

Editorial

The Demise of Surgical Code # 63020: why health care costs must be transformed into widgets

Neurosurgeon [Dr Wise] rendering a second opinion after full evaluation: “Well, Ms Paine, you have a ruptured disk in your neck which is pinching a nerve. If the pain is at an intolerable level, then I agree with Dr Young that you are a candidate for surgery.”

The patient, a college student [Ms Paine]: “Dr Wise, I just can’t tolerate this pain anymore. When can I have the surgery? Dr Young is leaving town for a vacation and I wish to go ahead and schedule it with you. He did tell me briefly about the procedure, but he didn’t go into much detail.”

Dr Wise: “There are 2 ways to take out a ruptured disk in the neck—one is through the front of the neck, the other is from the back. In your case, I recommend that we do it from the back.”

Ms Paine: “Dr Young didn’t mention anything about an operation on the back of the neck. He operated on a friend of mine who, I think, had a similar problem and she had her surgery in the front of her neck—and she seems to be doing well. I believe she told me she had a ‘fusion’ of the bones in her neck.”

Dr Wise: “Well, I believe the posterior procedure, from the back of your neck, is better for you for several reasons; they have to do with potential complications, though rare, from an anterior fusion. So when you examine the pros and the cons, I recommend the posterior operation, which is called a ‘cervical laminotomy’.”

Ms Paine: “What are the pros and the cons of both types of operations?”

Dr Wise: “I believe the only advantage of an anterior operation, in such a case as yours, is that there may be less pain in the initial period after surgery. From the front, we operate along natural planes of the neck and therefore spread the tissues rather than doing any cutting of tissue. From the back, we have to separate the muscle from the backbone, which causes more pain during the first week or so following the surgery.”

Ms Paine: “All right, then what are the negatives about a fusion from the front of the neck?”

Dr Wise: “There are several, in my opinion. First, though there is less pain than from taking the muscle off the back of the spine, there are some potential problems from spreading and retracting the tissues in the front of your neck. For instance, some patients have some difficulty swallowing for some weeks after surgery. Also, patients can wake up with hoarseness, though this is rare. Another common complaint, for some days or weeks after a fusion, is a pain or pressure sensation in the back, between the shoulder blades. But again, all these problems are unusual and if they occur, they almost always clear up in a matter of weeks.”

Ms Paine: “These don’t seem so bad. Are there any serious complications?”

Dr Wise: “Anytime we operate around the spinal cord and nerves, there is always some potential for injury causing weakness or paralysis, but this is the case with either approach. However, from the front there is one dreaded complication, which involves the development of a blood clot between the spine and the windpipe. This can be a very dangerous and scary scenario, but it is rare and certain preventative measures can be taken.”

Ms Paine: “Can such a complication result from the operation from the back?”

Dr Wise: “Not really. The main complication from the posterior approach is inadvertent injury to the nerve when it is manipulated to remove the small piece of disk underneath. This can result in weakness or numbness, though rarely functionally significant or permanent. This is basically a matter of careful technique, rather than an unexpected complication.”

Ms Paine: “And you have done many of these types of operations?”

Dr Wise: “Yes, from both approaches. And let me say again, that my preference for you is specific to the type of pathology that you have. There are times when an anterior fusion is the best approach.”

Ms Paine: “It’s a bit confusing. But I gather that if it were you, or your daughter or wife, you would have the same preference.”

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Dr Wise: “Certainly, in fact, I did have a similar procedure several years ago.”

Ms Paine: “I have been reading on the Internet about those artificial disks. What is your thought on these?”

Dr Wise: “These are put in from the front and take the place of a fusion. They are designed to preserve motion. Although called ‘artificial disks,’ physiologically, they don’t function exactly like a real disk. They are not yet FDA approved, but I can imagine the occasional patient when the artificial disk may represent a good option.”

Ms Paine: “Why is it so important to preserve motion?”

Dr Wise: “Well, there is one other long-term problem from a fusion that I haven’t talked about, which is addressed by such motion preservation. This is related to the fact that when 2 vertebrae are fused together, the adjacent disks take more wear and tear over time and eventually one of them can break down and cause symptoms. This problem is worse when more than one segment is fused. It is sometimes referred to as ‘adjacent segment disease.’”

Ms Paine: “But in my case, if I understand correctly, you would not do a fusion from the back but rather just take out a small piece of the disk. And so this ‘motion preservation’ really has no relevance.”

Dr Wise: “That is correct. It is important to realize that the fusion part of the anterior operation does not have anything to do with the treatment of your pain. It is done because the entire disk has been removed through this approach and we cannot leave that space empty, without some ill effects, potentially. From the back, as we just take out the small piece of the disk, a fusion is not necessary. The artificial disk is a ‘motion preservation’ device, which is in vogue in spinal surgery. But in reality, the best way to preserve motion is to avoid doing a fusion, when possible. Then the true physiologic motion is preserved.”

Ms Paine: “So in a nutshell, the posterior operation is safer, especially from the standpoint of life-threatening complications, and does not predispose the patient to any long-term problems. The only downside is perhaps more pain after surgery.”

Dr Wise: “Yes that is essentially correct. But rarely, another piece of disk can come out in the future and cause similar symptoms. Such a recurrence is much less of a problem in the neck than after similar surgery for a ruptured disk in the lower back, despite the fact that the procedures are essentially the same. Generally, patients do extremely well, and it is one of the most gratifying operations I do.”

Ms Paine: “Dr Wise, I am a college student and have a limited budget. Can you tell me how much an operation might cost me out-of-pocket?”

Dr Wise: “I assume you are talking about the ‘laminotomy,’ the posterior operation.”

Ms Paine: “Well, is there is significant difference in cost depending on which approach is used?”

Dr Wise: “Very much so, in this instance. A laminotomy is a 1-code procedure, whereas an anterior fusion can have

up to 4 or even 5 codes—and each code has a charge associated with it. So you can imagine that the total surgical charge for an anterior fusion will be significantly greater, maybe even 3 to 4 times that of a laminotomy.”

Ms Paine: “I don’t understand. Isn’t an anterior fusion considered just one operation?”

Dr Wise: “Yes, but payment for surgical services is not done on a ‘completed treatment’ basis. Rather, payment is based on the surgical steps, each one with a separate code, that are taken during the operation.”

Ms Paine: “Let me get this straight. You are saying that the laminotomy is a smaller operation than the anterior fusion, having only one charge code, and therefore my copayment will be significantly less with this approach than with an anterior fusion? And, furthermore, as we have previously discussed, it is the best operation for me?”

Dr Wise: “Yes. And by the way, that one surgical code number for a laminotomy on the neck is 63020.”

Ms Paine: “Dr Wise, why didn’t Dr Young say anything about a laminotomy, if this is all true?”

Dr Wise: “Frankly, I doubt if Dr Young is comfortable with this approach, or does not have enough experience with it to understand its advantages. But I must add, emphatically, that Dr Young is a very good surgeon and has offered you the best option in his hands. And, in truth, the preponderance of spinal surgeons anywhere would have also suggested an anterior fusion.”

Ms Paine: “But if a laminotomy is a good procedure, and the best for me, I imagine that there lots of other patients that should have it, or at least a choice, after hearing the pros and cons. I really don’t understand why all spinal surgeons shouldn’t be comfortable doing a laminotomy.”

Dr Wise: “Dr Young is an orthopedic spinal surgeon. And the laminotomy has been, historically, predominantly in the domain of neurosurgery. But yes, in my opinion, all spinal surgeons should be comfortable with the procedure. Though, to tell you the truth, its use is waning, even in neurosurgical circles.”

Ms Paine: “I still don’t get it. How could that be so if it is such a good procedure in certain instances?”

Dr Wise: “Unfortunately, the bottom line is the bottom line. Surgical code number 63020 is getting overwhelmed by the power of profit.”

Ms Paine: “Are you saying that simply because an anterior fusion pays more, it is becoming the procedure of choice for all cases such as mine?”

Dr Wise: “That is what is happening. But let me say that the forces are subtle. Dr Young sincerely believes that an anterior fusion is the best option for you. Yet, this conviction has been formulated to a large degree economically, in ways of which he is likely unaware.”

Ms Paine: “Dr Wise, I didn’t tell you that I am an economics major. So I am very intrigued by all of this. Tell me how economic forces have created a scenario when a surgeon can’t or won’t offer the best operation for a particular surgical problem.”

Dr Wise: “Let’s first examine those economic forces. They take form even at the training stage. Most training programs, orthopedic or neurosurgical, are under constant pressure to produce as much income as possible. As the trainees, called ‘residents,’ must learn how to do the anterior fusion operation, it is not difficult to imagine why there is no real incentive for intense instruction in the laminotomy procedure. And if you furthermore take into consideration the resident’s natural proclivity to want to do the newest and most involved procedure, then you might understand how these young surgeons can complete their residency with extensive experience in the anterior fusion operation, but with only a rudimentary exposure to the laminotomy and its rationale.”

Ms Paine: “Let me interrupt. So the anterior fusion is considered a ‘cutting edge’ operation, no pun intended?”

Dr Wise: “Not in the general sense, now. But all the new developments in cervical spinal surgery, for problems similar to yours, are modifications of the anterior technique. We have already discussed the artificial disk, which is the newest craze. But there have been many other devices and techniques developed, purportedly to improve the fusion process.”

Ms Paine: “And yet, as you implied earlier, the actual fusion part of the operation has no direct bearing on the intended outcome of giving the patient relief from pain.”

Dr Wise: “That is true, in cases such as yours. However, I don’t want to leave the impression that these new devices, called ‘hardware’ in the surgical parlance, have not been beneficial. They do allow us to do a fusion without having to take a piece of bone from the patient’s hip or using potentially hazardous cadaver bone, and maybe they have diminished the number of times when the bones don’t actually grow together into the fused state. However, in all honesty, problems with anterior fusions were quite rare in the hands of experienced surgeons before development of all these plates and cages and spacers of various shapes and forms.”

Ms Paine: “I am beginning to see the picture. I take it that these ‘hardware’ devices are expensive.”

Dr Wise: “The profits taken by the surgical device producers are huge. And therefore, this profit force has integrated itself into the actual science of spinal surgery. In fact, many surgeons, some highly respected, serve as paid consultants to these hardware companies. Some have patent agreements with them, even.”

Ms Paine: “This seems unethical to me. At the very least, it is disturbing that surgeons can have these other economic interests, which could influence how they treat a patient.”

Dr Wise: “Well, I am not sure it is always unethical. But I agree that when a surgeon has nonmedical business interests, directly linked to that of his clinical obligations, then there is always the potential for the corruption of medical professionalism, and it does happen. But by and large, most spinal surgeons are competent and ethical.”

Ms Paine: “I am not sure I buy that. If that were the case, then they would make the effort to learn the laminotomy technique so that they can offer it for conditions such as mine.”

Dr Wise: “These surgeons may not have made a conscious decision to do otherwise. But they are players in the health care market, and so function in economic self-interest. The problem is that they are somewhat unwittingly caught up within a health care system with perverted market forces. And so the demise of surgical code number 63020 has happened essentially as a natural course of events within this system.”

Ms Paine: “Can you explain that?”

Dr Wise: “One of the fundamental flaws in health care economics is the system of payment based on the innumerable steps taken rather than on a discrete medical-service product rendered. Thus, there are few open competitive market forces in health care.”

Ms Paine: “So there are no products that can be compared in value, which is the fundamental process in a market system and which keeps downward pressure on prices and the inverse on quality.”

Dr Wise: “Exactly. Let’s suppose that we could get rid of a surgical reimbursement system based on the innumerable coded steps taken during an operative procedure. For instance, in your case, one surgical charge could be rendered for ‘surgical treatment of a ruptured disk in the neck.’ Now, such a pricing system changes everything.”

Ms Paine: “So whatever surgery is done, whether an anterior fusion or a laminotomy, the charge would remain the same?”

Dr Wise: “Precisely, and imagine what that would do to incentives. It takes economics out of the decision-making process. Now there are no subtle disincentives for a surgeon to do the simplest and quickest procedure for any particular problem at hand. In cases such as yours, the option for a laminotomy would eventually make a general resurgence in the world of spinal surgery, in my estimation.”

Ms Paine: “Because it is easier to do?”

Dr Wise: “Well in experienced hands, it is both quicker and safer, as we discussed. But remember, there are certain other cases of ruptured disks that are best treated anteriorly, so spinal surgeons need to gain experience in both types of operations so that they can offer the best choice for each patient. And even with the anterior operation, it’s my guess that they will become somewhat less extensive, if surgical charges are no longer produced by each technique added to the procedure.”

Ms Paine: “You mean surgeons sometimes purposefully do more than is necessary in the anterior operation?”

Dr Wise: “Not exactly, it’s just that the present reimbursement system rewards larger operations. So these subtle economic forces eventually materialize into a larger and more complex procedure. In the anterior operation, for example, many surgeons now screw a plate over the front of the spine after taking out the disk and putting something in

its place. This placement of a plate adds an extra code to the operation.”

Ms Paine: “So the plate is really not necessary?”

Dr Wise: “In my opinion, it is not really justified in most cases. I use just a cage—which is a titanium cylindrical spacer, and is easy to put in—to take the place of the disk that has been removed. The fusion rate is very good with this technique. I used to put in a cylindrical piece of cadaver bone after drilling a trough for it and had minimal problems. I never add a plate to the front of the vertebrae unless there is reason to suspect significant instability, as with some post-traumatic situations. Now, many surgeons put a plate over every fusion. This increases charges and reimbursement. It can be justified as promoting the fusion process when more than one level is fused, but some surgeons put it in when just one disk is removed and the bones fused.”

Ms Paine: “And again, in a lot of these cases such as mine, a fusion is not a necessary part of treatment but rather something that is only necessary because the surgeon takes the disk out from the front of the neck.”

Dr Wise: “Yes, but let’s get back to the economics. Besides incentive realignment, there is another very important reason for changing the system from one that is driven by a multitude of costs to one that has established prices for completed service. This has to do, as you alluded to earlier, with the establishment of competitive forces within an open market.”

Ms Paine: “I understand—established ‘prices’ are well defined and thus can be ‘shopped’ so to speak, whereas ‘costs’ are not predetermined and therefore cannot function as a competitive entity in the open market. In other words, medical care costs must be changed into ‘widgets’ before competitive controls can be operative.”

Dr Wise: “Precisely. There can be no value comparison if there is only some nebulous array of unpredictable ‘costs,’ and not ‘prices’—or ‘widgets,’ as you have stated.”

Ms Paine: “So how can the ‘costs’ of surgery be bundled into competitive ‘prices’ in a way that will instill these competitive forces into the system?”

Dr Wise: “Actually, all surgeries could be grouped into a hierarchy of treatment-based categories, with each one having a charge: the ‘price,’ established in an open market. This would cross specialty lines. For instance, let’s assume that a surgery for a ‘ruptured cervical disk,’ as in your case, was at the same category level as that for ‘gallbladder disease,’ and for purpose of example, let’s say these are designated as category 6 surgeries. Then, the general surgeon and the spinal surgeon, in a sense, would be in economic competition with each other, as well as with those in their own specialty.”

Ms Paine: “Since the price for a category 6 surgery in spinal surgery could now be compared with the price for surgery at the same level in general surgery?”

Dr Wise: “But remember, in a true open market the price of a surgery in each category would be established individually by each surgeon, or by an associated group of surgeons.”

Ms Paine: “Either way, the buyer, whoever is paying for the surgery, can now make a value-based decision in these surgical situations.”

Dr Wise: “Yes, but realistically, health care can never be a totally open market. But the transformation of its ‘costs’ into ‘prices’ will have a far-reaching effect on incentives as well as on its competitive dynamics, as we have discussed with regard to your surgery.”

Ms Paine: “Are there ways to do a similar transformation in other areas of health care?”

Dr Wise: “The most obvious, and possibly the most important, would be in changing the way hospitals bill for services. Consider what would happen if they could only bill on a daily-rate schedule of some sort. Then hospital incentives would likewise be realigned appropriately for internal efficiency. At present, it is in their best economic interest for there to be a maximization of charges for in-hospital care: charges for every laboratory investigation, every diagnostic test, for every piece of equipment used, for every radiographic study, etc. Likewise for supplies that are used—where there is often an astronomical markup from the price of purchase.”

Ms Paine: “But if they didn’t have that markup potential, because of daily-rate billing, then they would have a much greater incentive for bargaining with suppliers, as well as for more efficient provision of services.”

Dr Wise: “Yes, and in a thousand other little ways, the hospitals will become more efficient. A good example is in those surgical cases when it is necessary for me to leave a drain in the operative site for 24 hours. These drains are sutured to the skin, and this suture needs to be cut before pulling the drain. All that is necessary for this is a simple scalpel blade, which costs almost nothing. However, the hospital would rather I use a disposable suture-removal kit so that the patient can be charged around \$35 for this one-time snip of a suture. I can assure you that if they had to bill on a daily-rate basis, those scalpel blades would be much more available on the floors for such use.”

Ms Paine: “And a daily-rate schedule for hospitals would also facilitate competitive dynamics in the health care market.”

Dr Wise: “Certainly. Now the buyer—that entity paying the bills—can compare the price of one hospital with another, and subsequently make a value judgment. There would also have to be some incentives for the hospital in the discharge of the patient, but these could be formulated easily enough.”

Ms Paine: “Can I assume that such transformation of health care ‘costs’ into ‘prices’ can be done throughout the system?”

Dr Wise: “Yes, I believe so. And hopefully the creativity for such a system-wide transformation will be forthcoming. If not, health care as a market system is doomed to failure. If we don’t allow the market to work, because we do not define discrete competitive prices within, then eventually the unrestrained profit-taking will cause a complete collapse of American health care, and we are seeing it happening before our very eyes. At that time, a regulated system will be put

into place, and this will be cost-controlled only. Quality will be a secondary issue—if at all, as there will be no shopping of value.”

Ms Paine: “And that would be the most inefficient system possible. If a capitalistic economy works with other goods and services, then it should be able to work in health care.”

Dr Wise: “It can work. But remember, the profit-takers will mount a vigorous and well-funded defense of the status quo, politically. I am talking about the insurance companies, the medical suppliers, some health care and hospital management systems, and even some physicians. But all these entities will be thinking only about themselves, and in the present, rather than about the good of the community and about future generations; they will be self-serving in

their denunciation of any radical changes in health care economics. Certainly, the pursuit of economic self-interest is an important part of the open market formula; however, we do not have an open market now, and therefore initiatives to defend the present system should be recognized for what they really are: attempts to continue profiting from the system, to the ultimate detriment of patient care, now and in the future.”

Ms Paine: “By the way, when can you do a laminotomy on me?”

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