applications

Received as an individual

SPECIAL STATUS **Hospital-based**	Yes
SPECIAL STATUS **Health Professional Shortage Area (HPSA)**	Yes
SPECIAL STATUS **Non-patient facing**	Yes
SPECIAL STATUS **Rural**	Yes

Received as a group

SPECIAL STATUS **Hospital-based**	Yes
SPECIAL STATUS **Health Professional Shortage Area (HPSA)**	Yes
SPECIAL STATUS **Non-patient facing**	Yes
SPECIAL STATUS **Rural**	Yes

MIPS NPI Lookup

Provider type	Doctor of Medicine
Associated practices (TINs)	1
Associated APMs	1
Qualifying APM Participant (QP) Status	Qualifying APM Participant (QP)
Enrolled in Medicare before January 1, 2018	Yes

Reporting Requirements Overview

⊘ Not Required to Report for MIPS

[redacted] is a Qualifying APM Participant (QP). Therefore this clinician does not have to submit data for MIPS in this system.

APM participation (1)

Classification	Advanced MIPS APM (Combo)
Model	Next Generation ACO Model / null

MIPS Overview

Performance Category	Category Weight		
	Performance Year 2017	Performance Year 2018	Performance Year 2019 - 2020
Quality	60%	50%	45%
Promoting Interoperability	25%	25%	25%
Cost	0%	10%	15%
Improvement Activities	15%	15%	15%

Based on performance across these categories, clinicians can face negative payment adjustments that have been increasing over time.

For 2022 payment (based on 2020 performance), a maximum negative adjustment of 9 percent applies.

MIPS Participation Options

- Clinicians can participate in MIPS in several ways, including:
  - As an individual clinician (reporting at the TIN/NPI level)
  - As a group (reporting at the TIN level)

- If you are part of a group:
  - Check to see if your group is handling reporting on clinicians' behalf
  - Multi-specialty groups that report as a "group" can rely on measures which might not be applicable to the services you provide, so be sure to evaluate your entire group's reporting strategy

MIPS Data Collection Types for Individual Clinicians**

	Claims*	Qualified Registry	Qualified Clinical Data Registry (QCDR)	Certified EHR Technology	CMS Web-based Attestation
Quality	✓	✓	✓	✓	
Improvement Activities		✓	✓	✓	✓
Promoting Interoperability		✓	✓	✓	✓
Cost	Administrative claims (no submission required)				

Starting in 2019, clinicians can use different reporting mechanisms across categories and **multiple mechanisms** within each category.

* Limited to small practices only starting with 2019
** Reporting options for group reporting vary to an extent.

Quality Performance Category: General Requirements

	2020
Required Measures	6 measures, including 1 outcome or high priority measure, but "all or nothing" scoring does *not* apply. If more than 6 measures are submitted, CMS will base your final score on the 6 with the highest score.
Data Completeness	Report each measure for at least **70%** of applicable patients across all patients (or Medicare patients only for Claims Reporting)
Performance Period	Full calendar year
Achievement Points	10 points per measure, compared to national benchmarks • Failure to meet data completeness: 0 points (or 3 points for small practices) • Reporting on <20 patients: 3 points • Reporting on measure with no benchmark: 3 points
Improvement Points	• CMS will measure "improvement" at the quality category level

Quality Performance Category: Topped Out Measures and Bonus Points

- Topped Out Measures
  - 7-point cap applies to measures topped out for two years
  - If a measure is topped out for at least 3 years, it could be proposed for removal in the 4th year
  - CMS may also accelerate removal of highly topped out (98-100%) measures within a year for future years
- Bonus Points
  - High priority measures:
    - 2 points for Outcome and Patient Experience measures
    - 1 point for other high priority measures: Appropriate Use; Patient Safety; Efficiency; Care Coordination; Opioid-related
    - Not available for reporting via Web Interface
  - End-to-end electronic reporting:
    - 1 point for each measure submitted using end-to-end electronic reporting
  - Bonus points are available even if they are for measures that are not in the top 6 scored measures, but data completeness and case minimum requirements apply in most cases.

2020 MIPS Physical Medicine Specialty Measure Set

	Measure	Reporting Option		
Outcome or High Priority?		Claims	EHR	Registry
X	QPP #47: Advance Care Plan	X		X
~~X~~	~~QPP #109: Osteoarthritis (OA): Function and Pain Assessment~~	~~X~~		~~X~~
	QPP #128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	X	X	X
X	QPP #130: Documentation of Current Medications in the Medical Record	C	C	C
~~X~~	~~QPP #131: Pain Assessment and Follow-Up~~	~~X~~		~~X~~
X	QPP#154: Falls: Risk Assessment	C		C
X	QPP #155: Falls: Plan of Care	C		C
X	QPP #182: Functional Outcome Assessment	C		X
	QPP #226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	X	X	X
	QPP #317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	X	X	X
X	QPP #374: Closing the Referral Loop: Receipt of Specialist Report		X	X
	QPP #402: Tobacco Use and Help with Quitting Among Adolescents			X
X	QPP #408: Opioid Therapy Follow-up Evaluation			C
X	QPP #412: Documentation of Signed Opioid Treatment Agreement			C
X	QPP #414: Evaluation or Interview for Risk of Opioid Misuse			C
	QPP #431: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling			X
X	QPP #468: Continuity of Pharmacotherapy for Opioid Use Disorder			X

C indicates 7-point cap for 2019. X indicates topped out status for 2019, but no 7-point cap. 2020 status may differ.

Eligible Measure Applicability (EMA) Process

- According to CMS, the EMA is "an enhanced version of Measure-Applicability Validation (MAV) process previously used for PQRS"
- Only available for Claims and Registry reporting (not EHR, Qualified Clinical Data Registries, or Web-Interface reporting)
- If the EMA process finds an applicable measure was available, the missing measure is scored with a performance of zero
- If process finds no applicable measure was available, the missing measures are removed from the calculation and the quality performance score will be based on remaining measures. ***This would allow you to still potentially achieve the maximum score in the Quality Performance Category even though you are reporting fewer measures than other clinicians.***

Cost Performance Category

- In 2020, the Cost Performance Category weight will remain at 15% of the MIPS Final Score. Performance will be based on the Medicare Spending Per Beneficiary (MSPB) Measure, the Total Per Capita Cost (TPCC) Measure, and applicable episode-based cost measures, all weighted equally.
  - All measures will receive a score of 1 to 10 points, and the final cost performance category score will average performance across all applicable measures.
  - If you do not qualify to be scored on any measure at all, then your cost category weight will go down to 0%.

- While performance on these measures will be based on the full 2020 calendar year, there is **no affirmative reporting obligation**: CMS calculates measure performance based off administrative claims data.

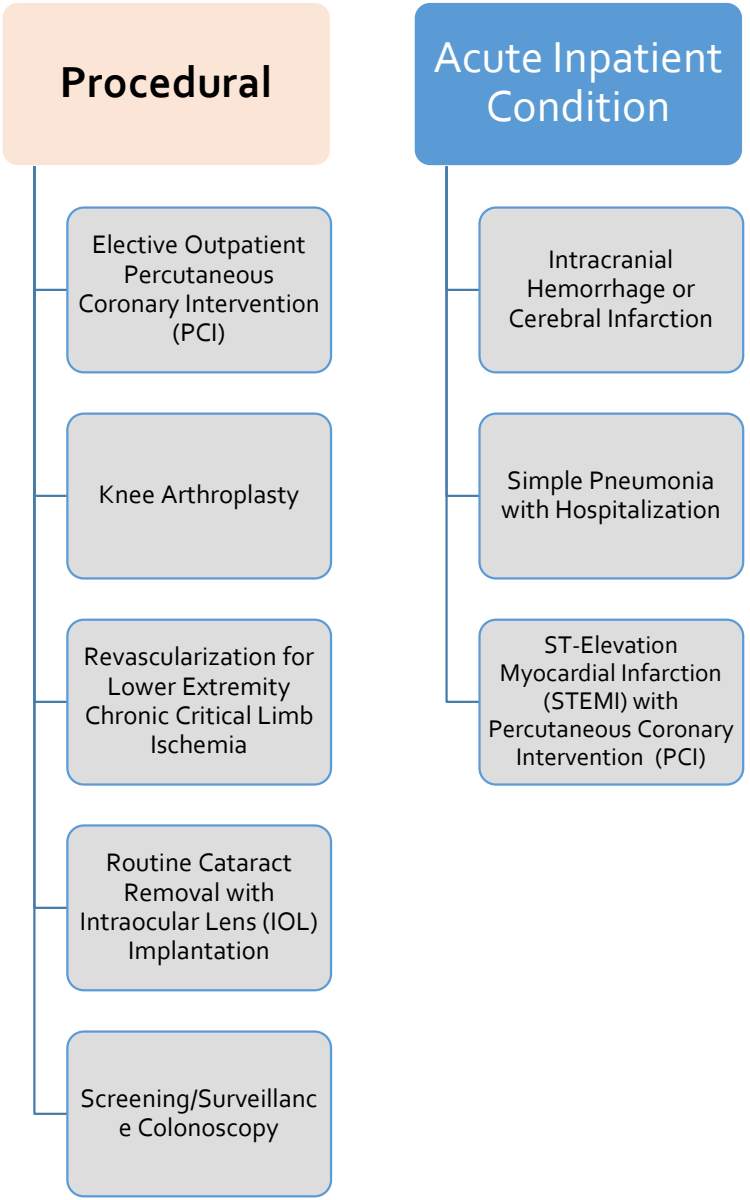
Reconfigured TPCC and MSPB Measures for 2020

- Key changes to TPCC measure:
  - Updates the attribution methodology **to better identify primary care relationships**, including by excluding certain specialties not likely to be responsible for primary care, **including PM&R**
  - Changes the risk adjustment methodology and assessment methodology **to evaluate beneficiaries' costs on a month-by-month basis, rather than an annual basis**
  - Requires a 20-beneficiary case minimum for groups or individuals to be scored
- Key changes to MSPB measure:
  - Current MSPB measure attributes at TIN/NPI level; new methodology **attributes at BOTH the group (TIN) and TIN/NPI level**
  - Creates **separate attribution methods for medical and surgical episodes** in order to "*ensure effective attribution and compare similar clinicians*"
  - Using a DRG-based methodology, attempts to **remove unrelated services from the cost calculation**
  - Requires a 35-episode case minimum for groups or individuals to be scored.

2019 Episode-Based Cost Measures

Procedural

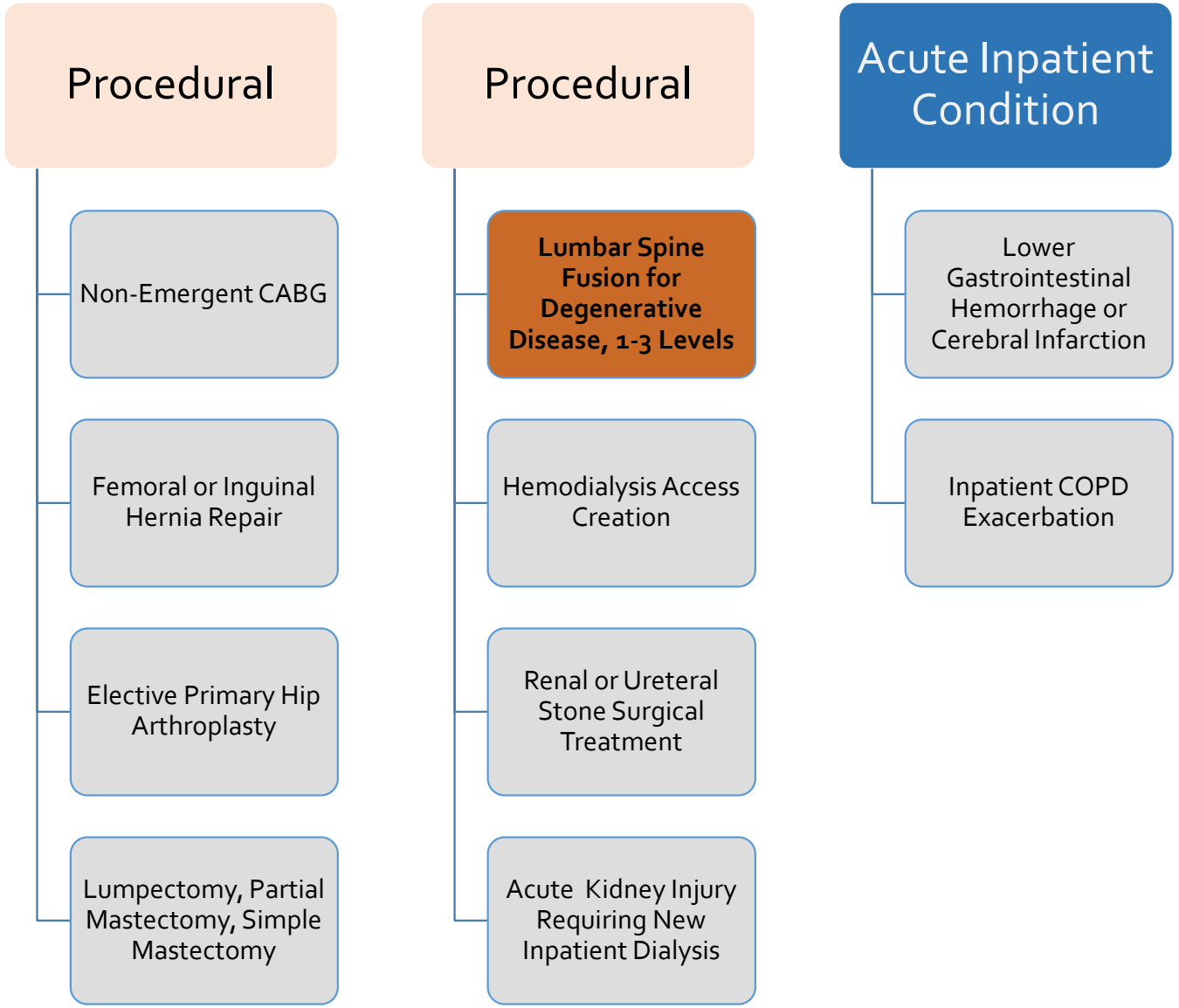
10 case minimum to be scored



Acute Inpatient Condition

20 case minimum to be scored

Additional Episode-based Cost Measures for 2020



Cost Performance Category: Reporting of Patient Relationship Categories and Codes

- Starting January 1, 2018, clinicians can now **voluntarily** report Level II HCPCS modifiers that reflect 5 patient relationship categories that CMS operationalized last year.
- These codes are intended to to communicate to CMS a clinician's role in patient care, to support more accurate attribution under the Cost Performance Category measures
- CMS expects to eventually incorporate these into cost measurement, but is not doing so at this time.

No.	HCPCS Modifier	Patient Relationship Categories
1x	X1	Continuous/broad services
2x	X2	Continuous/focused services
3x	X3	Episodic/broad services
4x	X4	Episodic/focused services
5x	X5	Only as ordered by another clinician

Promoting Interoperability (PI) Performance Category

- PI Performance Category (formerly Advancing Care Information) is premised on previous **EHR Meaningful Use** program
- Performance-based scoring across all measures (separate base and performance scoring discontinued)
- CMS is continuing to require use of 2015 Edition CEHRT for the 2020 performance period.
- Reporting is required for at least 90 consecutive days in 2020.
- Certain categories of clinicians (e.g. hospital-based clinicians; ASC-based clinicians) are eligible for automatic or application-based reweighting of the PI category.

Promoting Interoperability (PI) Performance Category

2020 Measures	Maximum Points
E-prescribing	10
Support Electronic Referral Loops by Sending Health information	20
Support Electronic Referral Loops by Receiving and Incorporating Health Information	20
Provide Patients Electronic Access to their Health Information	40
Report to two different public health agencies or registries for any of the following: • Immunization Registry Reporting • Electronic Case Reporting • Public Health Registry Reporting • Clinical Data Registry Reporting • Syndromic Surveillance Reporting	10
Bonus*: Query of Prescription Drug Monitoring Program (PDMP) (Yes/no response starting for 2019)*	5
~~***Bonus:*** *Verify Opioid Treatment Agreement*~~	~~5~~

Improvement Activities Performance Category

- Most physicians or groups will be responsible for sufficiently reporting **up to 4 IAs** to receive full credit under the IA Performance Categories
  - Small groups and physicians in rural areas and Health Professional Shortage Areas (HPSAs) may be eligible to report on 2 IAs and receive full credit
- Reporting under the IA Performance Category will be **attestation-based** (either through Registry- or QCDR- or EHR-based reporting options or via a CMS IA Attestation Website).
  - Not all registries, QCDRs, or EHRs are equipped for IA reporting so be sure to **confirm with your vendor**.
- Individuals or groups will have to attest to engaging in the activities for at least 90 continuous days.
- Scoring advantages under IA Performance Category for participating in Alternative Payment Models (APMs)

Improvement Activities Performance Category: Changes for 2020

- **Improvement Activities:** 2 new IAs, 7 modified IAs, and 15 IAs removed. New IAs include:
  - Drug Cost Transparency
  - Reporting of MACRA patient relationship codes using HCPCS modifiers (on 50 percent or more of claims)
- **Group Participation:** CMS increased the participation threshold required for groups to receive credit starting with 2020:
  - Current standard: At least 1 clinician must complete an IA for a continuous 90-day period
  - 2020 standard: At least 50% of clinicians in the practice need to perform the same IA during any continuous 90-day period

Facility-Based Measurement

- CMS finalized the availability of facility-based measurement for the quality and cost performance categories starting with the 2019 performance period.
- Facility-based individuals and groups could be scored on MIPS cost and quality based on an attributed hospital's performance under the Hospital Value Based Purchasing Program
  - Individual:
    - 75% or more of covered professional services furnished in inpatient hospital (POS 21), on-campus outpatient hospital (POS 22), or emergency department settings (POS 23); AND
    - At least 1 service billed in POS 21 or POS 23
  - Group: At least 75 percent of NPIs in the group determined to be facility-based at the individual level
- For clinicians or groups determined to be facility-based, CMS will use facility-based scoring if it results in a more favorable combined cost and quality score than data submitted via MIPS - ***no active election required.***

Facility-Based Measurement

- Clinician performance under facility-based measurement will be tied to an attributed hospital:
  - Individuals tied to hospital at which they provide services to most Medicare patients
  - Groups tied to hospital at which a plurality of their facility-based clinicians are attributed
- Clinicians can now look up information that applies for 2019 performance*, including:
  - Whether they are facility-based
  - What their attributed hospital is
  - What that hospital's Hospital VBP scores are that will apply for 2019 (only released in late October 2019)
  - ***HOWEVER: Clinicians will not know how their hospitals' performance translates to MIPS scoring by the 2019 submission deadline.***

*Data that will apply for 2020 performance is not yet available

Special Treatment of Small Practices

- If you practice in a group of 15 or fewer eligible clinicians, CMS has provided several special accommodations:
  - Continued availability of Part B claims based quality reporting (even for group reporting)
  - Minimum score of 3 points on all quality measures (even without meeting data completeness requirements)
  - Lower reporting burden under the Improvement Activities category
  - Availability of a "small practice hardship exemption" for the Promoting Interoperability category
    - Note that this exemption is not automatic or guaranteed
  - A small practice bonus of 6 points added to the numerator of the quality performance category

Final Scoring

- Final scores will add together performance across each category, adjusted for the weight of each category.
  - If CMS cannot score certain categories (e.g. the cost or PI category), then CMS will increase the weight of other categories (usually the quality category).
- CMS will add a "complex patient bonus" to the MIPS final score that is intended to account for the relative complexity of each clinician's patient population (subject to a cap of 5 points).

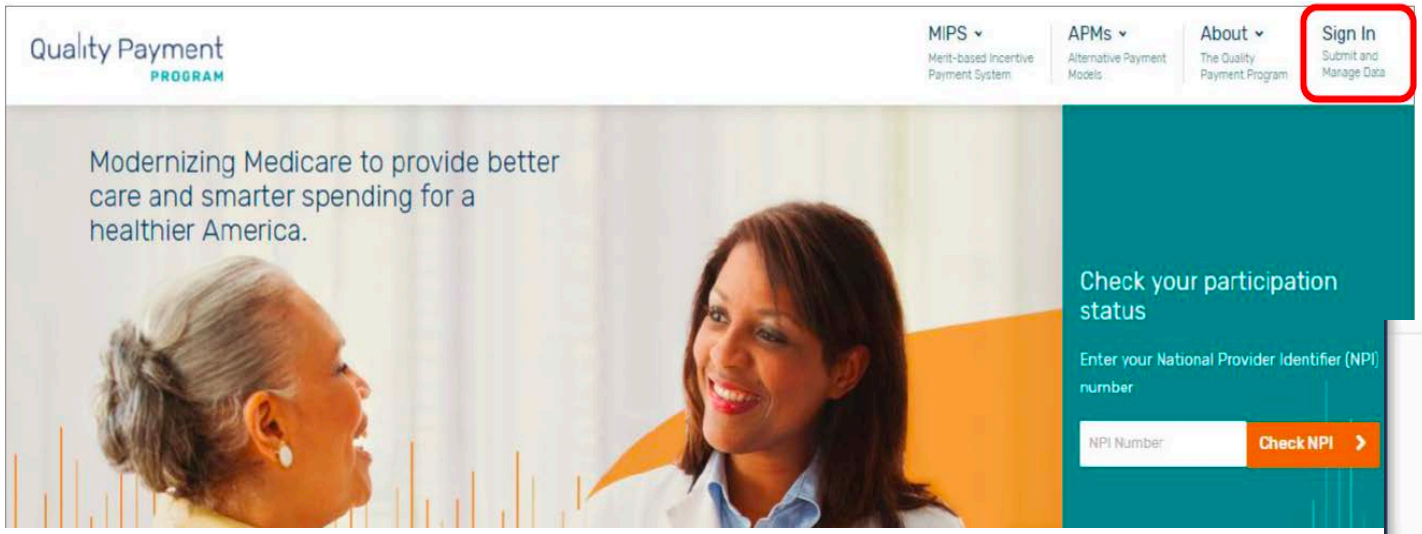
2020 MIPS Final Score

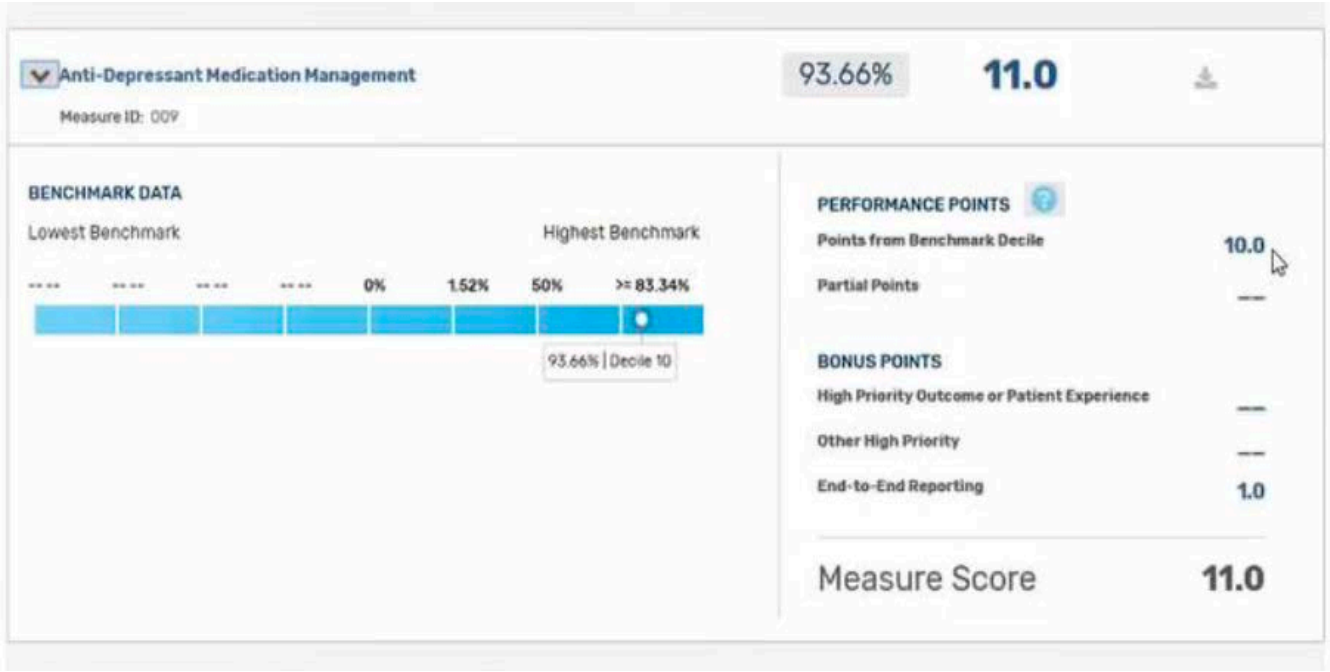
2020 Final Score	2022 Payment Adjustment
85 – 100 points	• Positive adjustment • Eligible for exceptional performance bonus
45.01 – 84.99 points	• Positive adjustment • Not eligible for exceptional performance bonus
45 points	• **Neutral payment adjustment**
11.26 - 44.99	• Negative adjustment > -9% and < 0%
0 – 11.25 points	• Negative payment adjustment of -9%

2017 and 2018 Performance Data

	2017 Performance	2018 Performance (Estimated)
Performance threshold	3 points	15 points
Participation rate	95%	98%
Overall national mean score	74.01	86.91
Overall national median score	88.97	99.63
Percent of clinicians qualifying for positive adjustment	93%	98%
Percent of small practices qualifying for positive adjustment	74%	85%
Percent of clinicians qualifying for exceptional performance bonus	71%	N/A
Maximum upward payment adjustment	1.88%	1.68%

Performance Feedback





Final for 2021: MIPS Value Pathways (MVPs)

- CMS finalized a new MVP participation framework that will start beginning in 2021.
- Rather than allowing selection from the full current measure and IA inventories, measures and activities in an MVP would be connected around a clinician specialty or clinical condition (e.g. diabetes or surgical care)
- CMS' goals for MVPs include:
  - Moving away from siloed activities toward an aligned set of more meaningful and relevant options that connect measures and activities across the 4 performance categories
  - Removing barriers to APM participation
  - Reduce reporting burden
- CMS anticipates working with stakeholders to develop this new framework, including developing MVPs that account for variation in specialty, size, and composition of clinical practices.
- CMS contemplated the notion of mandatory use of MVPs in the proposed rule, but has not decided one way or another.

Closing Reminders

- 2019 data submission runs through March 31, 2020.
  - Performance in 2019 affects payment in 2021, subject to a maximum negative adjustment of 7 percent.
  - A MIPS final score of 30 points is needed to avoid a penalty for 2019 performance/2021 payment.
- MIPS is not "all or nothing" like previous programs; in general, extra effort can help you move up the scoring ladder.
- Even if you are employed, ensure that reporting requirements are being met as MIPS applies to all entities submitting claims under the Medicare Physician Fee Schedule
- Available measures (and measure specifications and scoring) can change from year to year, so you will need to revisit your reporting strategy annually
- The increase in the performance threshold for 2020 and 2021 means that you will have to achieve higher scores to avoid a penalty. To have the best possible chance at achieving a positive update, develop a reporting strategy in the PI and Improvement Activities performance categories.

MIPS Outlook

- Despite criticisms, MIPS is not likely going away in the near future, and most clinicians will be required to participate in MIPS due to a lack of relevant Advanced APMs.
- For future years, CMS is required to continue increasing the performance threshold until it reaches mean or median performance by Year 6 (performance in 2022).
- CMS will continue to cap or remove topped-out measures and other "low value" measures. CMS will also move forward with its plans to implement MIPS Value Pathways. Clinicians and groups should take this into consideration when developing a long-term reporting strategy.

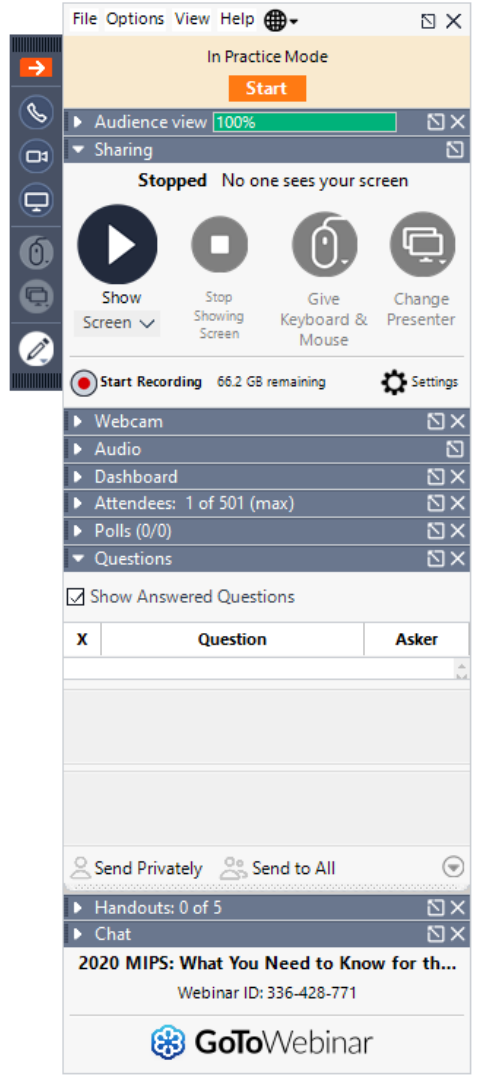
AAPM&R Resources

- Keep an eye out for the 2020 February and March *Physiatrist*
  - *February will include an article by Cindy Moon on 2020 Reporting*
  - *March will include a checklist of activities to do throughout the year to ensure you are on track*
- Website Resources
  - In February 2020, all AAPM&R MIPS Resources will be updated including:
    - MIPS Category Guides
    - MIPS Checklist
    - Additional Resources

Questions?

- As a reminder, please use the “Questions” feature to ask a question.

- E-mail: healthpolicy@aapmr.org



Appendices

Episode Parameters: Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels

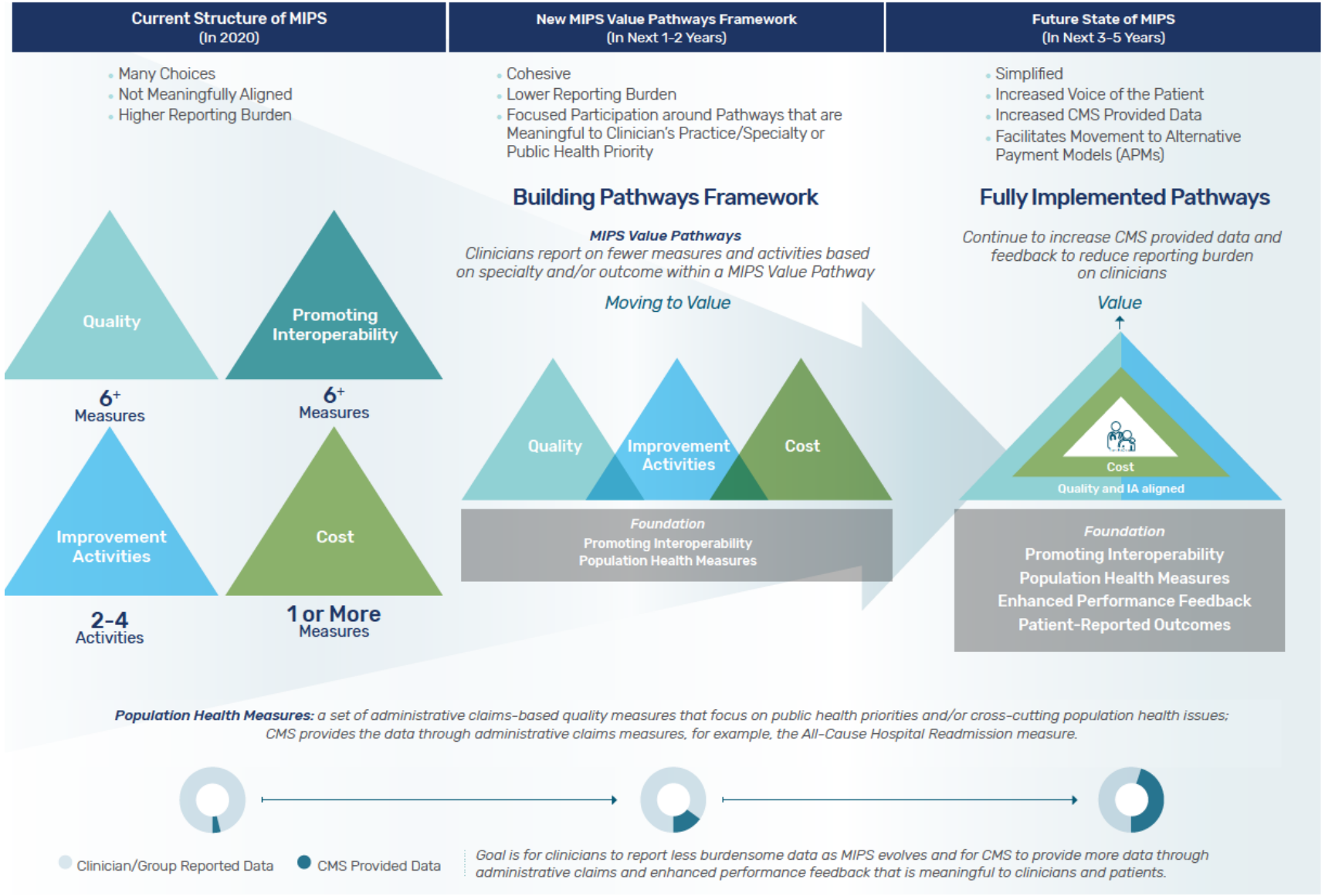
- "*[R]ecommended for development . . . because of its high impact in terms of patient population and Medicare spending, and the opportunity for incentivizing cost-effective, high-quality clinical care in this area.*"
- Triggered based on claims data from: ambulatory surgical centers (ASCs), hospital outpatient departments (HOPDs), and acute inpatient hospitals
- 30 days before trigger; 90 days after
- Generally includes:
  - Preoperative Work-Up
  - Anesthesia / Pain Management
  - Wound Care
  - Post-Acute Care
  - Durable Medical Equipment (DME)
  - Cardiovascular Complications
  - Thromboembolism (DVT/PE)
  - Infection and GI Complications
  - Mechanical Complication / Need for Revision
  - Neurological Complications

Episode Parameters: Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels

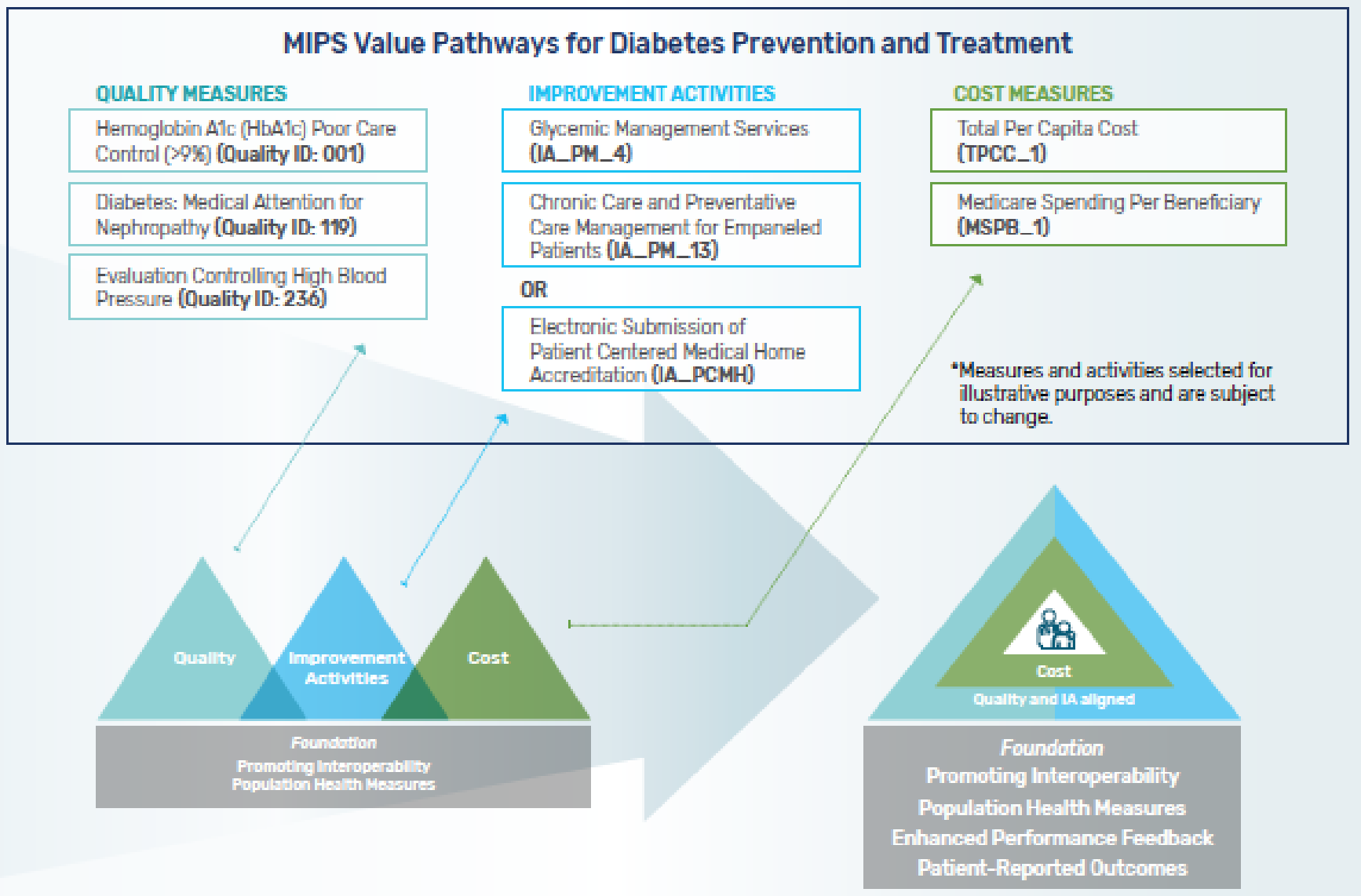
Episode Triggered by claim with CPT code:	
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar)
22612	Arthrodesis, posterior or posterolateral technique, single level; lumbar [with lateral transverse technique, when performed]
22630	Arthrodesis, posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace, lumbar
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace, lumbar
Subgroups:	
1.	One-Level Lumbar Fusion
2.	Two-Level Lumbar Fusion
3.	Three-Level Lumbar Fusion
Exclusions include (but not limited to):	
Cancer	
Infection	
Trauma	
Scoliosis/kyphosis	

MVP Illustrations

MVP Illustration



MVP Diabetes Example



MVP Surgery Example