



CANS

NEWSLETTER

California Association of Neurological Surgeons

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President's Message

William L. Caton III, M.D.

During the past year, I have spoken with many members of CANS who have noted problems in dealing with Blue Cross of California-Anthem. Repeatedly, codes submitted by neurosurgeons for neurosurgical procedures have been down-coded and payments have been reduced or withheld by Blue Cross-Anthem. Further, individual physicians have been unable to access the medical review documents and/or speak directly with the peer reviewers and medical directors who are supervising the claims process.

In view of this, I initiated several discussions with Blue Cross-Anthem, including speaking directly with medical directors, peer reviewers and corporate counsel. Initially, one of the medical directors took an active role in listening and addressing my concerns regarding Blue Cross-Anthem. He noted that Blue Cross-Anthem wished to have an active dialogue with the physicians.

As a result of my conversations with the medical director, I had the opportunity to meet and confer with a senior Blue Cross Medical Director, who is a medical doctor and currently supervises the coding for surgical procedures. During the meet and conference, the Medical Director was attentive, cordial, straightforward, and thoughtful. It became apparent that there are significant differences of opinion between California neurosurgeons and that of Blue Cross-Anthem's medical directors, medical reviewers, and peer-reviewers.

In particular, I discussed with him the problems facing CANS members, including Blue Cross-Anthem's arbitrary decisions and changes of neurosurgeons' codings and reimbursements. Specifically, I discussed Blue Cross-Anthem's rather inconsistent and often arbitrary decision to down-code billed neurosurgical CPT-codes. He asserted that the reviewers were hired as independent consultants of Blue Cross-Anthem and were not motivated to down-code as a way to cut costs for Blue Cross-Anthem. However, he did concur that the medical reviewers and peer reviewers were not necessarily trained in the surgical discipline for which they were hired as consultants.

I discussed the following problems we as CANS members face on a daily basis:

1. Denial of payments for appropriate surgical procedures;
2. Arbitrary changes of codes for surgical levels, and in particular, the use of interspace levels rather than vertebral levels as designated by the AMA coding manual;
3. Frequent bundling of codes that should not be bundled (i.e., taking surgical codes for fusions from multilevel spondylolisthesis and then moving them into scoliosis fusion codes so as to decrease the payment);
4. Inconsistencies and inappropriate determination of partial vertebrectomies versus microdiscectomies;
5. Inconsistencies of reviews by physicians from case-to-case.

During this meet and confer process with the Medical Director of coding, I had the opportunity to go through a series of cases, both real and theoretical, to obtain some answers. He acknowledged that Blue Cross-Anthem should pay for the appropriately coded levels of surgery and should not arbitrarily deny payment.

He agreed that Blue Cross-Anthem should consistently distinguish between the coding of interspace levels and that of vertebral levels. He concurred that there were specific cases wherein Blue Cross-Anthem failed to correctly distinguish between the two codes. He noted that Blue Cross-Anthem reviewers insist that the 63047 procedure refers to nerve root decompression, and that it can only be billed with a 63048 if two nerve roots are decompressed rather than one. He commented that if

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the physician does not mention the two nerve roots being treated with these procedures, Blue Cross-Anthem will compensate accordingly.

He also recognized that, in some instances, the reviewers may be inappropriately changing the coding of spondylolisthesis to that of scoliosis. It is apparent from the claims I presented to Blue Cross-Anthem, that a particular peer-reviewer was inappropriately changing the coding on a regular basis. I suggested that the peer-reviewer was not familiar with the operative procedures, wherein the Medical Director insisted the change in coding was done in good faith.

Further, the CANS Board has, along with many other neurosurgical and orthopedic institutions in the United States, defined a partial vertebrectomy as being removal of 50% or greater of the vertebral body. Blue Cross-Anthem has failed to consistently compensate physicians for the partial vertebrectomies. It is clear from the claims I presented to Blue Cross-Anthem, that Blue Cross-Anthem is denying claims wherein the operative report documents "one-half of the vertebral body" had been removed instead of "50% of the vertebral body." In other words, in the cases presented at the conference, if a physician documents the procedure using words, rather than numbers, the peer reviewer is denying the claim as a partial vertebrectomy.

Blue Cross-Anthem also proffered that if, in the course of the operative procedure, 50% of the vertebral body had been removed, and then a further procedure was done, Blue Cross-Anthem would compensate the procedure as a partial vertebrectomy. However, if the 50% removal of the vertebral body included the removal of bone for such a procedure as the Cloward anterior fusion, Blue Cross-Anthem would not compensate as a 50% removal.

The Blue Cross Medical Director maintained that the peer reviewers not only follow the AMA Guidelines, but also the North American Spine Society Guidelines for coding and reimbursement. Indeed, he noted to me that he would update the NASS guidelines that he felt were inconsistent with the neurosurgical guidelines as suggested by the AMA. I have yet to receive any publications that show the inconsistencies.

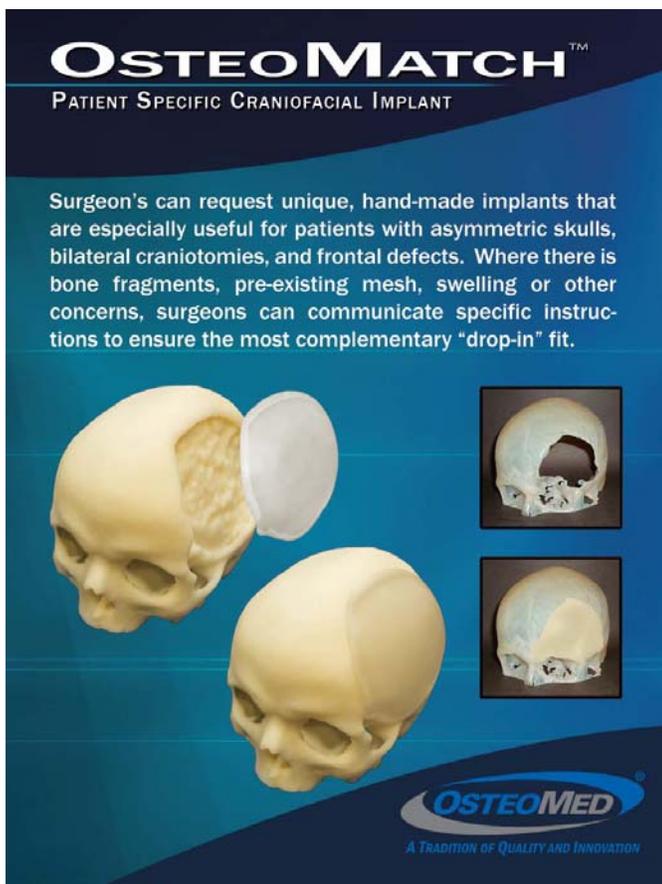
I also discussed with the Medical Director, Blue Cross-Anthem's denials of specific procedures, in particular, Blue Cross-Anthem's failure to compensate for the use of interspinous spacers. Per Blue Cross-Anthem, the spacers are experimental and would not be covered. He acknowledged that while Blue Cross-Anthem may have initially authorized

the procedure, it was in error and Blue Cross-Anthem had no obligation to pay for a procedure if Blue Cross-Anthem deemed it to be experimental.

He did indicate that Blue Cross-Anthem plans to proactively review all requests for spinal procedures. He stated that Blue Cross-Anthem would look for neurological exam abnormalities, and that procedures done for pain in the lumbar spine without neurological abnormalities may not be certified for reimbursement.

Physicians under contract with Blue Cross-Anthem have the opportunity to meet and confer with medical reviewers, medical directors and corporate counsel to discuss issues/problems on a case-by-case basis. There is a binding arbitration clause in most of the Blue Cross-Anthem contracts and as such, if there is not a meeting of the minds, the physician may demand a binding arbitration. If a case is taken to arbitration, Blue Cross-Anthem must report this to the State Department of Insurance. The loser of arbitration shall be deemed responsible for paying the costs of the arbitration. Unfortunately, due to the arbitration clause in most contracts, the physician is unable to initiate an action against Blue Cross-Anthem in either state or federal court.

I shall continue to pursue this for the CANS members during the rest of the year and will give an update later in the year when I have further information from Blue Cross-Anthem. ❖



Every Day Low Prices and Us

Randall W. Smith, M.D., Editor

Last month, this newsletter commented on the federal stimulus legislation and its promulgation of electronic health records (EHR). Now comes Wal-Mart with an offer of a cut rate EHR system for a 25K setup fee per doc and an annual maintenance fee of 5K. Of course Wal-Mart doesn't know squat about EHRs so they are just acting as middleman between the doc and eClinicalWorks, a company that has the software and really does the work. Their single doc setup drops to 10K for additional docs in same office; the 5K a year maintenance is per doc. Considering the federal money on the table (44K per doc over 5 years for setup and annual upkeep but payouts not beginning until 2011), one might be encouraged to get on the Wal-Mart bandwagon since if you are up and running before 2011 you still get the 44K. But a few questions arise. To get the feds 44K they require the EHR system to be incorporated into your practice at a certain level of penetration into practice tasks. Does the eClinicalWorks system fulfill those at the price quoted? Further, how easy will your eClinicalWorks EHR interact with the system(s) at the hospitals you use? Only talking to yourself can really limit an EHR's usefulness. Finally, who has used the company's system and is delighted with it? All these questions need to be answered and answered thoroughly by eClinicalWorks.

On a bigger scale, do you need to lead the way? If the EHR is so wonderful, why is it that only 1.5% of hospitals have instituted comprehensive electronic records and less than 20% of docs have done so? Certainly cost has been an issue but it's also because this paradigm shift is hard and involved and the docs and hospitals are not convinced it is wonderful. As you know, the feds plan on fining docs that don't have an EMR system by 2015 as they are blithely convinced the EHR is wonderful. Their warm embrace of the concept, full of a lot of assumptions and estimates as it is, does not make it a foregone winning idea. But they think it is and as usual, they have the money. Remember, the feds PQRI program, a pretty simple concept pretty easy to join and submit data to, had 50% of those that submitted data fail to qualify for the bonus not because half the docs gave up but because technical glitches and no method of feedback to the docs who had their submissions tossed was in place and there was no appeal process. Nice work, CMS and we are completely confident the EHR program will be as smooth.

So, what now for the California neurosurgeon who is not practicing at Kaiser or the VA? One might counsel caution and a bit of a wait and see attitude. The CMA thinks there is no rush to jump into this EHR pond until we know a bit more about the temperature and depth of the water. They have a nice Q&A on their Web site which is available to all (www.cmanet.org/HIT). In the meantime, *Caveat Emptor*. ❖

Tidbits from the Editor

DWC – Who is in Charge?

As this newsletter has reported, the California Division of Workers' Compensation (DWC) has been mulling over changing the doc fee schedule to an RBRVS system and also has been working on new treatment rules for spine injuries. Dr. Praveen Mummaneni, the neurosurgical member of the DWC Medical Committee that is advising the DWC on the treatment rules, has done yeoman work looking after the interests of our patients and our treatment options. What is happening with the DWC leadership recently is a bit worrisome. Carrie Nevans, acting Administrative Director (AD), failed to get legislative approval to become the permanent AD and now she has taken indefinite leave for unexplained personal reasons. The DWC Medical Director, Dr. Anne Searcy, resigned last December. The chief counsel for the DWC has been appointed to take Nevans' place. Not only does this upheaval put the fee schedule and treatment rules activities in some potential disarray but having a lawyer at the helm shouldn't generate a lot of warm and fuzzy feelings among docs. Punchline: The new fee schedule and spine treatment rules will probably not be a 2009 phenomenon.

One bit of good news: Dr. Mummaneni, who asked to be replaced on the DWC Medical Committee, has agreed to stay on until the new spine treatment rules are settled. In light of the personnel problems at DWC, that may be a bit longer than Praveen had anticipated. In the meantime, the 75% of CANS members who treat work comp patients owe Dr. Mummaneni a great big thanks. ❖

Neurosurgery Testifies to Congress

We repeatedly hear about how little political bang neurosurgery has since our numbers are so small. Where we get a bit more action is when it comes to med mal issues considering the average size of judgments against neurosurgeons and that we get sued about every two years. Jim Bean, the AANS President, was chosen by a large coalition of surgeons to testify before Congress about the liability crisis in many states and he comported himself well. Those of you who know Jim know he is pleasant, straight forward and reasonable. This translated well when he spoke before a House of Representative's Energy and Commerce health panel. His complete comments are attached to the E-mail you received in which this newsletter was also an attachment. ❖

THOUGHT OF THE MONTH: Now that I am 70, my supply of neurons is finally down to a manageable size. Also, things I buy won't wear out, particularly since I can't remember where I put them.

Letter to the Editor: Some Utility in the Halls of Organized Medicine

George Koenig, MD

Donald Prolo's article in the February 2009 CANS Bulletin is deserving of a sympathetic reply. Those of you who have known Don for many years will acknowledge his distinguished career representing medicine from hospital staff level through both organized state and national societies. He has been selected as President or Chairman of virtually every organization he has joined, all this on top of a remarkable career in scientific research and clinical excellence. He details nicely the years spent in the CMA and AMA House of Delegates and how the experience can be a long walk for a short ride.

Unfortunately Don shares with most of us a surgical personality. He recognizes a problem, arrives at a solution, and then (not unreasonably) expects to implement that solution. Equally unfortunately, not all delegates to either House of Delegates are so constructed and, even more unfortunately, not many of our woes are soluble solely by the houses of medicine, both because of their societal complexity and/or our organizational financial constraints.

Neurosurgery has played a disproportionate role in both CMA and AMA while admittedly the "glory" has been identified elsewhere. For example, while AANS and CNS representation in the AMA House of Delegates is admittedly small there are multiple other neurosurgeons in various other roles (usually members of their state delegations) who meet together. Katie Orrico, CEO of the AANS/CNS Washington Committee, is widely acknowledged for her leadership role (not infrequently to the annoyance of AMA staff) in issues of interest to both neurosurgeons and surgeons of all specialties.

Most of us identify easily with our neurosurgery organizations, as well we should. At the same time one simply cannot deny that statewide the CMA and nationally the AMA are our 800-lb. gorillas and, whether we like it or not, they are recognized as such by the California Legislature and Congress respectively. Neurosurgeons are less than one percent of the physician population and while we are respected for all we do we cannot match these organizations in all the ways they represent us. I, too, have sat in the CMA House of Delegates in various roles and represented the AANS for 7 years at AMA, sometimes convinced that I could have thrombosed a hemorrhoid under more pleasant circumstances. I did, however, come away from those years equally convinced that our presence and our efforts were absolutely essential.

On a closing note, let me remind everyone that our beloved MICRA had its origins with the Crisis Committee, the precursor of CANS. The efforts of Cone Pevehouse, Bob Florin, John Kusske, Phil Lippe, and so many other leaders in CANS working in legislative, workmen's comp, and countless other arenas have produced both professional and monetary benefits to California neurosurgery that can never be clearly quantified. Further, if all of us had donated to CMA political action (CALPAC) and/or to the AMA PAC (AMPAC) or to the neurosurgery political action group over the years (the trial lawyers contribute almost unanimously in amounts per month exceeding what we are asked for per year) our medical scene might look quite different. Meanwhile, our continued presence and support of our organized associations (warts and all) are our best options, our frustrations notwithstanding. ❖

CSNS Resolutions for May

The Council of State Neurosurgical Societies will meet May 1-2 in San Diego to consider, among other issues, the following eight resolutions. Anyone desiring the complete text of the resolutions should contact the editor and anyone wishing to give input regarding the resolutions should contact the leader of the CSNS California delegation, Dr. Caton, via our Executive Secretary (E-mail addresses below).

Resolution I: BE IT RESOLVED, that the CSNS calls upon the parent bodies of organized neurosurgery to provide definitive, official, consensus-driven direction on the employment of high dose steroids in the treatment of acute spinal cord injury.

Resolution II: BE IT RESOLVED; that the CSNS request the AANS and CNS direct delegates to the AMA (American Medical Association) and ACS (American College of Surgeons) to promote resolutions in those bodies that reflect:

1. True PEER review is specialty specific.
2. PEER review is a privilege and responsibility in the practice of medicine.
3. PEER review for precertification/denial of individual patient treatment decisions creates a doctor/patient relationship incumbent with all the ethical and legal responsibilities and consequences.
4. Physicians participating in PEER review and precertification decisions must provide their name, address, specialty and training as well as medical license information to the patient.
5. Insurance companies and Worker Compensation agencies be made aware of these principles and the medical practice and legal responsibilities assumed by them and the physicians they employ for such activities.

BE IT FURTHER RESOLVED, that the AANS and CNS through the CSNS develop a position statement addressing these points pertaining to the effect on the quality of neurosurgical practice for submission to the AANS and CNS for approval. (*Editor's note: The resolution's author uses the PEER review designation for what most of us know as Utilization/Pre-authorization review.*)

Resolution III: BE IT RESOLVED, that the CSNS request the AANS/CNS to prepare a position statement supporting neurosurgeons who choose not to participate in private insurance contracts, and

BE IT FURTHER RESOLVED, that the CSNS request the AANS/CNS prepare a position statement regarding acceptable methods for determining usual and customary fees; and

BE IT FURTHER RESOLVED, that the CSNS request the AANS/CNS to request the Washington Committee provide resources to states where this practice is being threatened.

Resolution IV: BE IT RESOLVED, that the CSNS ask the ABNS, AANS, and CNS to issue a joint position statement to the AAST asserting that the training required to fully understand and care for both acute surgical and non-surgical traumatic brain injuries requires several years of dedicated study and practice; and

BE IT FURTHER RESOLVED, that the position statement includes the assertion only those completing an ABNS-certified training program should provide primary management for acute traumatic brain injuries after initial evaluation and triage is performed.

Resolution V: BE IT RESOLVED, that the CSNS investigate whether currently available skills competency training and virtual reality training tools could efficiently contribute to neurosurgery resident training and potentially improve quality of patient care; and

BE IT FURTHER RESOLVED, that if appropriate tools exist, the CSNS investigate potential means of introducing them into resident training; and

BE IT FURTHER RESOLVED, that an *ad hoc* committee be formed to present a report on the above findings to the plenary session of the fall 2009 CSNS meeting.

Resolution VI: BE IT RESOLVED, that the CSNS encourage the utilization of a password-protected "Tool Box" to allow for an active repository of categorically organized information storing topical financial, legal and economic documents affecting neurosurgical practice; and

BE IT FURTHER RESOLVED, that this “Tool Box” be used as a complete reference library including policies, protocols, procedures, rules and regulations, government compliance documents (Medicare, Joint Commission), care maps, standard orders, continuing medical education accreditation compliance resources, informed consent forms, research tools (protocol development, grant application guidelines and opportunities), and other resources related to neurosurgical healthcare delivery which can be modified as needed for individual or institutional use under the direction of a neurosurgeon; and

BE IT FURTHER RESOLVED, that the CSNS remind its members on a quarterly basis, through e-mail blasts, requesting submission to this “Tool Box” to encourage and enhance the research capabilities of neurosurgeons seeking expedient information and exemplary resources for their own individual or institutional use.

Resolution VII: BE IT RESOLVED, that the CSNS urges the AANS, CSNS and Washington Committee to support the general principle of the Physician Payments Sunshine Act which will clearly specify reporting criteria for payments received by physicians from pharmaceutical and device companies and work to support its passage in a form acceptable to neurosurgery, and

BE IT FURTHER RESOLVED that the CSNS create an educational module about defining, avoiding, and resolving Conflicts of Interest.

Resolution VIII: BE IT RESOLVED, that the CSNS urges the AANS and CNS, through the Washington Committee, to support the general principle of a national medical device registry based on the concept of a unique device identification (UDI) number. ❖

Neurosurgical Position

Any CANS member who is looking for a new associate/partner/PA/NP or who is looking for a position (all California neurosurgery residents are CANS members and get this newsletter) is free to submit a 150 word summary of a position available or of one's qualifications for a one time posting in this newsletter. Submit your text to me by E-mail (rws-avopro@sbcglobal.net) or fax (858 683-2022). ❖

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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