



CANS

NEWSLETTER

California Association of Neurological Surgeons

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The Stimulus Legislation and Us

Randall W. Smith, M.D., Editor

By the time you read this, the media hype regarding the stimulus bill will probably have numbed your brain to the point of tune out. However, it is hard to resist noting a couple of issues that will clearly impact docs, maybe not tomorrow, but surely in the future. Firstly, the bill allots some \$17.2B for Health Information Technology which purportedly will trickle down to some \$11M per hospital and from \$40K to \$65K for individual physicians to adopt electronic health records (EHRs). This maneuver is based upon the concept that EHRs reduce costs and improve patient safety. One can understand why electronic prescribing will reduce some errors and rapid interchange of digital medical information could save money by preventing unnecessary duplication of services, but implementing such EHRs isn't going to be like loading Quickbooks into your office computer. There is no widely accepted EHR program and many if not most programs available were designed by computer wizards without doc input and are still works in progress. Compatibility issues between the doc's office and the hospitals at which he/she practices abound. One prominent hospital in San Diego has had so many problems with the EHR system it chose, that part of the medical staff, citing lost medication orders and an arcane process for information retrieval, have requested scrapping the whole attempt and starting all over. The Veteran's Administration apparently has an EHR system that functions well for them but who knows how that will translate into the non-federal world. It seems likely that when the dust settles on this issue many years hence, it will have improved patient safety to some extent and not saved a net nickel.

The second issue is the bill throws \$1.1B at doing or supervising comparative effectiveness research with which the Feds have had very limited experience as well as providing funding for a contract under which the Institute of Medicine will make recommendations by June 30, 2009 (get real!) for national priorities for comparative effectiveness research. It also mandates establishing a Federal Coordinating Council for Comparative Effectiveness Research. That council will be composed of 15 federal officials (half either docs or others with clinical expertise—whomever that might include) which will recommend and coordinate research but will not be able to establish clinical guidelines or "mandate coverage, reimbursement or other policies for any public or private payers." And if you believe that statement and that the comparative effectiveness research won't result in mandatory guidelines and restrict or prohibit certain treatments or stifle new technology, I once again have a real nice bridge in New York I would like to sell for a song.

There are real changes a-brewing and once the caldron comes to a boil, there will probably be millions more Americans with some sort of insurance which, along with Medicare, will provide only what the Feds feel is cost effective, all other insurers will follow suit and in the room with you and your patient will be a big brother rule book. What can CANS or the CMA or the AMA or you do about any of this? Not too much though we need to be sure to give the EHR our best effort and keep a sharp eye on the comparative effectiveness research so that treatments that are questionable get the benefit of the doubt rather than being tossed out with the trash. ❖

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APHORISM OF THE MONTH: *Seat belts are not as confining as wheelchairs.*

Letter to the Editor: Existential Futility in the Halls of Organized Medicine

Donald J. Prolo, MD, FACS, Consultant to the CANS Board

From 1996-2008, I served as CANS Delegate to the CMA House of Delegates. After participating in various roles in the Santa Clara County Medical Association, I was President 2006-2007. During the years 2003 through 2007 I participated in the AMA House of Delegates. These various roles have disappointed my hope that organized medical associations are truly dedicated and effective in advancing the interests of patients and practicing physicians. Though a chorus of denials and disparagement of this observation will likely follow from the culture of medical association staff and co-opted physician leaders, the facts bear witness otherwise.

Medical associations (CMA, AMA and local medical societies) putatively develop policy through input from members to benefit the public and members. In reality employed staff and leaders are selected or “elected” to propagate in perpetuity the inbred culture at each level, greatly influencing the conduct of these organizations with methods escaping the eyes of very busy physicians and with goals that are often self-serving in the pursuit of mollification of various constituencies.

The House of Delegates of the CMA and AMA are legislative assemblies, wherein members input resolutions leading to policy on various issues impacting physician professionalism, the practice of medicine and relational societal issues that then direct the conduct of the associations.

Resolutions introduced into the House of Delegates of the CMA first are heard at an annual meeting in Reference Committees directed toward various issues of relevance to the practice of medicine (e.g. public health, science and technology, medical practice, medical service, medical education, legislation, professional ethics, constitution and bylaws, etc.). Members and Chairs of these committees are selected by Speakers of the House; each Reference Committee is staffed by association employees (often lawyers), who actively guide and influence its work-product. The resolution is then recommended by the Reference Committee for approval, amendment, referral for study and report back to the House, referral to the Board of Trustees for decision or for disapproval by the House. The reigning physician leadership and association salaried staff and CEO are highly influential and controlling in the final disposition of the resolutions that are brought forth by the Reference Committee before the entire House of Delegates. Delegates then review the work of the reference committees in their caucuses (ours is the Specialty Delegation). Thereafter Delegates and Delegations may accept the results of the Reference Committee (and place the recommendation on a “Consent” calendar). Alternatively, Delegates may extract the resolution for debate by the entire House on the recommendation of the Reference Committee, then vote for the recommended version, the original resolution, offer amendments or otherwise deal with the issue at hand, all according to Sturgis’s *The Standard Code of Parliamentary Procedure*. Executive Committee leadership (Chair, Vice-Chair of the Board of Trustees, President, President-elect, and Past President) and association staff can thereafter greatly influence the eventual fate of a resolution. The resolution’s mandate can be actively implemented, referred for further study and thereafter buried, or simply resisted passively through inattention.

Recently I reviewed the 42 resolutions I introduced as author or co-author in the CMA House of Delegates over the twelve years 1996 through 2007. Though most were approved, only one resulted in decisive action and that not under the aegis of the CMA. The exception was Resolution 903-97: **HEALTH CARE PROFESSIONAL’S COALITION ACT OF 1996, HR 3770 (CAMPBELL)**. This bill was passed on June 30, 2000 as HR 1304 by the United States House of Representatives by a vote of 276 ayes to 134 nays through the efforts of Congressman Tom Campbell and because of the profound respect Mr. Campbell has for the medical profession and his sense of injustice being perpetrated against physicians. It was subsequently denied a hearing in the US Senate. Mr. Campbell advocated the cause of physicians because of direct pleas for his help by many of his friends in the doctor community, not because of intercession by organized medicine, which support came after his intentions and the path to its eventual success were established.

On January 8, 2009, the California Supreme Court rendered its opinion on the Prospect Medical Group, Inc. v. Northridge Emergency Medical Group et al. to ban the balance billing of patients by emergency room physicians. Justices tilted for health care service plans (HMOs, PPOs) at three major decisional pivot points: (1) Emergency room physicians had *implied* contracts with HMOs, not with patients, even though affirmative decisions had been made previously by physicians not to sign such a contract; (2) The best possible health care for the public at the lowest possible cost must be ensured by *transferring the financial risk of health care from patients to providers*; (3) A patient will have little basis by which to determine whether a bill is *reasonable* and not “gouging” and, “because the HMO is obligated to pay the bill, no legitimate reason exists for the patient to have to do so.”

My Resolution 414-2006, *Assisting Patients Obtain Third-Party Reimbursement* was passed by the CMA House **and never implemented**, that would have established *Programs for Patient Advocacy* (insurance committees) in medical societies throughout California, that would have assisted patients in determining *reasonableness* of charges by physicians and assisting them in disputing a health plan's determinations that diminish or deny reimbursement to an enrollee or support the case against the physician's bill as being excessive. If my adopted resolution had been implemented and Supreme Court justices had considered this positive effort by medical societies, their argument protecting patients from unreasonable charges would have been irrelevant and negated.

In retrospect my twelve years of quixotic efforts have wasted time, energy, expense and disappointed expectations of some positive effect and reinforced my final conclusions:

CANS is a strong, assertive organization for California neurosurgeons and advocacy through direct relationships and interventions with political leaders is most effective in promoting policy initiatives through CANS for neurosurgeons and for the welfare of their patients. Convincing other members of the House of Medicine to follow and expecting general medical associations to lead in these neurosurgical imperatives is a Sisyphean task.

(Editor's note—Sisyphean=Sisyphus= a legendary king of Corinth condemned eternally to repeat the cycle of rolling a heavy rock up a hill in Hades only to have it roll down again as it nears the top.) ❖

Letter to the Editor: Come On Young Neurosurgeons...

Praveen V. Mummaneni, M.D., CANS Board Member

At the recent CANS annual meeting in Monterey, I was struck by the relatively small percentage of attendees who were under the age of 45. As the youngest member of the CANS board, I want to "get the message out" that CANS serves all practicing neurosurgeons in the state of California. This organization protects our interests, and those of us under the age of 45 have the most to gain/lose in the years to come. We "young" neurosurgeons will be in practice for two or more decades. If we don't monitor our state's legislative and judicial issues, our way of life may be significantly altered in a negative fashion.

"What has CANS done for me?" you ask. Let me tell you. Young neurosurgeons benefit greatly from California's MICRA legislation. The state's limits on pain and suffering monetary awards in medical malpractice cases has helped to keep California's malpractice insurance premiums sane, stable, and affordable. I was happily surprised several years ago when I moved from Emory University in Atlanta to UCSF and found that my malpractice premiums were cut by 2/3. In Georgia, I paid over \$120,000 a year for malpractice coverage, and now I pay about \$40,000. Georgia, unlike California, has not had malpractice reform, and it makes a huge difference. CANS is one of the groups responsible for pushing MICRA legislation in the past, and CANS continues to monitor and oppose attempts by the state trial bar to overturn MICRA each legislative cycle. In addition, CANS monitors and pushes other issues of significant importance to all practicing neurosurgeons including: balance billing of insurance companies for out of network emergency room fees, worker's compensation fee schedule changes, reasonable compensation for "on-call" coverage and access to neurosurgical care for patients with Medicare/MediCal. Without monitoring, these issues could easily change neurosurgical practice from a viable small business enterprise to a situation where neurosurgeons can't pay their overhead and leave the state.

Am I being overly dramatic? No. Just look at states like Pennsylvania and Florida where a large percentage of neurosurgeons have ceased to take call or fled the state altogether. Don't get into a car accident in south Georgia or north Florida because if you sustain a head injury, you are likely to be airlifted to a university hospital over a hundred miles away to find on-call neurosurgical care. There are almost no on-call private practice neurosurgeons in those areas now. I know; I received those patients when I practiced at Emory. Some of them did not survive the trip.

So, get involved in CANS. We "young" neurosurgeons can't reasonably expect neurosurgeons over the age of 60, many of whom have retired from active practice, to take care of these issues for us indefinitely. The current CANS board is to be commended for their ceaseless and strenuous work on our behalf. Let's supplement their ranks and become active participants in our own destiny. ❖

Tidbits from the Editor

CA gets 5 hospitals in top 50 list—all in LA

HealthGrades, an independent grading outfit in Colorado, just published their 50 best non-federal hospitals list from among the 5,000 or so such hospitals in the USA. Cedars-Sinai, Glendale Adventist, Glendale Memorial, Good Samaritan and Saint John's were the only CA hospitals to make the list. HealthGrades analyzed approximately 110 million Medicare patient records from fiscal years 1999 through 2007 for 26 medical procedures and conditions including back and neck surgery with or without fusion. HealthGrades uses risk-adjusted data to compare on equal footing hospitals that treated sicker patients. Hospitals with risk-adjusted mortality and complication rates that scored in the top five percent or better nationally and who received this designation for at least the past six consecutive years were recognized as America's 50 Best Hospitals. We can always question methodology in these kinds of rankings but it never hurts to get a laurel. Congratulations to our fellow neurosurgeons who work at these five hospitals as their performance has to figure in the outcomes. ❖

CMA Survey—spare them a piece of your mind

The CMA is conducting a survey for input on what they do well, what they don't and what they should. Here is your chance to pet or vent or wax innovative. If you take this less than 10 minute survey, they promise to share the results with you. You don't need to be a CMA member to participate but don't put it off as the survey closes on Monday March 2nd. Their message:

Your opinion counts! As a physician practicing in California we realize there are a number of challenges you face daily. The California Medical Association wants to reach out to all physicians for critical input which will help us better serve you from legislative advocacy to reimbursement issues to education regarding the federal stimulus package. Please take a few minutes to complete the following online survey. This anonymous information will be used to help us better meet the needs of physicians statewide. Please click on the link below to take the survey. Your honest feedback is greatly appreciated.

http://www.surveymonkey.com/s.aspx?sm=3lYHzoTtz3LooXXPWKilog_3d_3d ❖

Mummaneni steps down from job well done; Position open

Praveen Mummaneni, Associate Professor of Neurosurgery at UCSF and a spine specialist, has represented neurosurgery on the California DWC Medical Evidence Evaluation and Advisory Committee for the past two years. As a co-author of the guidelines for performance of fusions for degenerative disease of the lumbar spine published in the JNS:Spine in 2005 and a co-author of similar cervical guidelines soon to be published in the JNS, he has been a great resource for the committee and a stalwart representative of surgical interests in the treatment of spine disease in the work comp system. His efforts and time, all voluntary and without compensation, are well appreciated by CANS and should also be by all neurosurgeons and orthopedic surgeons in the state. Due to the press of other obligations, he finds it necessary to step down from the committee once the new spine surgery guidelines are finalized and is encouraging CANS to nominate a replacement. He feels that whomever follows him needs to have a good knowledge of the current ACOEM treatment guidelines as well as the ODG guidelines and be prepared to critically review the literature provided to the committee and be ever watchful for attempts by some to either prohibit legitimate forms of surgery or make it difficult to get authorization for procedures even if among the options for treatment. Praveen also feels that our neurosurgical representative need not be an academic neurosurgeon but should be someone experienced in treating work comp patients and be well versed in the indications for all forms of spinal surgery including emergent, elective and minimally invasive procedures and have experience with pretty much all forms of spinal fusion as well as arthroplasty. He has kindly volunteered to consult with his replacement to bring him/her up to speed. The committee meets in Oakland about every two months on a Wednesday from 10AM-3PM and travel to the meeting from anywhere in CA is reimbursed. Any CANS member interested in being nominated for the position should contact our executive secretary Janine Tash at janinetash@sbcglobal.net. Be prepared to provide a CV. ❖

An almost predictable unintended consequence

As we should have guessed, the ruling by the California Department of Managed Health Care banning balance billing of patients for ED care delivered to patients whose medical insurance company does not have a contract with the ED care provider, which was upheld by the CA Supreme Court, has attracted the vultures. The latter are the patients and their attorneys who now are filing 1 class action law suits to recover any money they paid docs who did balance bill them *before* the above rulings were made. As we know, anyone can file a lawsuit about anything, and we certainly would not want to preclude the patients noted above from suing their sworn enemies, namely those docs that took care of them in their time of need, but one has to wonder about the impetus to file such suits that extends beyond avarice. Not being versed in law, we will not opine on the theory of prosecuting persons for engaging in a legal activity which subsequently becomes illegal (such as slavery or smoking in restaurants), but we do recognize the driving force behind the plaintiff's bar and their customers. Considering how neurophysiologic research in the era of functional MRIs has advanced to the point of identifying cerebral centers for depression and obsessive compulsive disorder to the point where brain stimulation devices have been approved by the FDA to reduce such behavioral problems, we can only hope that the cerebral greed locus will be identified in the near future. Modifying the activity of the greed center might result in some relief for docs as well as the millions of Americans presently suffering through the misery created by financial wizards who must have a greed gyrus the size of a grapefruit. ❖

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Feds won't pay for mistakes

CMS has declared that operating on the wrong patient, operating on the wrong body part or doing the wrong operation will not be paid for on Medicare patients. The text of their wrong body part decision:

A surgical or other invasive procedure is considered to have been performed on the wrong body part if it is not consistent with the correctly documented informed consent for that patient including surgery on the right body part, but on the wrong location on the body; for example, left versus right (appendages and/or organs), or at the wrong level (spine). Emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent are not considered erroneous under this decision. Also, the event is not intended to capture changes in the plan upon surgical entry into the patient due to the discovery of pathology in close proximity to the intended site when the risk of a second surgery outweighs the benefit of patient consultation; or the discovery of an unusual physical configuration (e.g., adhesions, spine level/extra vertebrae).

Of course not getting paid is not the highest profile issue for a neurosurgeon who makes such a mistake. The malpractice cost for such errors will probably be at least \$250,000 and include the angst of being sued and getting to know a lawyer all too well. The more important issue is the patient injury which we all want to avoid and these kinds of mistakes are almost always avoidable with some extra care. Readers of this newsletter shouldn't need a reminder to establish a time-out protocol to assure the right patient and the correct side and that the correct films are in the OR put up with correct orientation. The issue of the correct spinal level is a bit dicier, particularly in the thoracic region or in the very obese. In these cases, getting the radiologist to instantaneously examine the localizing films taken in the OR and confirming what you think about level should be SOP. ❖

Psoriasis and neurosurgeons

It is noted that some immune suppressive agents probably increase the likelihood of contracting progressive multifocal leukoencephalopathy" (PML) as the immunosuppressive allow a typically harmless virus that almost everybody carries (often referred to as JC virus) to attack cerebral myelin causing brain swelling which is almost always fatal. The connection between the drugs and PML first surfaced with the use of Tysabri to treat multiple sclerosis but considering the ravages of MS it was felt to be worth the risk. Now comes the immunosuppressive Raptiva which is used to treat psoriasis, a much more common and less threatening disease. How the FDA deals with this (the Europeans have already recommended banning Raptiva) remains to be seen but should one of us be consulted on a patient exhibiting unusual weakness, loss of coordination, changes in vision, difficulty speaking and personality changes and who has an MRI showing swelling, having some acquaintance with this issue and taking a sharp PMH might be a smart move. How to deal with the brain swelling is uncharted territory for us. ❖

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Questions or comments can be sent to the editor, Randall W. Smith, M.D., at rws-avopro@sbcglobal.net or to the CANS office at janinetash@sbcglobal.net. Past issues of the monthly newsletter are available on the CANS website at www.cans1.org.

The newsletter is a mix of fact, rumor and opinion. The facts are hopefully clearly stated. The rest is open to interpretation. The opinion is mine. R.S. The assistance of Janine Tash and Dr. Bill Caton in the preparation of this newsletter is acknowledged and appreciated. If you do not wish to receive this newsletter in the future, please E-mail or fax Janine Tash janinetash@sbcglobal.net, (916-457-8202) with the word "unsubscribe" in the subject line.

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