



# CANS

# NEWSLETTER

California Association of Neurological Surgeons

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## CANS Board Wrestles with Reform

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

**T**he healthcare reformation debate in DC has certainly been intensively covered in the press and this newsletter's readers are probably approaching the brain-numbing level that results in an automatic turnoff. Although we may individually decide to quietly leave the issue to be decided by others, our professional organizations don't really have that option and CANS is no exception. The CANS Board of Directors has been debating the healthcare overhaul as reflected in House Resolution 3200 for over two weeks and reaching a solid consensus has not been achieved. But much like the national debate, some things appear to emerge:

1. There appears to be agreement among CANS BOD members that something needs to be done about the uninsured. Mandating that everyone must obtain health insurance would bring the 20+ million folks who can likely afford the insurance but choose not to have any into the insured fold. The mandate would force the 10+ million who are eligible for predominantly Medicaid to actually sign up for it. Nothing in the mandate would eliminate the 8+ million who are between jobs and will continue to be counted as uninsured no matter what we do unless they purchase a portable personal policy instead of relying on the employer to supply one. And the 10+ million illegal immigrants who fill out the commonly quoted 48 million uninsured will probably stay uninsured since they don't officially exist. The mandate should benefit the hospitals that will have to provide less uncompensated care (explaining their offer to decrease costs by 150 billion over ten years nicely offset by more than 150 billion in improved collections—these guys are neither benevolent nor stupid) and docs should see a decrease in providing uncompensated care particularly if you deal with emergencies in hospital.

2. Most Board members do not see that mandating electronic medical records, commencing a best practices determination and reducing fraud and abuse will likely save any big costs in the next 10 years considering the long lead time for these issues to potentially bring change. There is considerable concern that the proposed Independent Medical Advisory Committee (IMAC) which would be populated by President Obama and function outside of Congress to determine what services will be provided by Medicare, Medicaid and the proposed Medicare-like government sponsored health plan option, will quickly become a rationing agency for care options. That Committee would also control physician reimbursement and as the government plan and Medicare and Medicaid exceed estimated costs, provider compensation will be the simplest item to reduce. This Committee will have the ability to reduce doc payments unilaterally unless a Congressional override is passed within 30 days (starting from scratch, what has Congress ever done in 30 days except declare WWII and adjourn?) but it can only recommend increasing doc fees since that maneuver will require more money and Congress will have to provide the increase. Looks like trouble.

3. There is little agreement about supporting the Medicare-like government sponsored health plan as many suspect that such a plan will initially be priced artificially low, attract

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many millions of enrollees who like the price or can't get the Blues to cover them and their pre-existing conditions for a sensible premium and it won't be long before the actual cost of providing coverage in the government plan will skyrocket (like it did in Massachusetts, the poster boy for the individual mandate and a government sponsored option) and the initial promise of better-than-Medicare provider compensation will evaporate. The government plan is also suspected of eventually killing the private insurance/employer insurance market which tends to pay docs a bit better allowing them to treat Medicare and Medicaid patients at a loss.

4. There is some angst about the lack of any malpractice reform in the House bill which could reduce our overhead and the surtax on those making over 350K a year will likely affect a lot of docs. It is noted that no one has had the cojones to propose a 1% national sales tax which would have us all help pay for the new system including those who get a lot of subsidization. The rich will still pay a lot more because they spend a lot more.

The CANS BOD considered sending its own response to Congress, joining the few societies (led by the Medical Association of Georgia) who have repudiated the AMA endorsement of HR 3200 and created their own response or simply endorsing the position of the AANS/CNS on HR 3200 which is as follows:

- Ultimately, the public health insurance option will lead to a single-payer, government run healthcare system;
- Due to its high price-tag, the health system envisioned is unsustainable;
- Under the public health insurance option, the government is empowered to implement rules that would restrict patients' choice of physician and limit timely access to quality specialty care;
- The bill fails to recognize the looming workforce shortages in surgery by requiring that all unused medical residency training slots be allocated to primary care and placing the emphasis on national workforce policy on primary care, to the exclusion of surgical and other specialty care;
- The bill inappropriately expands the government's involvement in determining the quality of medical care and residency training programs;
- The bill permits the government to arbitrarily reduce reimbursement for valuable, life-saving specialty care for elderly patients, threatening treatment options;
- Patient-centered healthcare is threatened by provisions related to comparative effectiveness research, changes to office-based imaging and curtailing the development of physician-owned specialty hospitals; and
- The bill potentially stifles medical innovation and valuable continuing medical education programs. In addition, the House bill fails to include an essential element – medical liability reform. The AANS has also come out against the IMAC concept.

The CANS BOD ultimately decided to send its own response which is as follows:



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July 29, 2009

The Honorable Henry A. Waxman  
Chairman, Committee on Energy and Commerce  
U.S. House of Representatives  
2125 Rayburn House Office Building  
Washington DC 20515

Dear Chairman Waxman:

On behalf of the Board of Directors of the California Association of Neurological Surgeons, I write to express the strong opposition of our organization to **H.R. 3200, "America's Affordable Health Choices Act of 2009."** This proposed legislation represents a global assault upon and violation of the basic freedom of America's patients and their physicians to choose their treatment independent of massive governmental intrusion that would destructively interfere with the inviolable, sacrosanct patient/physician bond that has existed since Hippocrates. As presently constructed, H.R. 3200 must be defeated. We fervently urge members of your committee (and those of the House Education and Labor and House Ways and Means Committees) to withdraw this Orwellian bill from consideration by the entire House of Representatives.

Specific sections of H.R.3200 which we as American citizens and physicians believe are unacceptable include:

Sec. 1173 would "standardize electronic administrative transactions" and provide the Federal Government sweeping centralization of authority over health care and invade the privacy of all Americans. The financial and administrative standards would "enable the real-time (or near real-time) determination of an individual's financial responsibility at the point of service, and to the extent possible, prior to service, including whether an individual is eligible for a specific service with a specific physician at a specific facility, which may include utilization of a machine-readable health plan beneficiary identification card." (Page 58)

Sec. 102. "Protecting The Choice To Keep Current Coverage (a)(1) Limitation on New Enrollment (A) In General- Except as provided in this paragraph, the individual health insurance issuer offering such coverage does not enroll any individual in such coverage if the first effective date of coverage is on or after the first day of Y 1." (Page 16) (c) (1) "IN GENERAL- Individual health insurance coverage that is not grandfathered health insurance coverage under subsection (a) may only be offered on or after the first day of Y 1 as an Exchange-participating health benefits plan." First, insurers will not be allowed to sell any individual coverage outside the government's monopoly. Second, employers that can't afford to offer inflated coverage to their employees will be required to pay an eight percent fee that their employees cannot use to defray their cost of individual coverage through the exchange. This money effectively comes out of employees' pockets to help pay the government's bill to extend welfare relief to families making up to \$88,000 annually.

Even the British National Health Service allows citizens who can afford it to opt out and buy private health insurance and to be treated by doctors and hospitals outside the socialized system. H.R. 3200 only allows insurance purchase through the Exchange.

Sec. 312 stipulates that if you require employers to provide the expensive health insurance that workers would ultimately pay for it in lower wages and lost jobs. "For purposes of this section, any contributions on behalf of an employee with respect to which there is a corresponding reduction in the compensation of the employee shall not be treated as an amount paid by the employer." (Page 147) This is a major distortion of basic economics

Other aspects of H.R. 3200 that are unacceptable include the elimination of Health Savings Accounts; the failure to address tort reform as a means of reducing cost burdens of the practice of defensive medicine; the absence of a provision for private contracting of patients with physicians, which is a constitutional right; the vast expansion of scope of practice of nurse practitioners (usually a function of state legislatures); the omission of any consideration for collective bargaining by physicians; the nonfeasance and inattention to the demoralization of the physician community and its individualistic, entrepreneurial and innovative culture that responds to demands for higher quality, lower costs and greater access.

Your Committee has written legislation which, according to CBO Director Douglas Elmendorf, "significantly expands" costs, will increase the deficit and drive the nation more deeply into debt. Our organization would encourage the Congress to realistically address this issue before burdening the American people with this reckless disregard for economic and fiscal reality.

As citizens and physicians we pledge our individual energies and resources to defeat this malevolent legislation and those who insist on its passage and implementation.

Sincerely,

William L. Caton III, MD, President, California Association of Neurological Surgeons

What we all should be hoping is that there will be no rush to judgment as the President has urged (quick monumental decisions are like diving head first into 6 inches of water) and that during the Congressional August recess, our Senators and Representatives will get an earful from their constituents, think about things a bit and ultimately decide not to improve healthcare to the point of totally screwing it up. ❖

## President's Message: Health Care Legislation

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

**T**he nation is in turmoil concerning the proposed changes of the Health Care legislation. Virtually every patient who enters my office is quite concerned about having to change their health care or losing their ability to choose their physician. It is a constant theme that I have heard from my patients through the past few weeks.

Certainly, these proposed changes by the house bill as suggested by Congressman Waxman and Pelosi, et al has significant impact upon the medical care of everyone in the United States.

Many of our national organizations have taken strong stances. Some such as AMA seemed to have uniformly accepted the changes. Others, however, such as the American Association of Neurological Surgery and Congress of Neurological Surgeons have suggested significant changes in the proposed legislation.

Many other organizations have lambasted the proposals saying that it is totally unworkable. There is certainly some truth in this approach as well.

The board of directors and consultants of our organization have spent significant amount of time communicating with each other discussing our responses.

- I had asked several board members to draft their responses, in particular Dr. Prolo, to put together a strong response from CANS to Congressman Waxman and his helpers. A majority of the Board has voted to send the letter to Congressman Waxman. The text of that letter is in our editor's lead article this month (*see page 3*).
- The second step is that I have asked several CANS board members to participate in drafting a formal response suggesting improvements in the current legislative agenda. Multiple board members should be involved in this.
- Thirdly, I would ask that CANS members please respond to the CANS Executive Secretary with your suggestions for responses to the proposed health legislation.
- Lastly, the CANS board members shall send a letter of support to the AANS and CNS for their position in response to the proposed legislation.

Certainly, as it exists, there are several significant obstacles to the continued practice of neurosurgical care that we have provided over the course of our lifetimes and our practices.

The current house bill will significantly impact our treatment of our patients and our livelihood into the future. It is certainly worthwhile to have as many physicians as possible respond to these proposed federal changes and to notify their duly elected representatives of our feelings.

Certainly, we will continue to have an ongoing dialogue concerning the future legislation on health care. Many CANS members wish to take a proactive response and certainly this would be a wise path for our organization to pursue. ❖

**THOUGHT OF THE MONTH: Last month, this newsletter announced that there were a number of elected offices open for Board positions in the AANS and requesting suggestions from CANS members for neurosurgeons to nominate for those positions. The response—zero. One or two conclusions come to mind. Either CANS members don't give a whit about who is running the AANS or nearly no one reads the newsletter. I'd like to think it is the former but I sure could be wrong. The call for suggestions of nominees is repeated in this newsletter**

## Tidbits from the Editor

### When the Informed Patient Isn't

The US News and World Report recently published its annual ranking of US hospitals under the guise of helping patients be better informed about the “quality” of the hospitals they might use. They hyped the top 21 institutions for their overall excellence (three made it from CA—UCLA, UCSF and Stanford hospitals) based upon their ranking criteria which are significantly subjective at best and arcane at the worst. Given that, what information is available that might assist the discerning patient, who doesn't live near the top 21 (which is 80+% of the population), in evaluating their local choices? Here things get a bit tricky. There is no easily identified general hospital ranking beyond the top 21 and the patient must navigate the US News web site by selecting from among 16 specialty areas, one of which is Neurology and Neurosurgery (NNS). Each specialty area ranks the top 50 hospitals providing that service with scores running from 100 (Mayo Clinic for NNS) to the low 20s. The next thousand hospitals that offer that service are then listed alphabetically along with their US News scores ranging from the low 20s down to about 3. I guess the message is that if your local hospital or the one your doctor/consultant likes to use is not in the 1050 that are ranked in delivering a service, maybe you should consider being treated at one of the 1050 instead. Further, if a patient has an HNP and the consulting surgeon recommends a discectomy, then using the NNS rankings, my local hospital gets a score of 15.5 whereas if the surgeon is an orthoped, then the orthopedic specialty area ranking is 10.9. As any discerning patient can then easily see, he/she should have a neurosurgeon do the discectomy at that hospital. And thus the US News rankings, which don't evaluate specific surgeons or allow comparisons for specific procedures, do what they are designed to do which is give an overview of hospital care from 1000 feet in the air but don't do squat for ground level up close and personal useful information for the patient. Since you generally get what you pay for, the zip cost of the US News info is matched by its pretty much zip usefulness. ❖

### Wall Street Journal Dustup of Wang Issue

In last month's newsletter, we reported that the Wall Street Journal inappropriately characterized Jeff Wang, UCLA orthopedic surgeon who is alleged to have failed to report to the University most of the big bucks and stock options he received from device companies, as chief of the UCLA Spine Service when he was only chief of the Orthopedic spine service. Turns out he was indeed co-director of the UCLA Comprehensive Spine Center which appears to be a joint venture between orthopedics and neurosurgery and lists its faculty as comprised of 3 neurosurgeons (McBride, Holly and Batzdorf), two orthopods (Wang and Shamie) and a physiatrist. Little wonder that the WSJ translated this into Dr. Wang being director of UCLA's spine service. We withdraw our criticism of the Journal and further note that Dr. Wang has been removed as the UCLA Comprehensive Spine Center's co-director and suspect his co-appointment as a member of the UCLA Neurosurgery Department may be under review. ❖

### FTC Extends Red Flags Rule Deadline for Compliance

This newsletter has discussed the so-called Red Flags Rule under which companies and institutions including healthcare providers would be required to establish a way to identify potential identity theft risks at the business, find ways of detecting such threats, and install measures to prevent them. The program was to take effect Aug. 1, but will now be delayed until Nov. 1. Several groups, including the AMA, are lobbying to be exempted from the rule. Companies (and presumably docs) that fail to comply with the rule may face penalties of up to \$3,500 per violation. ❖

**ATTN Vendors:** CANS is now accepting newsletter ads.  
Please contact the executive office for complete price list and details.

## Letter to the Editor: Digital Neurosurgical Journals

*Martin Weiss, M.D., University of Southern California*

I read with interest your comments in the June issue of the CANS newsletter concerning publishing on-line. In 1996, when I completed my term as Chairman of the Editorial Board of The Journal of Neurosurgery, Dr. Jane and I decided to launch a new on-line journal in recognition of the emergence of the digital age. As you undoubtedly know, it is called Neurosurgical Focus and is a peer reviewed, index medicus and Library of Congress listed publication of "The JNS Publishing Group" (published by the AANS). It is an open access journal (does not require a subscription or password to access) that publishes a monthly Topic that contains peer reviewed manuscripts relative to the Topic. Each Topic has a group of "Topic Editors" who are recognized experts in the field, and John and I provide final editorial review (each manuscript is reviewed by at least 4 reviewers). Our intent was to create an on-line textbook of neurosurgery that has up to date material (most textbooks are 2- 3 years out of date by the time they are published) and that, unique to textbooks, provides peer review for anything that is published.

To my delight (and surprise) our most recent data from 2008 indicates that over 50,000 individuals visit the site each month with over 600,000 "visits" to various pages in the journal each month. We are now the world's most widely read neurosurgical journal (the JNS is in second place). I am told by my colleagues in the academic community that residents now use this as their primary textbook resource (certainly true of ours at USC), and we particularly enjoy a very large international audience since students and others around the world seem to have access to computers even though textbook purchasing might be prohibitively expensive.

Although we don't have specific demographics, the huge readership numbers suggest that we are reaching other medical disciplines as well as a general audience that has interest in a specific Topic. I make the topical selections and develop the editorial board for each Topic. As such, I have included discussions on issues such as cauda equina syndrome and its medical/legal implications (excellent material for defense in which plaintiff's lawyers claim the need for surgical intervention within hours of onset).

In addition, The Journal of Neurosurgery now uploads each new accepted article for The Journal to its on-line edition each Friday; so that articles are available on-line (and to PubMed) before they come out in the printed form. This makes authors very happy to have early publication of their accepted manuscripts.

Finally, at our last Editorial Board meeting in San Diego, Ed Laws undertook an assignment to negotiate with Jeff Bezos to have The Journal of Neurosurgery available on Kindle!!!

I never would have predicted this personally; but it's obvious that generations behind us are much more comfortable with the digital world. It's not 2050 but today that our residents can download the latest copy of Neurosurgical Focus on their I-Phones!!! ❖

***Editor's Note:*** Exploring digital publication of the JNS journals on E-readers is not far fetched. It is reported that the Amazon folk are investigating a Kindle version of many professional journals and there is already a Kindle version of the New England Journal of Medicine (for \$8.99/month). The trick for neurosurgery will be to interest those folks in our journals with their relatively small readership -- RS.

## 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). ❖

## Executive Office Report

Janine Tash

### CANS NOMINATIONS

The time of year has arrived to consider nominations for officers and directors as well as candidates for the Pevehouse and Ablin Awards. The Pevehouse Award is conferred upon a California neurosurgeon who has served both the community of neurosurgery and medicine in general in an extraordinary, effective and distinguished manner. The Ablin Award can be presented to a legislator or other public official for momentous efforts in achieving quality health care. Nomination letters will be sent within the next 2 weeks to CANS members so start thinking about people who you think would best represent your socio-economic interests. ❖

### AANS NOMINATIONS

The Nominating Committee of the *American Association of Neurological Surgeons* is requesting nominations for the positions of President-Elect, Vice President, Treasurer, two Board Directors and two Members of the Nominating Committee to be filled May 2010. Nomination deadline is September 1, 2009. E-mail, fax or phone your suggestions to Randy Smith, newsletter editor, at rws-avopro@sbcglobal.net, 858-6832022 (fax), 760-741-3809. ❖

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### ANNUAL MEETING

Plans are underway to plan a program next January that will provide interesting perspectives on the controversial topic of health care reform. Reserve the weekend of January 15-17, 2010 for the Grand Californian Hotel in Anaheim. This is MLK weekend so plan to stay over and enjoy Disneyland. A link to the hotel reservation website will be available the beginning of September. ❖

### PALMETTO MEET & GREET

Palmetto GBA administers Medicare health insurance in California for the Centers for Medicare & Medicaid Services (CMS). On July 28, along with the execs from the neurology and orthopaedic societies, I met with two Palmetto representatives (Wanda Holloway, Manager, Provider Outreach and Education, and Ruby Reed-Knighton, Ombudsman, Provider Outreach and Education) who are traveling around the country to put faces to names within the various medical associations. It was a very informative discussion and established good will between Palmetto and the specialties present. It was heartening to hear how hard Palmetto is working to establish good relationships with the providers and to continue to provide a quality work product. Some of the things discussed include:

#### 1. APPLICATION PROCESS

The *Provider Enrollment, Chain and Ownership System (PECOS)* is the application process for new providers. It is VERY important to fill out the application as accurately as possible, including all sub-specialty information, so that reimbursements are made in a timely manner. And remember to send in the certification information (which cannot be submitted electronically but must be mailed) within 15 days of completing the PECOS application. Palmetto has resolved the issue of having to speak with different people each time a call is made concerning the application; an individual analyst is now assigned to work on it from start to finish. In addition to your initial enrollment, it is extremely important to report to Palmetto any changes in practice, such as ownership changes, bank changes, business structure, etc.

## 2. RESOURCES

For any problems, your first point of contact should always be the Customer Service line (**866 931-3901**). Another good resource is the Palmetto website ([www.palmettogba.com](http://www.palmettogba.com)) which has sections on frequently asked questions (FAQ) and tools to help with things such as modifiers, denials, etc. When using the website, make sure you select **Jurisdiction 1, Part B**.

If you still cannot find the answer you need or you feel you have not received the level of service you require, then the next step is to contact the CANS office where your problem can be referred to an ombudsman. Because the ombudsmen are often out of the office traveling, a response may take several days.

Providers who experience trouble when submitting claims electronically using the Electronic Data Interchange (EDI) can call the Technology Support Center at **866 749- 4301**. ❖

## Medicare Payments for Neurosurgery

*Randall W. Smith, M.D.*

Due to adjustments in RVU values, the 2010 Medicare Physician Fee Schedule will include an average of a 2% increase for neurosurgeons. Examples:

CPT Code	Procedure Description	2009	2010
22554	Ant cerv fusion	\$1,200	\$1,236
22612	Lumbar post-lat fusion	1,485	1,563
22630	PLIF	1,433	1,505
22842	Lumbar pedicle screws	750	764
22845	Ant cerv instrumentation	719	734
22851	Interverte biomech device	399	409
35301	Carotid endarterectomy	1,068	1,120
61107	Twist drill- ventric	302	311
61154	Burr hole for SDH	1,145	1,225
61312	Crani for subdural	1,876	2,033
61313	Crani for ICH	1,798	1,930
61510	Craniotomy for tumor	1,993	2,122
61512	Crani for meningioma	2,356	2,492
61697	Brain aneurysm repair -- carotid (complex)	3,808	4,137
61698	Brain aneurysm repair – vert. basilar (complex)	4,082	4,551
61700	Craniotomy for aneurysm (simple)	3,211	3,348
61751	Stereotactic biopsy	1,250	1,352
61795	Intraop frameless stereotaxis	233	216
61796	Stereotactic Radiosurgery cranial (simple)	732	764
61798	Stereotactic Radiosurgery cranial (complex)	732	764
61800	Stereotactic Radiosurgery head frame placement	142	146

62223	VP shunt	945	1,019
62230	Shunt revision	763	816
62362	Programmable pump implant	385	411
63030	Lumbar discectomy	892	940
63042	Recurrent lumbar disc	1,222	1,272
63047	Lumbar laminectomy	1,015	1,070
63075	Ant cerv discectomy	1,284	1,341
63081	Ant cerv corpectomy	1,645	1,737
63620	Stereotactic Radiosurgery spine	732	764
63650	Perc epidural dorsal column stim	379	281
64718	Ulnar nerve transposition	517	561
64721	Carpal tunnel	377	401
99243	Office Consultation (will become Office Visit 99203)	125	103
	National Conversion Factor	\$36.07	\$36.07

The 2010 Fee is based on proposed Work, PE and MP RVUs and the current conversion factor is used for illustration purposes only. Until Congress acts, we do not know what the 2010 conversion factor will be, although we can be fairly certain that we will not get the scheduled 21.5% cut. ❖

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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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