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Not the Last Word

Not the Last Word: Unnecessary Surgery Can Never Be Done Well

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Nearly 20 years ago, Congress passed the Balanced Budget Act of 1997, triggering several major Medicare payment policy changes. One of the key provisions of this law was that the annual increase in healthcare spending could not exceed the growth of the Gross Domestic Product (GDP). Medicare accordingly created a Sustainable Growth Rate (SGR) formula to cap Medicare physician payments. Under the SGR, if in the previous year, GDP had grown by 2%, say, yet the volume of services had increased by 4%, the physician fee schedule in the coming year would automatically be reduced by approximately 2% to respect the limit.

The SGR functioned adequately at first, but in 2002, the formula was poised to inflict a 5% fee cut—a decrease so large it was politically untenable. In response, Congress passed a so-called "doc fix" bill to delay the cut. The doc fix did not waive the reduction but rather deferred it, in hopes that future GDP growth would outpace healthcare growth and obviate the need for any cut altogether.

As you may have noticed, that wish did not come true. Healthcare spending growth, driven by an ever-rising demand for services, consistently outpaced GDP growth. Congress was forced to pass a "temporary" doc fix an additional 16 times between 2003 and 2014, all the while snowballing the eventual SGR cut, should it ever be imposed.

In 2015, with the looming SGR tab running above 21%, Congress trashed the whole thing. Goodbye, SGR; hello, MIPS.

The Merit-based Incentive Payment System (MIPS), is a program that does not consider GDP growth, but rather bases payments primarily on healthcare quality measures. Under MIPS, the doctors with the best record of compliance with these measures get a bonus; doctors with a weaker record face a penalty.

An orthopaedic surgeon performing a knee replacement for arthritis, for example [9], would be rewarded for assessing function and pain, using a patient-specific risk calculator while obtaining informed consent, choosing the correct prophylactic antibiotic, and addressing the contingency of a venous thromboembolism. Those failing to do so would be paid less than the usual fee.

The American Academy of Orthopaedic Surgeons seemed to be pleased by the MIPS-for-SGR exchange, but "outlined a number of areas of concern" including the implementation timeline and the impact on smaller practices [2].

That muted response might miss the forest for the trees. By considering "quality," MIPS establishes Medicare's right to question individual

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medical judgments. Until now, Medicare has agreed to pay for all valid medical services. MIPS amends that: all valid services will be covered, as long as they are done well. Yet because unnecessary care can never be done well, the MIPS standard easily expands to paying only for services that Medicare deems indicated.

Recall that MIPS is built to be revenue neutral. Accordingly, if all surgeons get on board with best practices—and let's hope they do—Medicare will require another means of rewarding and punishing. MIPS, after all, is a zero-sum game.

Long-term outcomes might be the needed ingredient, but I doubt it. Many factors apart from quality influence clinical results; and by their very nature, long-term effects of treatment are not known for a long while.

My bet is that indications will be the means by which Medicare evaluates quality and attempts to constrain physician output. Although indications are admittedly hard to pin down, the differences in the incidence of certain surgeries by year or city (as seen for total knee replacement [4] or spinal fusion [6], to name two) suggest that somebody's standard is demonstrably wrong. If rates differ across time or place, either the strict criteria/low rate group is right or the lax criteria/high rate group is right. But if the incidence of the underlying disease is constant across groups, they cannot both be right. And if there is no proof either way, the strict criteria/low-rate group's standard could easily be adopted by Medicare as its own.

At present, many of the proposed measures of quality are anodyne and agreeable—who could argue with using the correct antibiotic? Still, because determinations of quality could one day include determinations of necessity, Medicare could decline to pay for operations that it believes should not have been done. For example, Medicare could reject the invoices for knee replacements in patients under the age of 55 with only mild osteoarthritis on radiographs—an operation that is evidently performed with some frequency [12]—even if the correct prophylactic antibiotic was used, the contingency of a venous thromboembolism was addressed, and the like.

Jump ahead to the not-so-distant future where all medical records are electronic—as MIPS shrewdly encourages—and machine-learning computer programs can comb through these records and assign an "indications rating" to every surgical decision. Medicare need not say: "Your decision to operate was bad"; it only has to say: "Your decision making in this case was on the 9th percentile of all comparable decisions, and this year, we can afford to pay only for the 10th percentile and up."

It is true that Medicare's attempt to limit physician output with the SGR formula failed to work, and to the extent that SGR did not attempt to distinguish between indicated care and wasteful care, nobody should mourn that failure. It's also true that MIPS is not guaranteed to work either. The same political pressure that quashed SGR can crush it, too. Yet whether it's MIPS or its successor, some rationing of musculoskeletal care is going to be needed. In America, more money is spent treating neck and back pain than is spent on asthma, heart failure, leukemia, cirrhosis, and breast cancer combined [8].

Because unnecessary surgery can never be done well, the focus of research must shift "from examining how to perform [surgery] to examining who should undergo [surgery]" [7]. Because unnecessary surgery can never be done well, we must expand our diagnostic acumen from determining what disease is present to discovering what treatments would be preferred [3]. Because unnecessary surgery can never be done well, MIPS—and the scrutiny of indications it can bring—may be just what is needed after all.

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Dr. Bernstein describes the sobering odyssey of Centers for Medicare &

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Medicaid Services' (CMS) attempts to control the skyrocketing costs of healthcare while physicians and their professional organizations lobby to maintain physician reimbursement. He predicts that the MIPS will lead to advanced algorithms and matrixes of quality, and ultimately, denial of payment for "unnecessary" surgery. Beyond, the specter of denial of reimbursement for surgery is denial of payment for many of the "routine" imaging and treatment recommendations commonly employed by orthopaedic surgeons.

Although MIPS is revenue neutral, Dr. Bernstein believes that "some rationing of musculoskeletal care is going to be necessary." I have every reason to believe that unless we change our model of healthcare delivery, that his predictions will come true. The literature describes an epidemic of overdiagnosis and overtreatment, and the treatment of individuals with low-back pain is a posterchild for excessive care. Widely accepted guidelines for the management of acute lower-back pain are available and withholding payment for an MRI or physical therapy in the management of acute low-back pain will be easy to accomplish. The government and insurance carriers will develop rigid standards of care, compromising our ability to deliver patient-centered care.

Maybe it is time that we critically analyze how we are caring for the public, and identify better strategies. Despite spending more per capita than any other Organization for Economic Co-operation and Development country, our quality-of-care pales in comparison to almost all of these countries [13].

I suggest that we redirect our efforts and focus on the welfare of our patients and the Primacy of Patient care [1]. This philosophical change of advocating for our patients will ultimately be better for our patients and professional satisfaction. If we lobby for better care and follow widely accepted guidelines and algorithms for the delivery of care for common musculoskeletal conditions, then rationing would never become necessary. Our present strategy to maintain income in an era of decreased reimbursement for evaluation, management, and surgical interventions has been to see more patients. In addition, we operate on multiple patients simultaneously and seek supplementary streams of revenue. In our efforts to deliver more care and maintain our income, we also generate enormous costs beyond our personal reimbursement. These strategies create more stress, less professional satisfaction, and burnout.

Unfortunately, the strategy of caring for more patients is also the nemesis of quality care and cost control. To maintain efficiency we perform a "physician-centric" encounter; brief evaluations with rapid recommendations on imaging and therapy. We spend less time enjoying our visits; less time teaching our patients, and avoid adversarial encounters by complying with requests for imaging, therapy, and pain medications. In a "patient-centric" encounter, we enjoy meeting our patients, the patient has sufficient time to explain his or her problem, and we spend the necessary time to examine our patient, and adequately discuss treatment strategies along with future indications for further testing and care.

4I believe there is a better way. We can accomplish our own orthopaedic surgeon triple aim: Improved professional satisfaction with less burnout, improved patient care, and societal health care cost savings. This can only be accomplished by reassessing the goals of our lobbying efforts and proposing patient-centered delivery models that allow us to deliver quality, state-of-the art, and evidenced-based care. We need to be adequately reimbursed for spending more time with our patients, allowing us to establish true patient-centered care centers. Meaningful-use criteria for orthopaedic surgeons should be designed to reflect what is important in musculoskeletal care, not what is important

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for a primary-care provider. We should be create and participate in shared risk models for musculoskeletal care that create real financial rewards for quality and not quantity. Innovative ideas, instead of tweaks of a failing system, will allow us to maintain our professionalism and respect the primacy of patient care. Innovation will achieve the orthopaedic triple aim and we will all come out as winners.

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Dr. Bernstein presents a detailed analysis of the challenges with the MIPS, a specific reimbursement paradigm under Medicare Access and CHIP Reauthorization Act (MACRA). As Dr. Bernstein eloquently stated, MIPS evaluates performance-based quality measures, resource utilization, engagement in clinical practice improvement activities, and the ability to advance care information (utilization of electronic health record). Exactly what direction this takes us in the future of health policy is not entirely known, as we have just entered the transition year (2017) for MACRA [11].

One of the major components of Dr. Bernstein's opinion is that the emphasis on quality measures may lead to Medicare questioning individual medical judgements. He further proposes that MIPS will soon include an assessment of indications. Although this thought is plausible, the internal feeling of an individual patient may not be easily discerned from standardized measure sets, as the decision to pursue surgery is inherently a patient choice. Although preoperative diagnostic testing provides objective variables that can inform a surgical decision, patients will provide the final call on whether or not to pursue a joint replacement. Although MIPS may link to surgical indications, rarely will we be faced with the burden of whether a surgery "should have been done."

To that point, MIPS will focus on postoperative outcomes and measurement sets that are easily reportable. In fact, orthopaedic surgeons can report up to 21 specialty-specific quality metrics [9]. Although the subjective component of postoperative pain and mood cannot fully be elucidated by current measure sets [10], there still needs to be evidence-based measures that are capable of adequately addressing this component of procedural outcome. Most surgeons would also agree that although a given operation may be technically perfect, it is the way the patient feels and can function that determines the satisfaction associated with surgery, both for the patient and the physician.

Regarding incentives, although we do agree with Dr. Bernstein's understanding of what may motivate some physicians, an often-overlooked component of MIPS is the government-allocated funding for the top 10% of performers who report performance metrics effectively. Approximately USD 500,000,000 is reserved for top performers; how these bonuses may be distributed has not been fully explained by the CMS, but this does offer "incentive" for physicians who comply strongly with the model [5]. Additionally, this does make MIPS a more government-funded system than a revenue-neutral pathway. As more details about the system are revealed, we will have further insight regarding such bonuses.

Finally, we commend Dr. Bernstein for demonstrating that, "MIPS is not guaranteed to work." Assessing how this may effect a given surgeon's practice is extremely difficult to predict. However, surgeons may be more cognizant of the national emphasis placed on assessing performance and

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value. Surgeons may decrease their caseloads or be more selective regarding whom they choose to treat. Alternatively, surgeons could attempt to perform more procedures to overcome performance deficiencies with volume.

Even with such uncertainty, it remains clear that orthopaedic surgeons and health systems must wok continuously to improve quality measurement and assessment. As health policy continues to take shape, active participation by orthopaedic surgeons is imperative for our patients.

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