



**President's Message:**  
**ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)**  
**[For Neurosurgeons-Good-Bad-or Indifferent]**

*William L. Caton III, M.D.*

**T**he Joint Commission requires collection of physician performance data. Medical staffs are currently required to collect physician -specific performance data on a regular basis in addition to the every two-year credential cycle. The goal of this "Ongoing Professional Practice Evaluation (OPPE)" is to ensure that all physicians with medical staff privileges are monitored routinely and regularly regardless of whether there are specific performance issues, to find problems in a timely manner, and to take appropriate steps to improve quality.

The specific data to be collected is to be determined by individual medical staffs but the Joint Commission suggestions include, among other things, procedures performed and their outcomes, pharmaceutical usage, diagnostic tests ordered, length of stay patterns, morbidity, and mortality data

The Joint Commission notes that the intent of the requirement for ongoing OPPE is to develop a standard for organizations looking at data on performance for all practitioners, with privileges on an ongoing basis rather than a two-year appointment process to allow them to take steps to improve performance on a more timely basis. The Joint Commission notes that the clearly defined process would include, but not be limited to:

1) Determining who will be responsible for reviewing performance data;

2) How often the data would be reviewed. They note the frequency for such evaluation can be defined by the organized medical staff at 3 months, 6 months, 9 months, etc. They do note that 12 months would be periodic rather than ongoing and therefore would have to be done more frequently. The process would be implemented to use the data to make decisions as to whether to continue, limit, or revoke privileges. This could include defining who can make and approve recommendations, e.g., the department chair when no action is necessary, the MEC, and the governing body for limitation or revocations.

3) How data will be incorporated into the credential files. There needs to be a defined process for the data to be in the record and for the review to occur.

The decision resulting from the review, whether to take action or continue the privilege, would need to be documented along with supporting data.

The type of data to be collected would need to be defined by an individual medical staff department and approved by the organized medical staff. The standards would require evaluation for all practitioners, not just those with performance issues. The departments will know best what type of data will flag both good and bad performance for the various practitioners in their departments. The organized medical staff will then determine if the correct type and amount of data is being collected.

The standard's rationale outlines suggested data that the organization might choose to collect along with the following suggestions for methodologies for collecting information. These include:

- a. Periodic chart review.
- b. Direct observation.
- c. Monitoring of diagnostic and treatment techniques.
- d. Discussions with other individuals involved in the care of the patient including consulting physicians, assistants to surgeons, nursing, and administrative personnel.

While some types of data apply to all positions, since performance is different for different practitioners, there may need to be specific data. In addition, since most practitioners perform well, there will be data on their actual performance, as well as those with performance issues. The fact that a

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practitioner does not fall out of a predefined screening criteria is not sufficient to meet the requirement for performance data on every practitioner. They note it is also important to remember that zero data is, in fact, data. Zero data can be evidence of good performance, e.g., no returns to the O.R., no complications, no complaints, no infections, etc. They also note it would be important to know when someone is not performing certain privileges in a given period of time. It would not be acceptable to find at the two-year report that someone was not performing a privilege for two years.

The information resulting from evaluations needs to be used to determine whether to continue, limit, or revoke any existing privileges at the time the information is analyzed. Based on the analysis, several possible actions could occur, but not be limited to:

- a. Determining that the practitioner is performing well within the desired expectations, and no further action is warranted.
- b. Determining that the issue exists that requires a focused evaluation.
- c. Revoking the privilege, because it is no longer required.
- d. Suspending the privilege, which suspend the data collection and notifying the practitioner that if they wish to reactivate it, they must request reactivation.
- e. Determining that zero performance should trigger a focused review whenever the practitioner actually performs the privilege.
- f. Determining the privilege should be continued, because the organization, as mentioned, is able to provide the privilege to his patients.

Evidence of these determinations will need to be included in each practitioner's credential file at the time of each review of the data.

These standards are now being enforced by the Joint Commission, when hospital periodic reviews are being accomplished. Each hospital is required to develop a set of protocols to comply with the regulatory requirements by ensuring that there is a defined process for the OPPE.

This information is obtained from the Joint Commission Website

<http://www.jointcommission.org/Accreditationprograms/hospitals/standards/09>

### **Comment**

Unfortunately, as one reads through the Joint Commission's requirements, it becomes apparent that abuses can occur within this organizational system. The issuance of surgical privileges is now being defined in a different fashion. The more specifically the defined privilege is, i.e., craniotomy for aneurysm, craniotomy for AVM, or craniotomy for tumor, etc., the more likelihood that some physicians will not meet the requirement of an adequate number of cases over a short time frame as defined by their institution.

The ongoing OPPE review on an every 3 to 6 month basis can certainly results in ultimately limiting physicians privileges. Indeed, the busy physician will be able to meet the demands of frequency of particular surgeries, but a physician less busy at an institution may well end up losing his privileges, although he is entirely capable of carrying them out and has been certified by the ABNS.

In addition to the potential abuse of the physician surrounding his privileges, the institutions are now going to be able to use these data reports to develop economic credentialing as well.

At a local institution in Southern California, they initiated an OPEE review for a pending Joint Commission visit that included economic data in addition to the physician performance data. They created a report showing the average charge for a DRG/procedure group and a "national average charge". These charges are the hospital bill. The hospital noted that the national charge data was not related to regional charges but was derived from information from a consultant. This was obtained from undefined data across the United States and had no correlation with California data. The hospital charges are generated entirely by the hospitals with dramatic markups for drugs, instrumentation etc and are no way related to true costs. When asked of the administration if these numbers were going to reflect future true costs and income generated in accordance with these same DRG numbers (economic credentialing), they refused to answer.

Unfortunately, it appears that this will be a way that hospital administrations will develop methodologies for economic credentialing under the guise of improving a physician performance.

These OPPE demands are going to be instituted at every hospital in California. Certainly, the neurosurgical sections should looked carefully at these "reviews," and be prudent as they enter into them.

There is a constant assault on physician independence in California by the Legislature, and hospitals are attempting more and more to reverse the ban on corporate practice of medicine. Although the OPPE reviews may be on their initial review a positive source of information, they certainly are subject to abuse.

I would your comments to our newsletter editor. We need as neurosurgeons in California to respond to these assaults on our profession. ❖

## Harassment 101, 102 and 103

*Randall W. Smith, M.D., Editor*

**101.** The Federal Trade Commission's (FTC's) "Red Flags Rule" becomes effective May 1. This regulation requires creditors (they who issue invoices or defer payments for services) including hospitals and physicians, to have a plan for avoiding identify theft of patients and helping them when theft has occurred. The American College of Surgeons and other physician groups joined the American Medical Association (AMA) in opposing the application of the rule to physicians but to no avail. Violations of the regulation will result in a penalty of up to \$2,500 per "knowing violation." The AMA has prepared a guidance document, along with sample policies, to assist physicians in bringing their existing HIPAA security and privacy policies into compliance with the Red Flags Rule. That document is attached to the E-mail you received that included this newsletter.

**102.** You may recall that sign you see in auto repair shops informing the customer that repair shops are monitored by the state and listing a phone number to call if you are unhappy with the repair shop so the state can investigate and potentially fine the shop. Well, the Medical Board of California thinks these signs are such a good idea they want to mandate we docs have one in our offices pointing out that the MBC stands ready and able to respond to complaints by our patients about any of our care they don't like. The MBC thinks this is a good way to inform patients about the Board and gives them an avenue for complaints instead of going down the "get an attorney" road. Docs and the CMA think this is instant escalation and would hope that patients complain directly to the doc or the local medical society so as to keep the angst local if possible. And if you don't like this posting rule, there is a bill going through the state legislature that would require docs to post their professional degree and state certification or license in the waiting room instead of sequestered away on the walls of our personal offices.

**103.** Some poor doc in New Jersey got socked with a \$635,000 judgment for failure to provide a sign language interpreter for a deaf patient. State and Federal antidiscrimination laws are supposed to ensure effective communication with patients who have language "difficulties" which apparently include patients who have poor or little English comprehension. The AMA suggests we document that a patient needing assistance has agreed that a family translator is satisfactory (though they don't like the family member translator idea) and that if the patient requests a formal interpreter, you need to supply one irrespective of the fact that the cost of such an interpreter may well turn the office visit into a negative income event. We love the idea of inquiring of every patient not named Smith as to whether they understand English or wish to have an interpreter. Talk about getting off on the right foot with a patient! ❖

### From the EXECUTIVE OFFICE

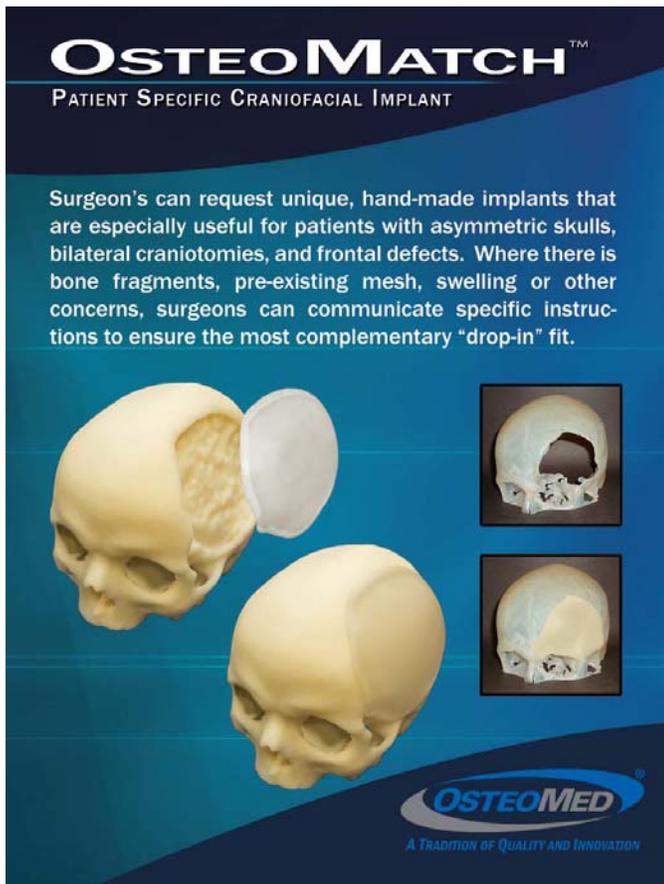
#### Membership Dues

Second dues notices will be sent next week so please pay promptly and make sure you carefully check the address and e-mail listed on the dues statements so that your contact information is kept current.



#### Annual Meeting

Reserve January 15-17, 2010 (Martin Luther King weekend) for CANS' return to Disney's Grand Californian Hotel in Anaheim. Meeting details will be posted to the CANS website as program plans develop. ❖



and pay for them even in the absence of neurological deficits. The whole procedure including implant, hospital stay, etc. costs approximately 50% of what the more "modern" techniques cost with same outcomes. ❖

## Letter to the Editor

*J. Paul Muizelaar, M.D., UC Davis*

CANS is doing great work, but I do not agree with everything Dr. Caton wrote in last month's newsletter. In particular, I have seen a number of cases where (neuro)surgeons charge for "partial vertebrectomies", when all they do is bite off the posterior osteophytes from the vertebral bodies or use a drill for a foraminotomy during ACD&F: This is a far cry from the truth (removing >50%)! An incomplete corpectomy must be extremely rare; I have never done it.

Furthermore, when we do, say a L4-5, laminectomy, median facetectomy and foraminotomy, we indeed decompress only one nerve root and only 63047 would be the correct code; to add 63048 would demand also doing L5-S1 or L3-4 (or any other level). We can, however, add -50 if procedure done bilaterally.

About Workers' Comp "back injuries" (and many other so-called injuries such as carpal tunnel), you know as well as I do that that is mostly BS, that the comp system needs to be **RADICALLY** overhauled. (I once removed a brachial plexus tumor under WC, because patient first noticed the numbness in her fingers while typing.....).

Finally, there is an FDA approved and proven effective use for interbody devices, i.e., the titanium interbody cages (such as Ray cages), so I do think Anthem should approve them

## Letter to the Editor

*Michael Robbins, M.D., Sacramento, CA, CANS Treasurer*

Recently our president Bill Caton reported on discussions he held with Blue Cross of California in relation to controversies regarding the reimbursement process and review of claims payment. Being currently a reviewer in this process, I have been asked to provide our members with some insight into how to diminish their conflicts and potentially reduce their "wasted" time and expense on appeals and denials of service.

First, we surgeons need to be totally honest and ethical in the reporting and billing process to the insurer. Just because you or your staff attended a coding course and were given advice about extra codes or additional modifiers or whatever "gimmicks" they were touting, does not mean you will receive or can demand payment for those codes.

The most crucial part of the reimbursement process is your operative note. Take the time to completely and accurately document the procedures you have performed and do not exaggerate or overstate your performance. This does not mean simply listing them; the body of your dictation must reflect the work that you have performed. Surgeons with expertise in your field do review these reports and know the difference between a "corpectomy" and a removal of endplates to insert a graft! Use anatomical details and actual measurements whenever possible (size matters)!

Familiarize yourself with the coding book and what the description of procedures mean as well as what is included in those procedures. A laminectomy for stenosis does pay differently than for a discectomy. A cranioplasty is not putting the bone plate back in after your tumor removal is finished. Understand the difference between vertebral levels vs. segments (usually includes the vertebra above and below a disk space).

Remember that certain procedures such as fluoroscopy, intra-operative nerve monitoring and injections of steroid or morphine at the end of procedures are not reimbursed separately and are considered by most payers as included in your primary procedure.

Finally, work with your practice administrators, office managers, and billing personnel to educate them in the work you do and allow them to educate you with the knowledge they have regarding the interpretation of codes, procedures and diagnoses. Making that a symbiotic relationship will ensure that you submit accurate, "clean" claims that lead to prompt reimbursement.

Now don't inundate me with complaints or disparagement for the system that exists with the insurer. I didn't invent the codes or design the system used for the review and payment of claims. I do, however, try to fairly give physicians the maximum allowable codes for the work they do. Take the time to accurately and honestly report the work you do and you can diminish your frustration with being promptly and fairly compensated. ❖

## Tidbits from the Editor

### Lower Locum Costs

Due to the efforts of Deborah Henry, CANS Board Director representing southern California, the AANS Web site now allows those of us interested in serving as a locum tenens to list ourselves as available along with the states in which we hold medical licenses. The goal is to allow those interested in employing a locum to connect with those willing to be a locum in order to reach a private agreement and avoid the cost of using a locum tenens company. To register as interested in serving as a locum, on the [aans.org](http://aans.org) Web site, click on the MyAANS icon, then log in and click on the Census-New option on the left list which will bring up your education and certification data. Click on the Locum Tenens option on the right Census Menu then check the box indicating your are interested in being contacted about locum work and add any states in which you hold a medical license besides California then click on "continue" a couple times and finally select the submit option on the last page of your data. If you are interested in hiring a locum, click on the left column Directory option in the members log-in section and at the bottom of the search page there is an option of checking a locum tenens box, choose CA as the licensure state and then click search and up will come those who hold CA licenses and are interested in being a locum. As of our newsletter publication date, no one has signed up as having a CA license and being interested in acting as a locum. ❖

### Pharmascolding

A panel was convened two years ago by the Institute on Medicine as a Profession, a nonprofit housed at the Columbia University College of Physicians and Surgeons. In 2006, this IMAP panel proposed conflict-of-interest policies for academic medical centers. Many medical schools adopted the policies, and most of those recommendations later were included in a 2008 Assn. of American Medical Colleges report. Now that 11-person panel (2 PhDs and 9 MDs), in an April 1 report in the Journal of the American Medical Association, has recommended that all physician organizations should strive for zero dollars in industry funding of their activities. Presuming that any industry funding is dirty, David J. Rothman, PhD, IMAP president and a panel member, says "We're asking medicine to clean its house". One must presume that Dr. Rothman's house, whatever that might be, is already clean. As the article stated, "The recommendations are rigorous and would require many PMAs (Professional Medical Associations) to transform their mode of operation and perhaps, to forgo valuable activities. To maintain integrity, sacrifice may be required. Nevertheless, these changes are in the best interest of the PMAs, the profession, their members, and the larger society." Steven Nissen, MD, a panel member and chair of the cardiovascular medicine department at the Cleveland Clinic's main campus, said "When professional medical societies accept money from industry, it creates an appearance of influence. And that appearance undermines the most important thing we own in medicine, and that's the trust of patients." (That is certainly one man's opinion. I would opine that our patient's trust of us isn't remotely affected by this issue as long as we care for them with their best interests in mind and have great drugs and devices to use in doing so.)

This self appointed panel was generous enough to allow as how keeping industry funding to less than 25% of budget would be an acceptable beginning for us docs. It turns out that most PMAs have less than 25% industry funding. The American Psychiatric Association, the American College of Physicians, the American Academy of Family Physicians

and the American Academy of Orthopaedic Surgeons and the AMA all have less than 25%. The AANS, according to its CEO, gets 5.21% of its Annual Meeting income and 8.16% of its annual Operating Income from industry. (The CNS CEO wouldn't disclose amounts without Executive Committee review and discussion.)

James H. Scully Jr., MD, the American Psychiatric Association medical director and CEO, also served on the IMAP panel. He said he disagreed with the group's zero-dollar goal for all industry support of physician organizations. "There are ways of being transparent and firewalling relationships that are in everyone's interest," Dr. Scully said. "And as we have [relationships], they will be quite open and reviewable." I would suggest we need an 11-0 vote for the death penalty. ❖

### Work Comp IME Creates Duty

Most of us who perform Comp IMEs or QMEs or AMEs have felt that such evaluations do not create a physician-patient relationship with all its inherent responsibilities. Not so in Arizona. A jury in that state decided that a doc who did an IME on a patient, and who had the patient sign a document indicating that such a relationship did not accrue to the evaluation, did indeed owe the patient a duty to advise him appropriately and when the patient dies from an accidental pain med overdose, the IME doc was responsible for 28.5% of a 5 million dollar damages award. The jury's thinking is a bit obscure and may fail on appeal but the idea that any doc seeing any patient for a professional opinion owes that patient a duty to advise care to avoid serious injury or death does carry some credence. I have always wondered when acting as an AME just what to do about giving advice when the MRI shows cord compression with myelomalacia or a lumbar spine MRI discovered a renal mass. The Arizona case suggests that when an IME detects vary serious issues that could result in real bad patient injury or death, the smart and ethical move is to clearly so state verbally to the patient during the evaluation and also clearly and with bolded and underlined emphasis, so state in the report generated. I also would send a report containing such recommendations directly to the patient who is often not included among the report's recipients. ❖

### CANS Spring Board meeting

The well attended spring Board meeting in the Sheraton Gateway hotel at LAX on April 25<sup>th</sup> resulted in:

1. Admission of 2 new members: Dr. **Maxwell Boakye** at Stanford and Dr. **Geoffrey Zubay** of San Diego.
2. Notation of the financials for the January annual meeting in Carmel which was attended by 59 docs and 18 exhibitors. The upshot was a loss of a bit less than 2K predominantly due to the cost of transporting the 100 diners from the Quail Lodge to the rather spectacular banquet at the Monterey Aquarium. It was felt that future banquets should be held at the meeting site if practical.
3. Voting a 10% salary bonus to the CANS Executive Secretary, Janine Tash, noting that she had rescinded her planned retirement and that if she ever left CANS, the organization would probably implode.
4. Discussion of plans for the 2010 annual meeting at the Disneyland California hotel particularly regarding the Sunday educational offerings which could include CME courses pertaining to (a) the biannually required 10 CME hours necessary to maintaining an OR fluoroscopy permit (b) the annual 12 trauma related CME hours required of neurosurgeons providing emergent care in trauma centers or (c) the biannual 12 CME hours required to maintain a work comp QME certificate. **CANS members are requested to communicate their interest in receiving general CME credit for the Saturday program and which Sunday CME activities listed above they would prefer. Respond to Janine Tash at [janinetash@sbcglobal.net](mailto:janinetash@sbcglobal.net).**
5. Noting that the Association of California Neurologists has indicated an interest in holding their annual meeting in conjunction with ours in January 2010 and attending our Saturday morning program. CANS has done this joint meeting before and found it difficult to allocate costs, responsibility, CME credits and exhibitors between the two groups. Further discussions will be held with the ACN.
6. Deciding that Dr. John Kusske, CANS Historian, should continue to digitize the records of the organization particularly including the various meeting minutes but that the paper records will continue to be maintained at the CANS

office in Sacramento. Ms. Tash was asked to research the cost of creating a password protected members only area on the Web site where the digitized records could be archived.

7. Deciding to contribute \$500 to the coalition to protect MICRA (the Medical Injury Compensation Reform Act) known as Californians Allied for Patient Protection (CAPP).

8. Deciding to support or remain neutral pending debate in San Diego on all the CSNS resolutions listed in last month's newsletter except Resolution II pertaining to Utilization Reviewers which was felt to need a lot of clarification and Resolution III pertaining to creating a Usual and Customary Fee schedule which was felt to be a regional issue and not a national one. ❖

**THOUGHT OF THE MONTH:** I usually try to conclude each monthly newsletter with a little chuckle. Can't say there is much to chuckle about in late April 2009. After reading the anticipated upshot of the Obama administration's medical system overhaul along with the latest AANS "Neurosurgeon", which features many articles on partnering, some conclusions seem warranted. First, the Fed's goal of reducing medical costs in the near term has to be built on some reduction in our fees. Second, partnering with your fellow neurosurgeons is essential since group negotiations will be more successful than solo or duo docs approaching the negotiating table. Third, the best source of improving or maintaining our income over the next few years will be our hospitals who have to have us for sustaining the DRG acuity index upon which they rely and to provide profitable services such as spine surgery and trauma care. Just hunkering down in your office hoping that the Fed's will be nice and that the hospital will help you out of the goodness of their hearts is sheer folly.—R.S. ❖

#### 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](mailto: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](mailto:rws-avopro@sbcglobal.net) or to the CANS office at [janinetash@sbcglobal.net](mailto:janinetash@sbcglobal.net). Past issues of the monthly newsletter are available on the CANS website at [www.cans1.org](http://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](mailto:janinetash@sbcglobal.net), (916-457-8202) with the word "unsubscribe" in the subject line.*

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