



CANS

NEWSLETTER

California Association of Neurological Surgeons

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President's Message

William L. Caton III, M.D.

Wanted: Neurosurgical volunteers for an international collaboration in neurosurgery and neuroscience in a major modern comprehensive cancer center in Bangalore, India

The Narayana Health Center is a comprehensive modern complex of multiple hospitals put together to provide care to the Indian citizens in the city of Bangalore and the state of Karnakata in southern India.

This center is the result of the vision of Dr. Devi Shetty, cardio-thoracic surgeon. When Dr. Shetty was living in Kolkata, India, he had the opportunity to care for Mother Theresa. Mother Theresa, he notes, badgered him to return back to Bangalore and establish a program for the poor of India to help provide health care.

Devi did indeed move back to Bangalore from Kolkata and, with the help of his family, founded a 1000-bed cardiac hospital. With Devi's perseverance and leadership, this cardiac center has now become the busiest open heart center in the world with an average 35 open heart surgery patients a day performed by 27 cardiac thoracic surgeons. Their pediatric cardiac ICU houses 80 children and provides free cardiac surgery for children throughout the world. At this point in time Dr. Shetty has operated on children from 27 different countries.

As time has passed, Devi realized that he needed to expand this center and to build up major medical centers throughout India. Currently, the Narayana Center in Bangalore also has a 400-bed eye hospital and 325-bed orthopedic hospital.

For Devi to continue to further his outreach to the Indian citizens, he then put together with the help of some major philanthropists a new 1000-bed comprehensive cancer hospital. This cancer hospital has set aside 100 beds for neurosurgical patients. Indeed the neurosurgical floor is approximately 50,000 square feet. Contained within this are eight neurosurgical operating rooms and a 16-bed neurosurgery ICU.

To fulfill his vision, Dr. Shetty has reached out for neurosurgical help to develop both a neurosurgical unit and a neuroscience center. The funding for the patients in this hospital has been provided by a charitable trust. The hospital was built with the idea in mind of providing not only inpatient care, but also outpatient care for cancer patients throughout the region. They anticipate the 1000-bed hospital to be virtually full within the next few months and that they will have 7000 outpatient visits a day. Although this number sounds gigantic, the cardiac hospital, which also has some general medical beds, has 4000 outpatient visits a day.

Dr. Shetty put together a group of philanthropists who have donated significant funds to building the hospital and outfitting it in a very modern fashion. The Board of Directors includes the major philanthropists in India. One has given a gift of ten million dollars to provide a clinical trial unit within the hospital itself.

The hospital is also supported by major Indian companies including *Infosys* and *Biocon*. Both of these companies are located in Bangalore and have been providing help and oversight for building of this institution.

Dr. Shetty has encouraged the collaborative effort of American neurosurgeons with the hospital and I have the opportunity to help organize this.

The goal is to have a visiting neurosurgical faculty there year around and to help build a collaborative effort in a basic neuroscience and applied medical science institute on the campus as well.

The funding for the patient care comes not only from charitable institutions but also from the State Government of Karnakata and also micro insurance

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programs. The initial micro insurance program involved the dairy farmers in this Indian state. Each dairy farmer contributed 8 cents a month to this program and the government contributed 12 cents monthly. Although \$2.40 per year sounds like a relatively small sum, by taking care of a large volume of patients and being cost efficient, they have the ability to ratchet down the cost significantly. Indeed the complete cost to come to Narayana Health Center and undergo a quadruple-vessel bypass procedure is only \$1500. This includes the hospital cost and surgical fees.

The initial opening of the hospital was in the past few weeks. I had the opportunity to organize an international symposium on collaborative medicine between the U.S. and India which we presented on June 2, 2009 in Bangalore.

The first visitors to be involved in this international collaborative effort included Dr. Sandra Levine, Chief Physician at City of Hope National Medical Center and Dr. Jack Lewin, Executive Director of American College of Cardiology. Each spoke on collaborative efforts. Dr. Levine discussed the collaboration of the City of Hope and cancer programs in the United States with the comprehensive cancer hospital in Bangalore. Dr. Lewin discussed an outreach of the American College of Cardiology to India and further collaborative efforts.

I had the opportunity to discuss the organization and collaboration of neurosurgery and neuroscience. I anticipate that with our combined efforts this brain tumor center will be one of the busiest centers in the world. I noted with the collaboration of the physicians, the state government, the fledgling insurance programs and the major corporate efforts of *Biocon* and *Infosys* that the Brain Tumor Institute was uniquely situated to broaden the horizons of the neurosurgical treatment of patients with brain tumors.

Dr. Sunil Hegde, rehabilitation physician talked about the fledgling efforts of building a rehabilitation system in India. At this time, rehabilitation medicine does not exist. Indeed in the whole state of Karnataka, there are only three rehab physicians.

In addition, we also put on the first annual neurosurgical symposium. Dr. Bruce Tranmer, Chairman Department of Neurosurgery, University of Vermont and Dr. Benham Badie from the City of Hope National Medical Center in Duarte, California participated in the symposium. At the seminar, Dr. Hegde and I also had the opportunity to present papers, as did a visiting radiation therapist.

Dr. Tranmer and Dr. Badie also collaborated on seven craniotomies over a three-day period. They participated in rounds and worked with the neurosurgical residents of the medical center. Our Indian colleagues were pleased with the collaboration.

This initial interaction of the American and Indian neurosurgeons was well received and will serve as our future model of collaboration.

Our goal is to have visiting U.S. faculty on a regular basis, ideally weekly or 2-3 weeks at a time throughout the year. We hope to have visiting neurosurgeons there every month and I would encourage visiting physicians to return annually if possible. The Indian neurosurgical residents and faculty noted they benefited significantly; Dr. Tranmer, Dr. Badie and I felt it was a good experience for us as well.

I encourage both private practice neurosurgeons as well as academic neurosurgeons to consider volunteering in this project. You will participate in rounds, neurosurgical conferences, talks and operative procedures. The Indian Government has acknowledged that the American training and licensure is adequate for an Indian temporary license. These will be awarded to American physicians while they are there on a temporary basis. The only restriction is that no procedures can be done for any financial gain.



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The current system is run by Dr. P. Hegde, the Chairman, Department of Neurosurgery in the Narayana cardiac hospital. He has three junior faculty and six residents at this time. He is helping in the organization of the brain tumor service. Dr. Paul Salins is the physician in charge of the Cancer Hospital and is recruiting more full time faculty. It is anticipated that a new residency in neurosurgery will also be formed at the Cancer Hospital.

Dr. P. Hegde will help oversee the visiting neurosurgeons' stay. There is free housing on the grounds for the surgeon and spouse, if they wish to come. There is also free housing for residents if they wish to attend. If a visiting physician wishes to have a hotel, there is one available for the neurosurgeon within two miles of the hospital. This is a five-star facility, which costs approximately \$175 a day. Also available is a new three bedroom, three bath condo in Bangalore a twenty minute drive from the hospital. This is provided as a courtesy at no charge from Dr. Salins. I have stayed at the condo and found it quite nice.

The overall goal of Dr. Shetty is to have this international collaboration in cancer care in neurosurgery and neuroscience. From a neurosurgical perspective, this allows us an opportunity to collaborate and most likely become the largest brain tumor center in the world. India has one billion, one hundred million people and only 800 neurosurgeons. The government and the philanthropists have made every effort to build several major centers around India to provide health care for their citizens.

Within Narayana Comprehensive Cancer Center, we will be able to obtain significant neurosurgical data from the first day onward. This will include developing protocols and carrying out novel chemotherapies with certainly a large number of patients. This should easily allow the center to become one of the busiest in the world.

This is a unique opportunity. I wish to encourage my fellow neurosurgeons in California and around the United States to consider participation. It is being done to help Indian patients. It is not the medical tourism facility and has no intention to be. They are eager to provide top notch comprehensive and compassionate care for the citizens and they do need our help. I shall look forward to hearing from anyone who is interested in potentially participating. The facility is modern, well built and the Indian physicians there are very well trained. They look forward to our collaborative effort. If you have a potential interest in being involved, please email me at wlciiimd@aol.com. ❖

What's Next—Chief of Toe Surgery?

Randall W. Smith, M.D., Editor

The recent brouhaha about UCLA orthopedic surgeon Jeffrey Wang's alleged failure to report to the University his nearly 460K in payments from various companies from 2004-2007 brings up an interesting point. The point for our concern is not any lapse on his part, which is an internal issue between him and UCLA, or that US Senator Charles Grassley, a frequent critic of schools doing a poor job of policing conflicts of interest among researchers, brought the whole issue to light probably from information he received from a UCLA whistleblower. Our concern is Dr. Wang being characterized as the UCLA Chief of Spine Surgery by the Wall Street Journal who broke the story.

What could have led the WSJ to declare Dr. Wang as Chief of UCLA Spine Surgery? Well, it turns out the UCLA Department of Orthopedics (which still thinks Neurosurgery is a division of the Department of Surgery) lists Dr. Wang as a full Professor and Chief of the Orthopedic Spine Service and the authors of the WSJ article incorrectly translated that into the UCLA Chief of Spine Surgery. We are happy to note that our friend, Neil Martin, Chief of UCLA Neurosurgery, has not abandoned the spine surgical field to the orthopods although Dr. Wang's co-appointment in the Neurosurgery Department may presently be a bit of a strain. We further note that Dr. Martin has resisted having Chiefs of anatomical areas and wonder if the Orthopedic Department will at some point have a Chief of Elbow Surgery, a Chief of Ankle Surgery or, God save us, a Chief of Digital Surgery. ❖



ANNUAL MEETING January 15-17, 2010, Disney's Grand Californian Hotel

ATTENTION Exhibitors: Registration information was mailed two weeks ago. If your company wants to participate and you have not seen the material, please contact janinetash@sbcglobal.net to reserve an exhibit space.

Letter to the Editor: Challenge to the Corporate Bar of Medicine

John Bonner, M.D.

There are currently two bills with much legislative support in the California legislature (AB 646, Swanson and AB 648, Chesbro), which are attempts by union forces to weaken or remove the Corporate Bar of Medicine in California. These bills would encourage the unionization of physicians, resulting in ability to hire and control physicians. **If these bills pass, they could be as destructive to the practice of medicine in California as the loss of MICRA would be.**

The Corporate Bar of Medicine, contained in the Business and Professional Code Sections 2400 and 2052, protects physicians from undue influence from non-physician entities. It does not allow the direct employment of physicians to practice medicine and allows only physicians to practice medicine. Many states do not have such protection, and we must make efforts to prevent such a loss to California physicians. We should contact our legislators to prevent passage of this legislation. The June 17, 2009 CMA Call To Action gives talking points and lists by California counties the legislators on key committees. (From CMA Call to Action: Phone calls are most effective, but emails and faxes are important too.)

A complete list of legislators on the Health Committee can be found at:

http://www.sen.ca.gov/ftp/sen/committee/STANDING/HEALTH/_home1/PROFILE.HTM .

A complete list of legislators on the Business, Professions and Economic Development Committee can be found at: http://www.senate.ca.gov/ftp/sen/committee/STANDING/BUSINESS/_home1/PROFILE.HTM .

More information on these bills can be found on the CMA website at: <http://www.cmanet.org/news/hotlist.asp>.

The loss of the Corporate Bar of Medicine is important, also, considering the current efforts by the federal administration to create a public option of medical insurance. If a federal health care plan is put into place, private coverage will certainly become less as government supported insurance will be cheaper due to federal subsidies. Further, a subsidized federal plan would also be more attractive to companies and the public in general. With mandated coverage of pre-existing conditions and fewer insured in the available pool, due to the conversion of this public option, the private insurance coverage will certainly become more expensive, probably evolving with time to a single payer system. I suspect this is the intention of the administration despite their present denial of such.

With the loss of the Corporate Bar of Medicine, hospital systems could employ physicians and require participation in the public insurance plan for privileges, or directly contract with the public insurance entities with physicians as an IPA or HMO system – with the hospital system retaining 10 to 20% of the expected low Medicare or Medicaid rates just as a price of doing business. Physicians may believe they could avoid dealing with the public option, but may soon find a paucity of patients otherwise. This in itself is a good reason to defend the present Corporate Bar of Medicine.

P.S. To obtain more information on the Corporate Bar of Medicine, please refer to the CANS Newsletter, Vol. 35, No. 6, June 2008, pp. 6-7 on the CANS website, CANS1.org, where the many CANS newsletters are available. ❖

THOUGHT OF THE MONTH: Dr. Mark Sklar, a solo internist in DC, wrote an open letter to the President and Congress that was published in the Wall Street Journal (*entire letter attached to the E-mail you received that includes this newsletter*). He makes some sensible points about physician compensation, solo practice, fraud and abuse and malpractice costs. He sounds like a nice guy you would like to have as your personal physician but the future of his genre, a solo doc, is surely doomed and his sensible ideas will be buried in the great medical overhaul presently in the hands of the politicians and the pseudo-experts who advise them. ❖

Tidbits from the Editor

Publish or Perish—digitally that is

Last month we commented on Mike Apuzzo's prediction that by 2050 all journals will be digital and we lamented that being tied to the computer to read our periodicals would be a bit of a pain. Now comes the Kindle, a \$400+ light, thin and Time magazine-sized device from Amazon that allows the download of books and newspapers and magazines into the device via the Sprint cell phone network. For \$2.99 a month, it will automatically download a Kindle version of The New Yorker the day it hits the newsstand or for \$14.99 a month, it will download that day's Kindle edition of the Wall Street Journal at the crack of dawn and no matter where in the USA the Kindle is at the moment. The Kindle takes a little getting used to and needs some work on a prop-up attachment for table reading but it is otherwise very readable and portable and it seems that all the stuff worth reading in the print editions is in the Kindle version which carries no advertising. Of course, considering the computer notebook concept, it won't be long before a full functioning computer will be the size, thickness and weight of the Kindle and with ubiquitous internet access, will allow reading the digital periodicals purely on-line. Such will probably kill the Kindle before the JNS would be recognized as a profitable download candidate but the Kindle supports Dr. Apuzzo's prediction which we would submit is probably far too conservative. ❖

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When to toss an old patient's record

CAP/MPT, the CANS endorsed professional liability coverage provider, and the CMA are now both recommending keeping medical records for at least 10 years from last active contact (previously it was seven). Although there is no State or Federal law about length of record retention, both groups point out that the Federal False Claims Act allows federal, state, and local law enforcement to investigate fraud in billing for Medicare/MediCal patients. An investigation under the False Claims Act usually includes a review of the patient's medical record, and investigations may go back 10 years. In addition to this, data collected by California medical professional liability carriers indicates that 99 percent of all claims against physicians and hospitals by patients are filed within 10 years of the incident giving rise to the claim. Pediatric neurosurgeons should use caution when dealing with medical records belonging to a minor. The CMA's *California Physician's Legal Handbook* states that a minor's records "should be kept longer in those cases where the 10 [years] elapse before the minor has reached the age of 18. In no event should a minor's records be destroyed until at least one year after the minor has reached the age of 18."

If you are considering digitizing your inactive records, the above admonitions would suggest you need to scan each and every piece of paper in the chart. Maybe paying a storage facility to archive the actual chart will be simpler and maybe cheaper. ❖

More EHR stuff to consider

Speaking of electronics, the ongoing hype about Electronic Health Records (EHRs or EMRs) and how the Feds are pushing and partially paying for us docs to convert to them continues. A recent AMA survey that included about 150 neurosurgery respondents indicates 21.8% have converted to all electronic record keeping. For the 4 out of 5 of us who are considering the conversion, the hook is what constitutes “meaningful use” of certified EHR technology which will be required to qualify for the 44K the Feds are willing to pay for each doc to convert between 2011 and 2015. Well, we won’t get the final meaningful use answers until later this year which are supposed to address which EHR technology will be certified and how you must use it to get the lucre. The American College of Surgeons and the AMA feel that electronic prescribing and participating in PQRI will certainly be part of meaningful use. Those of us who want to dive in now before the Federal determination as to which EHR providers will be certified should at a minimum get the purveyor chosen to guarantee any upgrade necessary to meet the certification process.

Of additional EHR interest, a group from Boston has recommended that a generic EHR program be created that we all could buy from a purveyor and then add on various applications to make the generic program compatible with our local hospitals’ EHR (which would be the generic program plus whatever additional applications they might want on board) or the program as used by local doc groups with which you might want interconnectivity. This way, you only pay for the applications you really need for practice in your locale and would know that the appropriate apps will work with others who use the same apps. At present, it is buy a EHR system and then good luck in making it compatible with the numerous other systems in use at local hospitals and other provider offices.

The preliminary list of what constitutes “meaningful use,” which is still under discussion by the Feds:

By 2011:

- Use computerized physician order entry for all order types, including medications.
- Incorporate laboratory tests into EHRs and share results electronically with public health agencies.
- Generate lists of patients by specific condition to use for quality improvement.
- Provide clinical summaries for patients after each encounter.
- Exchange key clinical information among health professionals (problems, medications, allergies, test results, etc.).

By 2013:

- Generate and transmit prescriptions electronically.
- Manage chronic conditions using patient lists and decision support tools.
- Use bar coding for medication administration.
- Offer secure patient-physician messaging capability.
- Record patient preferences in EHR.

By 2015:

- Achieve minimal levels of performance on quality, safety and efficiency measures.
- Give patients access to self-management tools.
- Access comprehensive patient data from all available sources.
- Conduct automated real-time surveillance on occurrences such as adverse events, disease outbreaks and bioterrorism.
- Incorporate clinical dashboards into EHR.

Is 44K enough to jump through all these hoops or should we just accept the 3% cut in Medicare and Medicaid payments and fry some other fish? ❖

New Post-op PT rules for Work Comp Patients

On July 18th, a new guideline governing the use of physical therapy in the post-surgery period goes into effect. The new guideline is considerably more user friendly than the previously used and somewhat vague ACOEM guideline and we owe thanks to the doc heavy DWC Medical Evidence and Evaluation Committee (Praveen Mummaneni is the neurosurgery member of the committee) for these improved rules. A few caveats and examples:

1. Only the surgeon who performed the operation, a nurse practitioner or physician assistant working with the surgeon, or a physician designated by that surgeon can make a determination of medical necessity and prescribe postsurgical treatment under this guideline.

2. In the event the patient sustains an exacerbation related to the procedure performed after treatment has been discontinued and it is determined that more visits are medically necessary, physical medicine treatment shall be provided within the postsurgical physical medicine period.

Carpal tunnel syndrome

Postsurgical treatment (open): 3-8 visits over 3-5 weeks

Postsurgical physical medicine treatment period: 3 months

Artificial Disc

Postsurgical treatment: 18 visits over 4 months

Postsurgical physical medicine treatment period: 6 months

Intervertebral disc disorders without myelopathy (ICD9 722.1; 722.2; 722.5; 722.6; 722.8):

Postsurgical treatment (discectomy/laminectomy): 16 visits over 8 weeks

Postsurgical treatment (fusion): 34 visits over 16 weeks

Postsurgical physical medicine treatment period: 6 months

Displacement of cervical intervertebral disc (ICD9 722.0):

Postsurgical treatment (discectomy/laminectomy): 16 visits over 8 weeks

Postsurgical treatment (fusion, after graft maturity): 24 visits over 16 weeks

Postsurgical physical medicine treatment period: 6 months

The full text of the guideline and a detailed list of post-surgery rules can be found at

http://www.dir.ca.gov/dwc/DWCPropRegs/MTUS_Regulations/MTUS_Regulations.htm. ❖

AANS Call for Nominations

The Nominating Committee of the *American Association of Neurological Surgeons* is requesting suggestions for positions to be filled in **May 2010**. It is important to think ahead and provide sufficient lead-time to permit our group to consider, in a collegial or corporate fashion, the choices to send forward to the Committee by the **September 1, 2009 deadline**.

The offices to be voted upon for the May 2010 AANS election are: 1) President-Elect; 2) Vice President; 3) Treasurer; 4) **two** Board Directors 5) **two** Members of the Nominating Committee.

Please communicate your recommendations to Dr. Smith at rws-avopro@sbcglobal.net and they will be forwarded to the Board of Directors for endorsement. For detailed criteria and guidelines, contact janinetash@sbcglobal.net.

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.

California Association of Neurological Surgeons, Inc.

5380 Elvas Avenue, Suite 216
Sacramento, CA 95819
Tel: 916 457-2267; Fax: 916 457-8202
www.cans1.org

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Editor: Randall W. Smith, M.D.
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