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Climbing the Ladder of Opportunity (Part 1)

The death knell of spine surgery and the opportunity for doctors of chiropractic to ascend the health care ladder.

By J.C. Smith, MA, DC

President Obama spoke of building "ladders of opportunity" in his State of the Union and Inauguration addresses. Due to his goal and other serendipitous events, let me explain that now is the time for the chiropractic profession to jump on this opportunity to ascend the health care ladder. This could be the breakthrough our profession has been waiting for to assert ourselves as the portal of entry in spine-related disorders (SRDs).

While problems registering people for "Obamacare" have gotten most of the attention in the news recently, other policy issues to lower costs have suddenly appeared on the news radar that play to our advantage – namely the recent confrontation between the Centers for Medicare & Medicaid Services (CMS) and the medical spine care industry.

This should not be surprising inasmuch as this is the Affordable Care Act and the accumulating shocking evidence against the cost-and clinical ineffectiveness of spine surgery. A leading voice in spine care, Mark Schoene – editor of *The BACKLetter*, an international spine research journal – admits that "such an important area of medicine has fallen to this level of dysfunction should be a national scandal."[1] Well, this national scandal is finally being addressed head-on by CMS and the Office of Inspector General (OIG).

Payors to the Rescue

Indeed, the scandal and money in spine care are both shocking. According to the *Short-Term National Q3FY13 Report–Target Area Summary Report*, the cost for medical back problems (non-surgical) nationwide for CMS alone totaled $381,556,000 from Q4 FY 2012 to Q3 FY 2013. Spinal fusion totaled $3,504,705,000 for the same fiscal period.[2]

Both categories together totaled $3,886,261,000 (that's $3.8 billion), which explains why CMS is taking a very close look at the huge costs for spine surgeries and hospitalization.

Considering that in 2006, the Dartmouth Institute of Health Policy[3] suggested 30-40 percent of spine surgeries (and the associated hospitalization costs) were unnecessary, a 40 percent reduction in this $3.886 billion-dollar cost equates to a $1.554 billion savings for one fiscal year alone.

The Office of Inspector General also believes there is an abundance of Medicare fraud. According to the *Medicare Fee-For-Service 2010 Improper Payment Report*, the error rate was 10.5 percent or $34.3 billion in improper payments.[4]

In this light, it is odd that some pundits still wonder why "Obamacare" / health care reform is necessary. Obviously the need to control these outrageous medical costs and fraud are paramount, and the new CMS PEPPER program will lead the way to real change in spine care.

PEPPER: The Death Knell for Spine Surgeries?

Since 2000, spine surgeons have gone wild and hospitals have been their biggest enablers. CMS now has decided to enforce the guidelines and withhold payment for questionable disc fusions. In March 2012, spinal fusion procedures were finally placed on the Medicare Program for Evaluating Payment Patterns Electronic Report (PEPPER) target list, which also included hospital admissions that have the highest propensity for improper payments.

CMS has already rendered Decision Memos denying payment on many controversial issues in medical care, including spine procedures such as percutaneous image-guided lumbar decompression for lumbar spinal stenosis, lumbar artificial disc replacement and thermal intradiscal procedures. Now under scrutiny is spinal fusion for the treatment of low back pain secondary to lumbar degenerative disc disease.

According to Schoene, "A CMS non-coverage decision can be something of a death knell for proprietary surgical procedures, particularly in a condition where so many prospective patients are elderly and covered by Medicare or Medicaid insurance policies."[5]

Without meaningful competition or restraints, per-procedure hospital charges rose drastically and arbitrarily in all three categories of spine surgeries from 2004 to 2009:[6]

- Decompression rose from $19,518 to $28,250
- Simple fusion rose from $50,336 to $79,521
- Complex fusion rose from $67,597 to $118,799

But this cash cow may now experience leaner times if CMS has its way. According to "The Future of Spine Surgery: Pervasive Scrutiny & Shifting Trends Create Uncertainty for Inpatient Spine Procedures," by Todd Schuck, senior director, business development, Specialty Healthcare Advisers, CMS has given its regional payors, aka, Medicare Administrative Contractors (MAC), greater prepayment authority. That enhanced authority allows for denial of payment after a procedure has been performed. Each MAC can have slight variation of CMS policy, called a local carrier determination (LCD).

Apparently the hospitals' "open-door" policy for any surgeon to do any surgery on anyone for any reason is coming to an end. Perhaps of most significance to chiropractors is the requirement that patients scheduled for elective spinal fusion procedures must have well-documented attempts at various forms of conservative care beforehand, just as the Agency for Health Care Policy & Research (AHCPR) guideline #14 on acute low back pain in adults recommended 20 years ago.[7]

According to the LCD from First Coast Service Options, Inc., "Coverage Indications Limitations and/or Medical Necessity" states:

"Low back pain is a common disorder affecting 80% of people at some point in their lives. Causes stem from a wide variety of conditions, although in some cases no specific etiology is identified. Age-related intervertebral disc degeneration, typically resulting in degeneration of the discs themselves, facet joint

arthrosis, and segmental instability are causative factors. Initial management can include rest, exercise program, avoidance of activities that aggravate pain, application of heat / cold modalities, pharmacotherapy, local injections, lumbar bracing, chiropractic manipulation, and physical therapy. When conservative therapy (non-surgical medical management) is unsuccessful after at least 3 to 12 months, depending on the diagnosis, lumbar spinal fusion may be considered for certain conditions."

According to Schuck, when any MAC performs a Spinal Fusion-Medical Necessity and Coding Analysis, they expect documentation in the patients' medical charts to reflect the appropriate diagnosis and include the following:

- Pre-procedure radiological findings or mention of the radiology report result in the medical record
- Failed conservative measures/treatment prior to surgery
- Documentation of duration of pain and/or impairment of function
- Physical exam documenting the functional pathology
- Documentation of instability if applicable

Finally, CMS and some private payors, such as the North Carolina BC/BS,[8] now basically realize that "bad discs" are "red herrings," adroitly described by Donald Murphy, DC,[9] because the evidence does not support a purely pathoanatomical model for spine-related disorders. Why? Because they also appear in pain-free people.[10]

The Ax Man Cometh

This decision is a huge step up our ladder of opportunity when payors are denying payment for inefficient medical spine care based upon evidence-based reasons that will certainly reduce the tsunami of unnecessary spine surgeries.

In October 2013, an update from Palmetto Government Benefits Administrators (GBA), another regional MAC, revealed the results of its prepayment service review of "Medicare severity" diagnosis-related groups (MS-DRG). Palmetto's findings for MS-DRG 460 (spine fusions) in North Carolina, Virginia and West Virginia exposed high error rates regarding lack of medical necessity documentation, no doubt causing a panic among spine surgeons and hospitals when this Palmetto MAC refused to pay them.

According to data published on the Palmetto GBA website, a prepayment review of 251 claims in North Carolina, Virginia and West Virginia led to 168 claims either completely or partially denied. The total reviewed was $6,356,890 and $4,141,771 was denied, resulting in a charge denial rate of 65 percent.[11]

Imagine the shock wave when payment for 65 percent of fusions was denied! Finally, there appears to be some sanity in the medical spine industry, at least by the payors at CMS.

According to Barry Zeman, former hospital CEO and consultant for Specialty Healthcare Advisers, "Today, with greater pre-payment review authority being given to MACs, it's creating a whole new ball game. Under a pre-payment review, MACs have greater authority to examine the medical necessity documentation prior to making payment. ... With ICD-10, the days of performing cases with less than adequate documentation are gone forever."[12]

Bloody Hospital Hands

Certainly hospitals are not above this fray. OIG and CMS are keenly interested in decreasing not only unnecessary surgeries, but also unnecessary hospitalization that is the most obvious benefactor and expensive element in this medical fraud.

On the average, Medicare pays these hospitals about $31,000 for each spinal fusion and surgeons about $12,000 per procedure.[13] Despite pleas of being nonprofit, hospital CEOs earn an average of almost $600,000 a year and the CEOs at hospitals with teaching institutions have a median salary of more than $1.66 million.[14]

The next round of the PEPPER guidelines has flagged these short-term, acute-care hospitals that are performing more than their "fair share" of spinal fusion procedures. CMS will focus on the medical necessity and, because most spinal-fusion procedures are performed on an inpatient basis to qualify for Medicare reimbursement, hospitals will have to evaluate whether patients need them at all. No longer can hospitals have an open-door policy to any surgeon who wants to fill a bed.

"This target area is different from most other admission target areas because we are not just asking hospitals to question whether the patient needed to be admitted. It's deeper – it's whether the patient needed the procedure, and if the patient didn't need the procedure, the admission most likely is not medically necessary," says Kim Hrehor, project director for TMF Health Quality Institute, which generates PEPPERs for CMS.[15]

"Medicare now requires physicians to document more conservative treatments before ordering spinal fusion, an expensive surgery that may have serious repercussions ... you would hope physicians would try the conservative route first without jumping into surgery," according to Hrehor.

Follow the Money

The media has also jumped on this tsunami of spine surgeries and hospitalization. On Oct. 27, 2013, *The Washington Post* published yet another critical article on spine surgery: "Spinal Fusions Serve as Case Study for Debate Over When Certain Surgeries Are Necessary," by Peter Whoriskey and Dan Keating. [16]

This is a must-read that includes the frank conclusion: "But at a broader level, the rapid rise of spinal fusions in the United States, especially for diagnoses that generally don't require the procedure, has raised questions from experts about whether, amid medical uncertainty, the financial rewards are spurring the boom."

The Washington Post investigation clearly illustrated this tsunami of spine surgeries in Florida alone:

- Fusions increased 16-fold from 969 in 1992 to 15,599 in 2012.
- Average case cost nearly tripled from $40,996 to $111,662.
- Half of the 15,599 were deemed of questionable necessity.
- Medical device and supplies also rose from $12,548 in 1992 to $50,570 per case in 2012.

The article revealed the huge costs of hospitalization and surgery for back fusion, so is it any wonder hospitals do not want chiropractors on staff when they would lose more than $100,000 per case?

DCs are too cost-effective to please hospital administrators inspired by a "perverse motivation" to use the most expensive treatments. Obviously money – nay, *a lot* of money – still drives the American medical spine industry, despite the research and guidelines to the contrary.

Stark Reality

The *Post* article also revealed that the Department of Justice is prosecuting a landmark case in what could turn out to be the largest Stark Law violation in U.S. history against Daytona, Fla.-based Halifax Medical Center [*U.S. ex rel. Baklid-Kunz v. Halifax Medical Center*].

The Stark Law concerns a limitation on certain physician referrals with hospitals if the physician has a financial relationship such as ownership, investment or compensation arrangements.

The government claims Halifax's contracts with nine physicians were improper, contending that the hospital improperly "incentivized" their physicians. Potential damages and penalties in the suit could hit $1 billion, making it one of the largest of its kind. In addition, the DOJ is seeking $750 million to $1 billion for 74,838 claims made between 2000 and 2010, totaling up to $823.2 million in penalties.[17]

Dr. Fredrico Vinas, a spine surgeon at the Halifax hospital, is accused of performing spinal fusion procedures that were not medically necessary. A news release by the hospital said, "Dr. Vinas requires every patient to have failed maximal non-surgical treatment, extensive physical therapy with analgesics and anti-inflammatory drugs as well as procedures by an independent interventional pain specialist."[18]

Notice there is no mention of chiropractic care or SMT in his definition of "maximal" nonsurgical treatment. As well, this typical medical protocol of drugs, PT, and epidural injections by an "interventional pain specialist" preceding surgery is the same medical care that has already been branded as "the poster child for inefficient spine care."[19]

Not only is this case that of a whistleblower patient suffering failed back surgery against an alleged knife-happy surgeon enabled by a greedy hospital; it may also be a case of the lack of legal informed consent if Dr. Vinas did not mention chiropractic care as part of "maximal" nonsurgical care.

The *Post* article said that the Halifax case will serve as a case study on the many financial incentives that come into play when a surgeon is deciding whether or not to operate, including kickbacks from Big Pharma, device manufacturers, MRI centers, and hospitals that pay surgeons for filling beds.

For example, another recent investigation into medical payola by the Senate Committee on Finance found the medical device giant Medtronic paid one spine surgeon $1.28 million in royalties in the first three quarters of 2010.[20]

According to *The Washington Post*, attempts by insurers and Medicare to curb excessive surgeries in the past have been squelched by negative publicity and heavy lobbying by the American Medical Association, the American Hospital Association, and the North American Spine Society (NASS), as we saw in the AHCPR aftermath.

In response to the *Post* article, the NASS Executive Committee responded with a press release stating:

"NASS is collaborating with Medicare and private insurers carriers to develop evidence-based guidelines for surgical intervention and to define conditions that are best treated without surgery. Spinal fusion is currently undergoing rigorous scrutiny; the indications for spinal fusion are being evaluated and re-evaluated constantly in an effort to develop optimal indications to serve the best interest of the patient."

Lest we remind CMS and NASS that despite "an effort to develop optimal indications to serve the best interest of the patient," the initial comparative study "to develop evidence-based guidelines" to determine the best algorithm for treatment began more than 20 years ago when the AHCPR conducted the most extensive meta-analysis ever done.[21]

Since 1994, many comparative studies21 have confirmed the inefficiency of medical spine care, such as the AHCPR's conclusion only one in 100 cases of acute low back pain requires surgery. This agency also failed to recommend narcotic painkillers, epidural steroid injections, standard physical therapy, or the majority of medical methods routinely used by the medical spine industry for spine-related disorders.[22]

However, the AHCPR's *Patient Guide* did list three "proven treatments" for acute low back pain in adults:[23]

- "Over-the-counter NSAIDs, which 'have fewer side effects than prescription medicines.'
- "Heat or cold applied to the back.
- "Spinal manipulation. This treatment (using the hands to apply force to the back to 'adjust' the spine) can be helpful for some people in the first month of low back symptoms. It should only be done by a professional with experience in manipulation."

The recommendation for SMT should not come as a surprise, considering NASS admitted in the October 2010 edition of *The Spine Journal* that spinal manipulation should be considered before surgery:[24]

"Several RCTs (random controlled trials) have been conducted to assess the efficacy of SMT (spinal manipulative therapy) for acute LBP (low back pain) using various methods. Results from most studies suggest that 5 to 10 sessions of SMT administered over 2 to 4 weeks achieve equivalent or superior improvement in pain and function when compared with other commonly used interventions, such as physical modalities, medication, education, or exercise, for short, intermediate, and long-term follow-up. Spine care clinicians should discuss the role of SMT as a treatment option for patients with acute LBP who do not find adequate symptomatic relief with self-care and education alone."

The NASS also admitted on its website: "Fusion under these conditions is usually viewed as a last resort and should be considered only after other conservative (nonsurgical) measures have failed."[25]

The admission by NASS that fusion should be a *last* resort and that SMT is a *first* resort has been unheard by the public and ignored by spine surgeons, hospitals, and general medical practitioners. Indeed, the medical inability to follow guidelines speaks louder than the lofty words expressed by the NASS "to develop evidence-based guidelines for surgical intervention and to define conditions that are best treated without surgery."

It appears NASS is simply blowing smoke to buy time by obfuscating the situation, but hopefully that deceptive talk will soon change. According to Schuck, "It appears likely that concentrated examination of the spine market consisting of pre- and post-payment reviews are here to stay" despite the protests of NASS or hospital CEOs.

Editor's Note: Part 2 of this article is scheduled to appear in the April 1 issue. A comprehensive reference list accompanies the online version of part 2.

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