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MESSAGE FROM THE MEDICAL EDITOR

Troubled Times

“We have the best Congress that money can buy.”

Will Rogers

“Money is better than poverty, if only for financial reasons.”

Woody Allen

“Money can’t buy you happiness, but it does bring you a more pleasant form of misery.”

Spike Milligan

**Facing an economic crisis,
our health care system
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On Tuesday, January 13, 2009, Michael Casey from Associated Press Wire Service reports described an effort to preserve sea birds on Macquarie Island. Located about halfway between Australia and Antarctica, Macquarie is the only island composed entirely of oceanic crust. All the cats on the island were removed or exterminated. Unfortunately, this led to an explosion in the rabbit population. The rabbits destroyed the vegetation that the birds required for cover. Ultimately, the move hurt the birds far more than the cats ever could have.

This story provides another illustration of the law of unintended consequences. Manipulation of complex and sensitive systems carries with it both risks and benefits. Change in one area typically impacts others. Facing an economic crisis, our health care system finds itself with reduced tax income to fund an increasing population of uninsured families. President Barack Obama has made health care reform a priority. In Congress, Senator Grassley leads efforts this year on the Sunshine Act which seeks to illuminate financial relationships between physicians and the device and pharmaceutical industries.

Building Bridges

Within the spine world, we face significant, but more specific challenges. NASS seeks

to keep its membership informed and engaged. In this issue of *SpineLine*, Dr. Branch’s President’s Message discusses both the organization’s and our individual roles as NASS members to inform these changes. He uses the analogy of bridge building to describe ongoing NASS efforts to partner with other specialty societies interested in spine care.

Dr. Branch cites these collaborative efforts’ importance in preserving patient access to increasingly scarce medical resources. He provides several examples. One reflects the ongoing MEDCAC (Medicare Evidence Development & Coverage Advisory Committee) panel examining the use of fusion in degenerative lumbar conditions. Initially assembled to examine the efficacy of fusion for axial low back pain, the MEDCAC inquiry has expanded to include fusion for other degenerative conditions. One of the problems has been clearly defining degenerative disc disease as an entity. Spine specialists will increasingly need to present their rationale for the treatments they offer and provide assistance in interpreting an often confusing nomenclature so that unrelated conditions and issues aren’t conflated.

Another coalition of spine societies presented lumbar and cervical disc replacement data to a Washington State panel. In this instance, the panel preserved patient access to these technologies in that state. These challenges to our practices will continue and

intensify. Failure to respond to these challenges will lead to redistribution of scarce health care resources into other areas and increasing limitations to the services we are able to provide.

Patient access to spine technologies is being actively assessed at the national level as well. In this month's socioeconomics and policy column, Donna Lahey, from the Spine Institute of Arizona and a member of the NASS Surgical Coding Committee, discusses the burgeoning CMS National Coverage Determinations (NCD) process. These NCDs seek to limit geographic variability in medical product and procedure coverage. Initiated in July 2008, the process began with a public comment period. As Ms. Lahey reports, any stakeholder can request an NCD, but many requests are internal to the CMS. For the comment period ending on September 28, 2008, four spine topics were identified: BMPs, vertebral augmentation procedures, lumbar fusion and cervical disc arthroplasty.

NASS joined other professional organizations by forming a task force to comment on coverage decisions for these expensive treatment modalities. Absent deformity or instability, the Task Force recommended that lumbar fusion not be covered in either Medicare or non-Medicare patients. The Task Force recommended coverage for vertebroplasty and kyphoplasty. Additionally, they wrote that, because kyphoplasty confers no additional benefit over vertebroplasty, it should not be reimbursed at a higher level. The Task Force recommended coverage for BMPs used in anterior lumbar fusions only. For cervical disc replacement, the group noted that the study groups did not include typical Medicare patients, but did recommend coverage in the non-Medicare population.

Obviously, for our voice to be heard, we will have to come together and provide a united front. This means that we individually will not always agree with the collective decision. Divisiveness will only cost us our seat at the table. Similarly, our answers cannot always be, "fund that at the highest possible level." We have

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to police our own use of scarce medical resources. Occasionally, the perspectives of NASS differ from the other organizations to which we belong. Rather than allowing payers and other stakeholders to "divide and conquer," Dr. Branch urges us to come together and foster the bridges between groups.

Ethics and Incentives

If seen as compromised, as individuals or as an organization, our efforts will have little impact. As with the Sunshine Act in Congress, our Ethics column this issue discusses conflicts of interest (COI). Jerome Schofferman, MD, from the SpineCare Medical Group and John Banja, PhD, from the Center for Ethics at Emory University present their article from the journal, *Pain*. This article examines conflicts of interest and their potential to influence medical decision-making.

The article begins by stating that a COI exists if "a reasonable observer finds it plausible that the average person could be (not necessarily would be) swayed by secondary interests." In this setting, primary interests include optimal patient care, the protection of research subjects and the presentation of unbiased information to audiences. Secondary interests, typified by financial relationships with the device and pharmaceutical industries, also include personal motivators (animosity or friendship) and professional interests (career advancement). Direct economic incentives include the reimbursements physicians receive for providing care.

Indirect or derivative economic incentives include consultancies and industry gifts. The authors report that these fees stimulate an unconscious need to reciprocate. Research has shown that profes-

sionals do not resist these influences well. Industry conflicts do not always affect physicians individually. For example, for every dollar spent on CME, industry revenues increase \$3.56. Given that industry funds 60% of CME activity, this nearly 400% return on investment must be quite impressive. Similarly, COI may affect research outcomes. In a study from Jefferson University published in *Spine* in 2005, industry-funded studies were 3.3 times more likely than other funding sources to yield positive results.

For each type of conflict, clear recommendations seek to change prevailing practices. Drs. Schofferman and Banja suggest that today's conflict resolution methods actually backfire. After disclosure, speakers present more biased advice. They call this "moral wiggle room." Similarly, to avoid the appearance of mistrust, patients are less likely to seek additional opinions after a COI has been disclosed. Ultimately, divestment is the only solution. Clearly, this divestment would require a massive change in the current medical culture. While many spine practitioners accept consulting fees or other remuneration from "industry," these fees are far from the strongest conflicts in their daily practice life. When seeking change, we should also consider the influence of insurance status, personality issues and language and race differences.

Although a consulting relationship may affect the brand of implant a patient receives, insurance status has far more wide ranging effects on care options. In many situations, the provider has to pay to provide the service. Currently, professionals cannot write pro bono services off their taxes. Allowing them to do so may provide an incentive to provide more care

to uninsured and Medicaid patients. Although arguably a form of cost shifting, a legislator in Missouri, State Senator Jason Crowell, has offered legislation that provides health care workers tax benefits as an incentive to see more Medicaid patients. In an Associated Press article, Mr. Crowell states, "It is an acknowledgment that we are not at the Medicare reimbursement rate and we are not covering costs. This is another way to hopefully prevent doctors, especially those providing specialist care, from refusing to see Medicaid patients."

When reimbursements fail to cover the cost of delivering care, "nonparticipating" doctors may bill patients for the balance. Here, the patient submits a claim to his insurance company. Any difference between the doctor's bill and the insurance company's settlement is borne by the patient. More typically, doctors simply accept the insurance company's payment. A physician participating in Medicare may not balance bill the patient. The doctor has agreed to the reimbursement level established by CMS. A similar relationship exists for doctors on an insurance company's preferred provider list.

Problems arise when patients are seen at nonparticipating hospitals, typically for urgent or emergency care. In California, the state Supreme Court recently ruled that physicians may not balance bill patients when they feel the insurer or HMO has underpaid them. Consumer groups laud the decision as a step to lift a "crushing" financial burden from patients' backs. But, in the long run, does this decision really help patients? As another example of unintended consequences, we can see an effort designed to protect patients financially, ultimately hurting them. In the long run, more physicians will simply refuse to provide ER coverage. Patients will have to travel longer distances to reach "in-network" facilities. Outcomes and follow-up difficulties will occur.

On one level, patients are more responsible for this situation than the media and common wisdom allow. Each of us signs on to an insurance plan, but few really understand the limits of the coverage. Even physicians poorly understand their

own coverage. Insurance policies are often written in dense legalese. Additionally, many patients have little choice in their insurance. Either their workplace provides limited coverage options or they simply cannot afford "Cadillac" policies.

Influence of the Tort System

The last few months have seen interesting developments on the medicolegal front. The California Supreme Court Case, *Van Horn v Watson* (2008 WL 5246046 [Cal. 2008]), has been widely reported. In this case, five individuals who had all been drinking, left a bar in two cars. Glen Watson lost control of his car and hit a light pole, causing the front air bags to deploy. Watson's passenger, Alexandra Van Horn, was stuck inside the car. A passenger in the other car, Lisa Torti, rendered aid. She pulled Van Horn from the car because she thought she saw smoke and a leaking liquid. Torti did not realize that Van Horn had a vertebral injury. Van Horn is now paraplegic. Of course, she sued Watson, the driver of her car. This case is interesting because she also sued Torti for negligently rendering aid. In California, the Good Samaritan statute protects individuals acting in good faith and rendering uncompensated care outside of a place in which health care is usually offered. In this case, the court concluded that Torti, in pulling Van Horn out of the car, was not actually rendering medical care and, therefore, was not protected by the statute.

While the Van Horn case may engage the reader, for spine specialists, a recent report on the Massachusetts Medical Society's (MMS) Web site offers more pertinent information. In November 2008, the MMS released the first in-depth study of "defensive medicine" across a wide spectrum of specialties and locations. Defined as tests, procedures, referrals, hospitalizations or prescriptions ordered by physicians out of the fear of being sued, the survey found defensive medicine to be widespread and expensive. In Massachusetts alone, the group "conservatively" estimated an annual minimum \$1.4 billion of medically unnecessary costs. Tests and diagnostic procedures ordered by physicians outside

of the eight specialties surveyed were not included. Observation admissions to hospitals, specialty referrals and consultations, and unnecessary prescriptions costs were also not included.

The study, the first to link defensive medicine directly with Medicare cost data, was conducted by Manish K. Sethi, MD, of the Department of Orthopedic Surgery of Massachusetts General Hospital and Robert H. Aseltine, Jr, PhD, of the Institute for Public Health Research at the University of Connecticut Health Center in Farmington. The report may be found at www.massmed.org/defensivemedicine.

Aside from the costs alone, malpractice fears reduce patient access to care. For example, 76% of the neurosurgeons and 51% of the orthopedists altered or limited their practice because of the fear of being sued. Eighty-three percent of physicians reported practicing defensive medicine. More specifically, a high percentage of various tests were ordered primarily for defensive reasons:

- 22% of X-ray studies
- 27% of MRIs
- 18% of laboratory tests
- 28% of specialty referrals and consultations
- 13% of hospital admissions

Dr. Sethi concluded that "the fear of medical liability is a serious burden on health care...The fear of being sued is driving physicians to defensive medicine and dramatically increasing health care costs." The authors added that these costs are the single biggest threat to health care reform.

Medicolegal issues have a significant impact on our Curve case. Section editor Heidi Prather, DO, presents a case of a 42-year-old police officer with a nine-week history of cervical radiculopathy and severe arm pain. To date, medical surgical management has failed to improve the pain and the patient has difficulty sleeping and working. At issue are the relative risks and benefits of cervical injections in this patient.

The types of cervical injections are dis-

cussed, especially the differences between selective nerve root blocks, which do not extend medial to the dorsal root ganglion and are performed with local anesthetic only and transforaminal injections. Drs. Behr and Fish from ULCA discuss the significant risks associated with intraforaminal cervical injections. Injections should be avoided when possible, but, if performed, an interlaminar technique is recommended. Dr. Smuck from Stanford assesses the same literature and reaches a different conclusion. Recognizing the severity of the complications associated with transforaminal injections, he suggests that they are more likely to reach the target pathology than are interlaminar injections. While admitting that prospective studies documenting the efficacy of various safety measures such as digital subtraction angiography are not available, the difficulties and ethics of this type of trial render it impractical. With experience and detailed knowledge of the anatomy and safety measures, Dr. Smuck contends, transforaminal injections can be performed with a reasonable degree of safety.

Cost Shifting, or, How Much Does Health Care Really Cost?

While the tort system adds markedly to health care costs, significant cost shifting occurs even within the typical group of payers. A recent study found Medicare and Medicaid reimbursements at levels often below the true cost of care delivery. John Pickering and Will Fox, principles and consulting actuaries at Millman, an independent consulting firm were paid by a group of private insurers, to provide the report.

This underpayment, these consultants claim, forces health care providers to pass unreimbursed costs to private indemnity carriers. The average family of four spends \$1,788 more on health care than they would if Medicare and Medicaid reimbursements were in line with private insurers. This is roughly a 10% surcharge. While a significant proportion of these funds comes from employers, families bear nearly \$400 directly in premiums. An additional \$276 is charged in coinsurance

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and deductibles. For families for whom health coverage teeters on the brink of affordability, this “hidden tax” puts insurance out of reach. Similarly, for small businesses struggling to provide health care benefits, these costs may push them over the edge. In that bad debt and charity care were not considered, the report likely underestimated the full extent of this cost shifting.

The recent collapse of the banking industry seems to have increased medical school applications. Will this interest last? Last month, the *New England Journal of Medicine* reported that almost one quarter of US medical students graduate more than \$200,000 in debt. Including associated fees, public medical schools cost state residents a median \$44,390 per year. Private school cost \$62,243. While medical students have more than \$2.5 billion available as financial aid, most of this money takes the form of nonsubsidized loans. The authors of the *NEJM* article claim these expenses limit entry to the profession. Further, the steep costs not only discourage low-income students from pursuing medical school, they also sway graduates toward higher-earning specialties.

Technology

The Invited Review this issue sits at the junction between new technology and malpractice risk. Dr. Chetan Patel discusses the evolution of computer-assisted spinal surgery. As with voice recognition software, computer-assistance for surgery has advanced dramatically. Users who have not recently tried the technology will be surprised at how much faster and more user friendly it has become.

We all like to pretend that implant malpositioning no longer occurs (espe-

cially in “our hands”). The literature does not agree. With guidance, we can reduce malposition rates and optimize screw trajectories. The more confident the surgeon is in the placement, the more likely they are to aggressively size and medialize the screws, especially in revision cases in which landmarks are altered or absent.

Computer assistance not only decreases radiation exposure, but may also decrease infection rates. With one of the newer systems, only a single pass from the imaging machine is required. Afterward, the extra personnel and the machinery can be excused from the room. Second passes of imaging machines have high rates of contamination. (Biswas D, Bible J, Whang PG, et al. Sterility of C-arm fluoroscopy during spinal surgery. *Spine*. 2008;33(17):1913-1917)

In our Coding Column, Chris Kauffman, MD, and David O’Brien, MD, present updates specifically focused on the application of newer technologies. First, language has been added to spinal decompression code 63020 (and previously 63030 and 63035) to incorporate endoscopic technique. The RVU assignment is identical to similar procedures performed in a traditional, open manner. Second, a CPT code has been assigned to cervical disc arthroplasty. Unfortunately, the procedure is given 43.15 total RVUs, significantly less than the 75.18 RVUs awarded for the predicate procedure, anterior cervical decompression, fusion and plate fixation. The cervical disc arthroplasty code, 22856, can be used alone, only. Cervical disc arthroplasty takes longer than a one level ACDF and requires more radiation exposure. As conflicts of interest are concerned, which will exert a greater influence on spine surgeons, a pen

from an implant company or getting paid less to do more work?

What Can We Do?

Dr. Branch gave us an overview of the bridge building needed to maintain access to quality spine specialty care. In this month's advocacy column, Raj Rao, MD, and Nicholas Schilligo provide both the imperative and the tools for advocacy for our patients and our practices. Previously, advocacy may have been an activity left to others, if practiced at all.

Today, too many groups can stake legitimate claims on our country's financial resources to assume that expensive spine care from serial injections to revision surgeries will continue to be funded. CMS has initiated far-reaching discussion of which technologies should be covered. Where the CMS goes, other payers will follow. President Obama's HHS nominee, whoever it may be, is expected to propose an aggressive plan for reforming our health care system.

We need to make a solid case for our services and the benefits they provide. Otherwise, one by one, important treatment modalities will lose coverage or will be reimbursed so poorly that we are no longer able to provide them. We need a seat at the table. As a first step, *actively* support your professional organizations' efforts. Most of us belong to several groups. Use your membership to bring the organization together to form a united front. None of us is "too busy" any longer to leave advocacy to others. Our collective efforts are important, but so too is

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our individual involvement. Advocacy is something each of us must do, or we won't be too busy any more. Call it an investment in our practices and in our ability to continue to provide quality care for our patients.

Dr. Rao and Mr. Schilligo describe the tools that make this process easy and pain free for the busy practitioner. NASS provides an online Legislative Action Center. This site allows you to send your representatives a message anytime night or day. You can research active legislation. Key bills are highlighted. Start at the local level. Get to know your representatives. More important, make sure they know you. Make sure they know your patients' struggles (and yours). They probably don't know (mine didn't) that when we get up at 3 AM, we usually LOSE money. Many don't know that our charity care cannot be deducted from our taxes. Teach them. Remind them that we will all be patients one day. Increasingly, we have to enlist our patients in these efforts as well. Increasingly, in-office discussions will include options NOT available. Patients should be educated as to how these matters impact them (the most). The NASS site allows patient access. Their appeal to

their legislators is also critical in preserving access.

Opportunities abound for NASS members to become more involved in the advocacy process. The Spine Advocates program is a free support service NASS offers members and patients interested in grass roots activities. Beginning with more regular telephone and email communication, the program supports Spine Advocates' activities in meeting with lawmakers and candidates locally and in Washington. Activities can range from simply hosting the lawmaker in a tour of your facility to talking with providers and patients to better understand their concerns, to providing testimony on Capitol Hill.

Advocacy at the local, state, and national levels is about personal relationships with lawmakers and their staff. The authors provide a number of practical examples of steps members can take to begin, foster and mature these relationships.

With this issue, I celebrate my second anniversary as the *SpineLine* editor. The great ideas for each issue arise from the *SpineLine* Editorial Board. The Board is always looking for new ideas and contributors. We'd love to hear from you!