CANS NEWSLETTER

California Association of Neurological Surgeons Volume 37 Number 7 July 2010

President's message

Kenneth Ott, M.D., F.A.C.S.

Where did we come from, who are we, where are we going?

Not my question. I think the attribution is Paul Gauguin. Came from Paris, was a stock broker, went to Polynesia, produced great art, died from syphilis. Life story in one happy and sad, incomplete sentence.

CANS was born in the early 1970s and came of age during the malpractice insurance crisis of 1975-1976. This occurred before most of our members entered practice, or were even born! Our founding members importantly influenced the MICRA legislation which is the envy of most states. It has mitigated the excesses of the tort bar greed for a quarter century, allowing us to stay in practice in California.

Today we are the largest and most active state neurosurgical organization in the U. S. We are 410 members, some retired but most of us are in active practice. We recently surveyed CANS members and we found that most of us have a traditional neurosurgical practice. 60% are in private practice, 25% academic and 8% practice in a foundation model (e.g. Kaiser Permanente). Also 40% practice either solo or with one other surgeon. We actively participate in emergency room and trauma coverage for our community hospitals…more than 60% contribute their time. Interestingly, about 1/3 of our surgeons who cover emergencies and trauma cases receive no stipend from hospitals.

As a socioeconomic society, there is little wonder most responders remain concerned about income (Medicare and insurance remittance) and costs (office overhead and malpractice costs). There were kudos to CANS for representing neurosurgeons' interests nationally (Council of State Neurosurgical Societies for example) and within the state of California (Work Comp and California Medical Association, for example). Best of all, 80% reported receiving the CANS newsletter with much appreciation for Randy Smith's efforts. But then I don't have to tell you about the newsletter as you are reading it now!

OK, so where are we going? We all realize we are entering the most important and potentially drastic change to the delivery of medical care since the institution of Medicare and Medi-Cal. The changes will be gradual and more intrusive than past government initiatives. The changes will revolutionize compensation, organization and eventually even practice patterns of neurosurgeons. No one knows where we are going but we hope to anticipate these changes during our annual meeting at the Ritz Carlton Hotel in San Francisco (January 14-16, 2011). The meeting title is: **"THE FUTURE OF YOUR NEUROSURGICAL PRACTICE AFTER HEALTH CARE REFORM."** Join us. ❖

Come to San Francisco's luxurious Ritz-Carlton for the **January 14-16, 2011 Annual Meeting**

"The Future of Your Neurosurgical Practice after Health Care Reform"

Reservations can be made by phone (800-241-3333) or via the link below:
https://www.ritzcarlton.com/en/Properties/SanFrancisco/Reservations/Default.htm?gc=cnscnsa&nr=1&ng=1.

The contracted hotel room rate of $225 is available from Thursday January 13 through Monday January 17, 2011.

INSIDE THIS ISSUE:

The Medical Board of California—Our Professional Mother-in-Law

Randall W. Smith, M.D., Editor

This writer, like all docs licensed in California, gets the quarterly Medical Board of California Newsletter. As the reader knows, the MBC is entirely funded by M.D., D.O., podiatric and physician assistants license fees and the publication is thus paid for by us. The newsletter documents actions taken by the Board against docs and others who are found wanting. I am sure most of us check the ding list to see if our name appears or the names of our friends and colleagues. The newsletter is generally well written and informative.

The July newsletter featured a front page story about the mandated "Notice to Consumers" document we all have to post in the office or give to each patient starting June 27, 2010. This little gem was felt to be necessary so all patients know where to go to file a bitch about a doc. The only other group in California who has to post a similar notice is the auto repair folk. Just why we docs were singled out for this customer caution eludes this writer. No such notice is necessary for lawyers, banks, policemen, insurance companies, gas stations, real estate agents /brokers, nurses, pharmacists or physical therapists. Apparently we docs are such a potential threat to the populace (who overwhelmingly consider docs trustworthy unlike how they feel about government) that every citizen needs the phone number and Web site address of the MBC in case they perceive they were mishandled. Oh well, another wart on medicine's backside isn't going to kill us, just make us a little more uncomfortable. Maybe that's the goal. (Please see this month's letter to the editor by Dr. Abou-Samra on page 3).

The notice you need to display can be downloaded from the MBC's Web site at www.mbc.ca.gov in the "WHAT'S NEW" section, click "Notice to Consumers Regulation". That notice needs to be in mandated 48 point type and Arial font. I am surprised they didn't mandate bright red text color and a picture of the governor looking constipated.

Also in the July newsletter was a one page spread on a State Senator from San Leandro. Just what such a quarterly feature brings to the table is completely unclear and would appear to have no place in a newsletter we pay for to bring us *useful* information. ❖

BRAIN WAVES

Deborah Henry, M.D., Associate Editor

Twenty-five hundred days. A conservative estimate would be two thousand. Somewhere between 5.5 and 6.8 years of my life, I have been on call. Taking the same amount of call through retirement age would add another 4 ½ years. Ten years of life. Half the life expectancy of Neolithic times. A third of the life expectancy of medieval Britain. A quarter of the life expectancy of the early 20th century American or the 21st century sub-Saharan African. I wonder how many years of his life Randy Smith was on call? Or for that matter, how many Bill Caton will still be on call? No alcohol for 10 years (not a big loss in my case, unless someone else is paying). No trips to Disneyland (it would take an hour to get from the Happiest Place on Earth to the Unhappiest Emergency Room). And a loss of a lot of those baby-making nights in my younger years. There was a time when staying up late was the cat's meow. Call nights as a medical student blossomed with the expectation of learning something new. Operating as a resident in the wee hours honed surgical skills. But somewhere along the way, call lost its dramatic glamour. Dr. McDreamy wasn't there bringing me early morning coffee and donuts. The adage of missing half the good cases on days not on call might have worked for Michael DeBakey, but somehow I think I can miss half those cases now. Let's face it: call gets harder as you get older. Doctors deserve to be paid while taking call (as do nurses, technicians, and the person who picks dead animals off the road). Altruism doesn't pay the bills. Nonetheless, there is no better high than saving a life. Not every doctor can say they've done that, but every neurosurgeon can-more than once. Maybe all that call is a good thing. ❖

Definition for the month:

Sarchasm (n): The gulf between the author of sarcastic wit and the person who doesn't get it.

Letter to the Editor: Our Professionalism

Moustapha Abou-Samra, M.D.

I was reading one of my patients' information sheets in preparation of meeting him for the first time. I usually review all the information provided by my staff but concentrate on the demographics and the pertinent clinical questionnaire that I developed over the years; I find what patients write or what they omit, and how they write it, to be very valuable.

It used to be that there were only two sheets: a registration form and a clinical questionnaire; now, there are additional sheets that seem to be added. The purpose? Killing more trees, I am afraid!

One, in particular, that I have gotten used to ignoring is the HIPAA notice that we are compelled to give to new patients …Last week, I noticed a new form, written on our stationary in large letters:

NOTICE TO CONSUMERS
Medical Doctors are licensed and regulated by the Medical Board of California
(800) 633-2322
www.mbc.ca.gov

Consumers? Linda, my office manager, knows better than making such a terrible mistake! She, along with everyone who works with me, knows how I feel about this. I don't have consumers, nor do I have clients; mine are patients and I love them! And don't call me provider. I detest such an appellation; I worked hard to become a "doctor"!

Immediately, before even seeing the patient and at the risk of being late, I went to Linda's office: you made a mistake that I'd like you to correct ASAP. Please refer to the people who come to my office seeking my neurosurgical opinion as patients!

Linda, the consummate professional, did not show any sign of glee, a sense I would have shown if I were right and the person who righteously is pointing out something to me is wrong. She simply produced a printed page, downloaded directly from the California Medical Board's web page.

Evidently, the language she printed on our newest form is something we, physicians that are trusted by patients with their lives, are REQUIRED to use VERBATIM!

What possible advantage does requiring physicians to address their patients as consumers have? Unfortunately, I can think of no other than further eroding our professional standing.

I do think that the reasons to call it quits are becoming more compelling! ❖

TIDBITS from the Editors

The new, proposed, tentative, possible work comp pay scale

The Department of Workers Compensation has re-published their proposal for a new doc pay scale embracing RBRVS and new conversion factors. They seem to realize that getting good surgeons who are willing to jump through all the work comp hoops will take pretty fair pay and the new proposal surgical RVU conversion factor is $56 which is about where it is now. No automatic increases as included in previous proposals (which seemed to reflect an understanding we docs haven't had a WC pay increase in 25 years) but no built in reductions either. One would guess there will be no big exodus of surgeons from the WC field with the $56 conversion factor, particularly since Medicare is about $36/RVU. The proposed $42/RVU conversion factor for filing those first injury reports as well as for our surgical consultations is ridiculously low considering all the mish-mash that has to be included in the reports and the proposed $11.69 payment for completing PR-2 reports is a laugh. If I were an Occ-Med doc, I would move to another state.

It is estimated that the proposed changes would add $51.7 million to annual WC medical payments which in 2009 totaled $3.68 billion in California. Interestingly, comp insurers lost $1.5 billion in California last year so one can expect some premium increases or insurer bankruptcies. Interestingly, physicians (which include chiropractors, acupuncturists

and psychologists) received $1.47 billion of the $3.68 billion which was a reduction from the $1.51 billion they got in 2008 and which is 40% of the money spent on treatment.

Since there appears to be a stable $1.5 billion on the table for docs, unlike what we can expect from Obamacare, surgeons might be wise to get into work comp if they aren't already. ❖

Update on EHR Stimulus Package and Meaningful use

Physician federal funding for use of the electronic health record starts in 2011. In order to qualify for this funding, non-hospital based physicians (physicians with at least 10% of the care they provide occurring outside the hospital) must meet three main components of meaningful use:

1. The use of a certified EHR in a meaningful manner
2. The use of certified EHR technology for electronic exchange of health information to improve quality of health care
3. The use of certified EHR technology to submit clinical quality and other measures.

On July 13, the CMS issued (in 228 pages) its stage 1 definition of the first component of "meaningful use." (http://healthit.hhs.gov/portal/server.pt).

Meaningful use of the EHR is divided into 25 CORE set of "objectives" and "measures," 20 of which must be completed for incentive payments. In addition, there is a MENU set where physicians will select 5 of the 10 most relevant items for their practice. Meaningful use may be demonstrated for any 90-day period in the calendar year starting with 2011. The first year reporting will use self-attestation and thereafter will (hopefully) be internet-based. The earlier one participates in the stimulus program, the greater the reimbursement (**see Table 1 on page 8 of this newsletter).**

Reimbursement may also be done through California Medi-Cal program for those who qualify. The State of California has yet to define "meaningful use," but it is unlikely that the definition will differ much from that of the federal government. The Medi-Cal program will, for most, have greater financial incentive (**see Table 2 on page 9**). To qualify, at least one physician in the group must see at least 30% Medi-Cal or Medi-Cal HMO patients. If one sees 30% Medi-Cal patients and e-prescribes, they may apply for funding from federal e-prescribing and the Medi-Cal EHR reimbursement program. Medicare stimulus funding for the EHR cannot be combined with any other federal incentive program.

As far as the second and third component of "meaningful use", the CMS has yet to determine what qualifies as a "certified" electronic health record and to date no technology has received official "certification." CMA expects that a list of certified vendors will be available in the fall.

Sources: www.cms.gov/EHRIncentivePrograms/35_Meanigful_Use.asp
www.ocma.org/files_ocma/Meaningful_Use_Summary_0.pdf
www.calphys.org/html/news.asp ❖

A chance for you to be heard

The **Council of State Neurosurgical Societies** will meet in San Francisco just before the Congress of Neurological Surgeons annual meeting in October. The major goal of that group is to bring to the attention of the AANS/CNS concerns or ideas from the various states as well as from individual neurosurgeons particularly regarding socio-economic issues related to the practice of neurosurgery. Examples of ideas emanating from this Council and leading to specific changes are those regarding requirements for sub-specialty fellowships, the creation of a neurosurgical Political Action Committee as well as a Web site packed with ideas for practice improvement (www.csnsonline.org) and a practice management organization (Neurosurgery Executives' Resource Value and Education Society; NERVES) committed to improving the efficiency of your practice (nervesadmin.com). Any California neurosurgeon can bring up an idea for consideration by the Council and you are encouraged to do so. Ideas for consideration by the Council have to be in the form of a resolution which CANS will formulate for you. Contact our Executive Secretary, Janine Tash, with your suggestion (janinetash@sbcglobal.net).

Any CANS member who is interested in attending the Council's meeting on October 15-17, either as an official delegate from California (we have nine delegate slots) or as a guest, should contact Ms. Tash. ❖

Editorial: Uncertain Rules

John T. Bonner, M.D., Associate Editor

Uncertainty regarding the delivery of healthcare in California appears to be the norm as our legislative process sputters. The California Legislature continues to be a variable organization, not consistent in interests or decision making. The budget is overdue as usual, and legislators appear more interested in making the Neverland Ranch a state park (certainly controversial and fiscally impossible) and changing what is officially the state rock (since the current one may contain scant amounts of asbestos). One can only hope that legislators will get down to more serious business, such as considering malpractice insurance programs for volunteer physicians. Unfortunately, this was not reported out of committee and appears unlikely to be approved this year.

On the other hand, I guess one must be careful what one wishes for when it comes to legislative activity. The Ashburn Bill, SB726, which erodes the ban on the corporate bar of medicine, continues to persist. We have discussed this issue before and, because of its significance to our practices and more importantly, to the benefit of our patients, it is worthwhile to emphasize our concerns. Perhaps surprisingly, many physicians are not familiar with the corporate bar of medicine, which simply states that only physicians can practice medicine – so hospital administrators and other organizations cannot. Your hospital administrator would love to see the corporate bar of medicine eliminated so the physician could be the employee of the hospital or medical delivery groups. California is only one of the few states that still has the corporate bar of medicine, which is felt to be a 'problem' by many hospital organizations and not properly recognized in its importance by most physicians, especially young recently-trained physicians who would rather sign an employment agreement for stability, lifestyle, and avoidance of private practice or group practice responsibilities.

And, there are other legislative uncertainties, such as those imposed by the Obama Health Plan, (i.e., insurance risk pools). There will be more to come in the future when the Health Plan is fully implemented.

On a national level, the appointment of Donald Berwick, M.D. as the administrator of the Centers for Medicare and Medicaid Services (Medical, CMS) surfaced during the congressional recess. The concerns about Dr. Berwick outlined by our CANS President, Ken Ott, in last months' newsletter appears to be well supported. The nomination, which occurred when congress was not in session, appears to have been a calculated decision by President Obama, as many in both parties of Congress likely would have opposed this very important nomination. The very fact that he was nominated and placed in this position in such a manner indicates that this physician's opinions are that of the Administration – of rationing health care and limiting access. Recently, Dr. Berwick was quoted as saying that the redistribution of income (wealth) is necessary to deliver national health care, a policy with which many of us would disagree. This suggests that rationing of health care, age limitations for consideration of care, and even more draconian policies may be expected – and soon.

Given so much uncertainty, there is one thing I would like to emphasize, particularly to our younger members. We are a healing profession – a noble profession that has been recognized as such for centuries. Often, the erosion of freedom occurs incrementally. I believe we need to be ever-vigilant, for ourselves and for our patients, lest we find our autonomy, and, along with it, the delivery of high quality care, simply cast aside as a footnote to history. ❖

Executive Office Report

Janine Tash, Executive Secretary

Neurosurgical Residents

CANS welcomes all new neurosurgical residents to California's training programs. Residents receive this monthly newsletter as well as articles of interest in periodic email messages titled "***CANS Connexion.***" Newsletter articles are generally focused on issues that will affect your practice once you complete your training. If your e-mail address cannot be found on your school's website, the newsletter will be sent to your training coordinator. Please contact me at janinetash@sbcglobal.net to receive your copy directly.

Membership in CANS is automatically granted to residents at no charge and upon completion of training, you can join CANS as an active member. This organization is committed to safeguarding the socio-economic health of the profession of neurosurgery (be sure to read the article on page one by President Ken Ott). We welcome your input.

CANS Nominations due by September 1

By now, members have received the 2011 nominations request for the various positions on the CANS Board of Directors. For those of you who indicated in the recent survey that you wanted to be more active in CANS, this would be a good opportunity to submit your name for consideration by the Nominating Committee who will prepare the 2011 slate of officers for vote by the membership later this year. Please submit nominations by September 1st.

The current Board Roster for 2010 is as follows **(* open positions are in bold text):**

Executive Committee			Term Expires:
Kenneth Ott, M.D.	San Diego	President	will become Immed Past President
Marc A. Vanefsky, M.D.	Anaheim	President-Elect	will become president
Austin R. T. Colohan, M.D.	**Loma Linda**	***1st Vice President**	**January 2011**
Theodore Kaczmar Jr., M.D.	**Salinas**	***2nd Vice President**	**January 2011**
Kimberly A. Page, M.D.	Redding	Secretary	January 2012
Michael H. Robbins, M.D.	**Sacramento**	***Treasurer**	**January 2011**
Directors			
Kenneth Blumenfeld, M.D.	**San Jose**	***Director-North**	**appointed until Jan 2011but can be elected to serve 1st full term**
Deborah C. Henry, M.D.	Loma Linda	Director-South	January 2012
J. Patrick Johnson, M.D.	**Los Angeles**	***Director-South**	**Jan 2011; has served two terms so cannot be re-elected as Director**
Phillip Kissel, M.D.	San Luis Obispo	Director-South	Jan 2013
Haig Minassian, M.D.	Whittier	Director-South	Jan 2013
Praveen V. Mummaneni, M.D.	San Francisco	Director-North	Jan 2012
Marshal Rosario, M.D.	Campbell	Director-North	Jan 2012

Consultants to the Board are Drs. John Bonner (Fresno), John Kusske (Orange), Philipp Lippe (San Jose), Donald Prolo (San Jose), Lawrence Shuer (Stanford), Randall Smith (Escondido) and Patrick Wade (Glendale). Consultants are not elected but appointed by the president. ❖

Meetings of Interest for the next 12 months:

CANS: Board Meeting, October 2, Los Angeles, CA
North American Spine Society: Annual Meeting, October 5-9, Orlando, FL
Western Neurosurgical Society: Annual Meeting, October 8-11, Santa Fe, NM
CSNS Meeting, October 15-16, San Francisco, CA
Congress of Neurological Surgeons: Annual Meeting, October 16-21, San Francisco, CA
Cervical Spine Research Society: Annual Meeting, December 2-4, Charlotte, NC
CANS: Annual Meeting, January 14-16, 2011, San Francisco, CA
Southern Neurosurgical Society: Annual Meeting, February 23-27, 2011, Orlando, FL
Neurosurgical Society of America: Annual Meeting, March 27-30, 2011, Island of Hawaii, HI
CSNS Meeting, April 8-9, 2011, Denver, CO
AANS: Annual Meeting, April 9-13, 2011, Denver, CO
New England Neurosurgical Society: Annual Meeting, June 11-12, 2011, Chatham, MA
Rocky Mountain NS Society: Annual Meeting, June 18-22, 2011, Taos, New Mexico

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). ❖

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 newsletter issues are available on the CANS website at www.cans1.org.

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

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. Ken Ott 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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Attachment 1

TABLE 1: MEDICARE
EHR INCENTIVE PROGRAM PAYMENT SCHEDULE

Payment Year	2011 Temporary Certification	2012 Permanent Certification Begins	2013	2014
2011	STAGE 1 $18000			
2012	STAGE 1 $12000	STAGE 1 $18000		
2013	STAGE 2 $8000	STAGE 1 $12000	STAGE 1 $15000	
2014	STAGE 2 $4000	STAGE 2 $8000	STAGE 1 $12000	STAGE 1 $12000
2015	TBD $2000	TBD $4000	TBD $8000	TBD $4000
2016	TBD N/a	TBD $2000	TBD $4000	TBD $4000
TOTAL	$44000	$44000	$39000	$24000

Attachment II

TABLE 2
MEDICAL EHR INCENTIVE PAMENT SCHEDULE

PAYMENT YEAR	FIRST YEAR 2011	FIRST YEAR 2012	FIRST YEAR 2013	FIRST YEAR 2014	FIRST YEAR 2015	FIRST YEAR 2016
2011	$21,250					
2012	$8,500	$21,500				
2013	$8,500	$8,500	$21,500			
2014	$8,500	$8,500	$8,500	$21,500		
2015	$8,500	$8,500	$8,500	$8,500	$21,500	
2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,500
2017		$8,500	$8,500	$8,500	$8,500	$8,500
2018			$8,500	$8,500	$8,500	$8,500
2019				$8,500	$8,500	$8,500
2020					$8,500	$8,500
2021						$8,500
TOTAL POSSIBLE	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750