State of Spine Surgery and Independent Practice

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Disclosures

- Aqueduct Neurosciences – Board of Directors
- angelMD – Chief Medical Officer
- Nuvasive – Health Policy Consultant
- Consultant
  - Medtronic Streamlined Design Systems
  - Synthes Outpatient Cervical Surgery
  - Surgery Partners, Outpatient Spine Surgery
  - Spineology, Wenzel, Stryker
Independent Practice vs Direct Hospital Employment

- **Growing trend for Direct Hospital Employment**
  - 2010: more than 50% of graduating residents
  - 2014: <10% of new recruits are independent/self-employed

- **Physician factors**
  - ↑financial pressure: ↑overhead + ↓reimbursement
  - Work-life balance
  - Administrative responsibilities of private practice

- **Hospital factors**
  - Physicians withdrew from ER and ICU coverage
  - “Hospitalists” provide emergency and inpatient care
  - Preferential hiring of certain lucrative specialties improve hospitals’ bottom line
  - Hospital and medical group consolidation
  - ACOs require large physician panels
Direct Hospital Employment

• AMA 2012 Practice Benchmark Survey: a slight majority (53%) of physicians owned their practices, down from 61 percent in 2007/2008; 42% of physicians were employees, and 5% were independent contractors.

• AMA 2014: 50.8% of physicians were owners of their practices; 43% were employees of their practice, 6.2% were independent contractors.

• More physicians worked directly for a hospital or in practices that had at least some hospital ownership in 2014 than in 2012 (32.8% vs 29%)
Independent Practice

- Independent private practice physicians are becoming extinct
Physicians as Owners by Specialty

- Pediatrics: 37%
- Emergency medicine: 38%
- Family medicine: 40%
- Psychiatry: 41%
- Surgery: 46%
- Internal medicine: 46%
- All: 53%
- Obstetrics/gynecology: 56%
- Internal medicine subspecialties: 62%
- Radiology: 64%
- Anesthesiology: 69%
- Surgical subspecialties: 72%

The Physicians Foundation/Merritt Hawkins survey vs AMA survey
Direct Hospital Employment - Issues

• Employed physicians see 17% few patients per day than independent physicians (Merritt Hawkins 2014)

• Direct hospital employment involves many other issues faced by employed physicians, hospitals, patients, and government regulatory agencies
Issues

- Corporate Practice of Medicine Doctrine
- Fiduciary duty to serve hospital employer
- Conflict of interest between ethical duty to care for patients and fiduciary duty to serve hospital employer
- Conflict of interest related to medical-legal liability
- Whether direct hospital employment improves or adversely affects access to care in urban areas vs rural communities
- Employment contracts
- Financial integration between physicians and hospitals has been associated with higher commercial prices and spending for outpatient care
Corporate Practice of Medicine Doctrine

- Prohibits corporations from providing professional medical services
- Bars employment of physicians by hospitals
  - States which prohibit direct employment of physicians: CA, CO, IO, OH, TX
  - Not-for-profit and for-profit hospitals are exempt from prohibition of CPOM in most states
- Created by AMA to protect public as well as doctors
- Divided loyalty and impaired confidence between interests of corporation and needs of patient
  - May lose freedom to make decision based on patients’ needs
- Prevents Sherman Anti-Trust violations and limitation in patient choice
  - When hospitals directly employ physicians, they are generally required to perform procedures, order tests, and make referrals within their place of employment.
- Outside competition and patient choice may suffer
- Hospitals may unfairly terminate non-employed physicians’ privileges to push a hired arrangement
Corporate Practice of Medicine Doctrine

• Overriding public policy concern is to ensure that “lay persons are not influencing the professional judgment and practice of medicine by physicians.”

• “Physicians sole interest is ethically to their patients. They don’t have a legal duty to make the hospital money, and that’s what we want to avoid.”

• Brett Michelin, Associate Director of Government Affairs, California Medical Association (AMA News, Aug. 3, 2009)
Conflict of Interest: Ethics

- Inherent conflict of interest between ethical duty to care of patients and fiduciary duty to serve hospital employer

- Physician employment increases cost of care
  - “The most expensive piece of medical equipment .... is a doctor’s pen. And, as a rule, hospital executives don’t own the pen caps. Doctors do.”
  - Hospital executives understand this and desire to harness this expensive piece of medical equipment to provide financial security to the hospital.
Conflict of Interest: Ethics

- Direct employment allows control of physicians
  - Increase in opportunity for financial factors to drive referrals, tests, procedures, imaging studies, surgeries

- Financial gain could supplant needs of patient despite ethics of physician to primarily be caregiver, not profit center

- Mayo Clinic recognized this conflict and eliminated financial barriers by pooling all physician and hospital revenues, and paid all employees a salary. Goal was to eliminate possibility that doctors would do anything to try to increase their income and to promote financially blind patient care decisions ➔ ACO
Higher Costs

• Financial integration between physicians and hospitals has been associated with higher commercial prices and spending for outpatient care, but not inpatient care.
  • Nesprash et al, Association of Financial Integration Between Physicians and Hospitals with Commercial Health Care Prices, JAMA Intern Med. Doi:10.1001/jamainternmed.2015.4610

• Study design, setting and participants:
  • Physician-hospital integration, measured using Medicare claims data as the share of physicians in an MSA who bill for outpatient services with a place-of-service code indicating employment or practice ownership by a hospital.
  • Annual inpatient and outpatient spending per enrollee and associated use of health care services, with utilization measured by price-standardized spending (sum of annual service counts multiplied by the national mean of allowed charges for the service).
  • 7,391,335 enrollees in 240 metropolitan statistical areas
Higher Costs

- Increase in physician-hospital integration was associated with a mean increase of $75 per enrollee in annual outpatient spending ($<.001) from 2008 to 2012.

- This increase in outpatient spending was driven almost entirely by price increases as associated changes in utilization were minimal.
Devaluation of Spine Surgery

- Spine surgeons are now at the bottom of the food chain
- The care for spine patients yields much greater financial benefits to many other providers than the surgeon
- These factors have contributed to more and more spine surgeons becoming hospital employees
Spine Surgeons currently receive $900 for performing microdiscectomy, a curative, definitive, procedure requiring the most training, and carrying the most liability.
How to Remain Independent

- Problems: Employment opportunities + devaluation of spine surgery = fewer independent spine surgeons
- Solution: Develop boutique practice with best in class reputation for quality, service, and price
- Solution: Develop ancillary revenue streams
  - Outpatient spine surgery center
  - Imaging center
  - Interventional pain management
  - Electrodiagnostics
  - Physical Therapy
  - DME
“To Build” or “Not to Build” … that is the question!

**Why** build?

- Practice Management and EMR Software
- Clinic
- Diagnostics
  - MRI
  - C-Arm
  - EMG/NCV
- Treatment Facility
  - ASC
  - P/T & Rehab
- Professional Staff
  - Neurosurgery
  - Non-operative Tx
  - Pain Management

Case Study #1: Lumbar HNP, Single Level
Revenue from patient with commercial insurance

- 99203 New Patient Office Visit (low) - $132
- 72148 {lumbar spine w/o contrast} - $1,400
- 95860 & 95903 & 95904 {EMG & NCV} - $2,598
- 63030 or 63042 or 63056 {1 level lumbar} - $1,236
**Case Study #2: Cervical HNP, Single Level**

**Why build?**

<table>
<thead>
<tr>
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<tr>
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<td>63020 or 63040 or 63075 {1 level cervical}</td>
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<tr>
<td>C-Arm</td>
<td>4 Visits</td>
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<tr>
<td>EMG/NCV</td>
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**Why build?**

**Practice Management and EMR Software**

**Clinic**

**Diagnostics**
- MRI
- C-Arm
- EMG/NCV

**Treatment Facility**
- ASC
- P/T & Rehab

**Professional Staff**
- Neurosurgery
- Non-operative Tx
- Pain Management

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Case Study #3: lumbar disc, 2 level
Revenue from patient with commercial insurance

- 99214 Established Patient - moderate
- 72158 {lumbar spine w & w/o
- 95861 & 95903 {EMG & NCV}
- 63042 & 63035 {2 level lumbar}
- 6 Visits
- 63042 & 63035 {2 level lumbar}
What was the question?

**Case Study #1: Lumbar HNP, Single Level**
Revenue from patient with commercial insurance

- Center: $5,366
- No Center: $1,368

**Case Study #2: Cervical HNP, Single Level**
Revenue from patient with commercial insurance

- Center: $8,421
- No Center: $1,992

**Case Study #3: Lumbar disc, 2 level**
Revenue from patient with commercial insurance

- Center: $7,023
- No Center: $2,128
Ancillary Revenue Streams
Promote Independence

- Ancillary revenue streams allow neurosurgeons to impact the quality of care in a more complete fashion.
- Makes economic sense and provides a financial substrate that supports independence.
- Legal constraints on the practice of medicine need to be focused on conflicts, oversight, and due process within vertically integrated hospital systems that directly employ physicians.
- Goal is to guarantee patient access and rights to care, unaffected by corporate or contractual interference with medical decision making.
- Risks of lay control of medical decisions and divided loyalty should not be tolerated.
- It is necessary to protect ethical patient care and the integrity of the medical profession.
- The increase in health care costs related to financial integration between physicians and hospitals needs to be transparent.
- Transparency promotes independent practice.