



CANS NEWSLETTER

California Association of Neurological Surgeons

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Tough time to be Prez

Randall W. Smith, M.D., Editor

Something of a milestone has occurred at the American Medical Association of which we should be mindful. For the first time in its 166 year history, **the President of the AMA is a neurosurgeon.** Peter Carmel, chairman of the Department of Neurological Surgery at the University of Medicine and Dentistry of New Jersey (UMDNJ) in Newark, took over the reins at the recent AMA meeting in Chicago. Dr. Carmel is no glad hander who tells funny stories over cocktails; he is a hard working pediatric neurosurgeon who is committed to the goals of the AMA to promote the art and science of medicine and the betterment of public health. He has served long and hard in the AMA hierarchy and on the Board of Trustees and his election culminates a career on the national stage of Medicine. During his tenure as chair of the AMA Council on Long Range Planning and Development, the council established proportional representation for specialty medical society members.

We can debate amongst ourselves as to the effectiveness of the AMA or how well it has represented our specialty's interests over the years, but we can't escape it being considered by the Feds as the biggest doc voice on medical issues. We can all applaud the work by the AANS/CNS Washington Committee as it attempts to bring some brain surgeon light to Capitol Hill but one can imagine how DC officials, particularly those who got there by being elected, view the political capital of the nation's 3-4 thousand neurosurgeons as compared to the AMA's presumed many, many thousands of members (not one mention of membership numbers on the entire AMA Web site).

Dr. Carmel conducted an Office Hours phone-in free for all with any interested AMA member on Thursday July 21st and this writer listened in. Since the program was not scripted, I was impressed with Peter's broad grasp of the many issues facing medicine and the AMA. We are lucky to have him at the helm at this time of major upheaval in Medicine and wish him well, particularly when he champions our interests in compensation and burdensome regulations and laws.

Of additional note, **Monica Wehby, M.D.**, neurosurgeon from Portland, Oregon, was also seated as one of the 21 members of the AMA Board of Trustees. Since Dr. Wehby is also a pediatric neurosurgeon, one wonders if pediatric neurosurgeons have a lot of spare time or are particularly susceptible to the national doc leadership bug. We doubt either explanation and presume the cream is rising. We wish Monica well also. ❖

ATTN: CANS Members

The CANS Board of Directors will meet in Oakland on September 24th for its fall meeting. If you would like an issue discussed, please submit your questions/comments to janinetash@sbcglobal.net who will add them to the agenda.

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CMA Leadership Academy

Marc A. Vanefsky, M.D., President

The 14th annual CMA Leadership Academy was held in Indian Wells, California at the beginning of June. The topic was "Successfully Negotiating Health Reform." Both schools of thought, repeal or reform, were presented. In California the cries for repeal appear to be dying out whereas the voice for reform appears to be gaining. My mantra of making reform work for both patients and providers seems to be taking hold. Dustin Corcoran of the CMA stated quite emphatically that fee for service remains a sacred cow but other panelists, including Mark Smith, made the point that some other form or reimbursement will be necessary to have a sustainable system. One of the keynote points was that medicine is changing and the technology will allow for a more efficient cost effective practice. One of the salient points was that the physician is no longer the most cost effective way of educating patients and that perhaps some of this part of a physician's day be off-loaded to a professional educator who may, in fact, be better at that task than we are. The physician may be best at interpreting the hemoglobin a1c but not the best at educating the patient about the diabetic diet.

Remember, in the old days you had to go to a physician to find out if you were pregnant or needed an Advil; those days are gone and we need to decide what the future is going to look like. ❖

President's Message: CANS 2012 Annual Meeting

Disney's Grand Californian Hotel, Anaheim, California, January 13-15, 2012

Marc A. Vanefsky, M.D.

We had a very successful Annual Meeting in January 2011 in San Francisco. But, as you know, the debate still rages. Will it be reform or repeal for the affordable health care act? Our 2012 meeting will look at the current debate and, I believe, give us new insight into the discussion. It is also an opportunity to weigh in and have our voices heard as part of the debate.

We will be at Disney's Grand Californian Hotel directly adjacent to the park. So please hold the dates and plan to attend with your family to take part in the discussions, spend time with old friends, and enjoy the hospitality of Disney and its parks. ❖

MEET YOUR CANS BOARD

Second Vice President: Michael S. Robbins, M.D.

Mike Robbins is an Ohioan who, after a B.S. from Case Western Reserve, got his M. D. from the Medical College of Ohio in Toledo and after not liking the taste of Kentucky where he interned, struck out for UC Davis for his neurosurgery training which he completed in 1985. After trying private practice in Michigan for a year, he found he missed the Sacramento area and has been in private practice there ever since. He is currently on the Board of Directors of the Hill Physicians Medical Group, one of the few successful IPAs in California. He has served as a northern California Board member for CANS as well as Treasurer before his current role as Vice-President. He is married to Margo and they have three grown children, Bradley, Zachary and Erica who are well educated (Zach is an anesthesiology resident at Tufts) and thus Mike needs to keep working for awhile. He is an inveterate golfer with a low index and also enjoys mystery novels, jazz and being a granddad to Zach's Elijah. ❖



Transitions in Neurosurgery

John T. Bonner, M.D., F.A.C.S., Associate Editor

Another month has passed without a federal budget and the concerns about what a default may have on the nation and all of us. Thus far it is difficult knowing what to believe and what our individual experience could be, especially in the financial/investment areas. Also, a lack of a federal budget makes Medicare and Medicaid (Medi-CAL) fees uncertain. The State of California budget is considered by many to be not rationally based so future fee effects may possibly occur.

An interesting and informative article concerning medical liability reform in the July 2011 Bulletin of the American College of Surgeons should be reviewed by all. It is noted that medical liability insurance premiums have steadily risen on average of 15% a year, despite declines in reimbursement. The article notes the MICRA benefit we have in California. We in California have seen a 238 percent increase in liability premiums since MICRA was enacted, while the rest of physicians in the US have experienced a 925 percent increase. MICRA needs to be preserved at all costs, as well as the Corporate Bar of Medicine (which provides that only physicians can practice medicine) to maintain the independence of medical care. We must remember that MICRA is always at risk, such as in Illinois where the Illinois Supreme Court declared MICRA-similar legislation (limited non-economic damages at \$500,000 for awards against physicians and \$1 million against hospitals) as unconstitutional due to separation of powers concerns. This legislation was successfully opposed by the Illinois State Bar Association and the Chicago Bar Association. (I guess we should not be surprised, trial attorneys.) This is the third time in the last 35 years that the Illinois Supreme Court has considered and struck down efforts to cap the awards given by juries, so it is unlikely that a similar effort will be made soon. It is no wonder that medical malpractice insurance is so unreasonably expensive in Illinois and elsewhere – not that it's cheap in California.

There are interesting articles implying that professional medical care is best delivered by recent medical graduates. This should concern those of us with gray (or no) hair and makes continuing medical education even more important. As an old-timer myself, I still hold that nothing can replace experience when it comes to treating patients.

A controversy that has repeatedly occurred is whether it is proper to treat one's immediate family members. This came up recently by a nurse's concern at a local hospital. The medical staff decided that there was no concern (I did not agree with this decision). Interestingly, the Washington Quality Assurance Commission (comparable to our Medical Board in California) in a Summer 2011 publication stated that one should not treat family members except in emergency or for routine short-term, minor problems (I would even hand these off). One should document the treatment and one should avoid prescribing controlled substances for family members. One also should not prescribe controlled substances for personal use, as it is illegal. I believe these decisions could be considered by all of us in our private family interaction. ❖

Brain Waves

Deborah Henry, M.D., Associate Editor

Did you catch the Women's World Cup soccer? Wow! What matches. Down to 10 players from the second half and on into overtime, the US women battled back against disappearing hope to all but themselves and created a miracle play. I sat in disbelief while watching the floating header end up in Brazil's goal as the overtime clock expired. Then Sunday's final was spellbinding as Japan's women, likewise determined, slipped a goal not once but twice into the net when the US women most assuredly had the win within their grasp.

So what does this have to do with neurosurgery? First, when one looks at the history of women's soccer in this country and worldwide, the world cup for women has only been around for 20 years as opposed to 81 years for the men and as a women's Olympic event for 15 years whereas it started in 1908 for the men. Credit for advancement of women's sports in the US is often given to 1970's Title IX: No person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance. This simple statement marks the changing attitude toward women not only in sports, but also education. In 1970, just under 8% of US physicians were female; this increased to 12% in 1980 and 17% in 1990. At this time too, **Antonia Novello** became the first woman US Surgeon General. By the year 2002, one quarter of the physicians in the US were women. In 2004, approximately 50% of the graduating medical school class was female, dropping slightly to 47% in this last graduating class of 2011. In 2007, the AANS requested a white paper looking at

recruitment of women into neurosurgery. Presently, approximately 20% of neurosurgical residents are female, triple the number since 2006.

Secondly, the US women's matches against Brazil and Japan remind us never to give up hope, that nebulous power within us and around us that takes insurmountable instances and creates possibilities. I had given up hope. To me there was no way that the US was going to score against Brazil. Down a "man" and with seconds left, it was clearly impossible. I was wrong. Likewise, the Japanese women did not give up. Lifting a struggling nation from under the triple whammy of earthquake, tsunami and nuclear meltdown, they rallied in a game that they were outplayed in almost everything but the final score. In essence, neurosurgeons have done the same—operating on the brain and spine without imaging for many years based on the hope that there was something they could do. Never giving up hope. ❖

Tidbits from the Editors

AANS Endorses an EHR

The AANS, through an alliance agreement with NextGen Healthcare Information Systems, offers AANS members discounts on efficient, award-winning EMR systems, designed to help physician practices improve quality, reduce risk, cut costs and increase revenues. NextGen's EMR system is appropriate for any size medical practice, from a small solo practice to a large, multi-provider, multi-location group. Providers that want to share and manage clinical and administrative patient information through a comprehensive, single-source application should visit www.nextgen.com or call 215/657-7010 to learn more. Neurosurgical templates are available.

(Remember—having a local office associated with any company chosen is important—Ed.) ❖

Some Hints About Claim Denials

Palmetto GBA, California's Medicare intermediary, recently reviewed many Medicare claim denials denied by Palmetto and other Medicare contractors. The review unveiled that 54 percent of the denied claims were due to provider documentation related technical errors that can be easily avoided by submitting adequate documentation to support services as reasonable and medically necessary. The denial reasons of these claims can be categorized as following:

Denial Reason #1: No medical record received after request for records

Resolution: When medical records are requested, send the records with a copy of the request within the time frame allowed on the request to the right contractor address.

Denial Reason #2: No signature (or illegible signature) on documents and illegible medical records

Resolution: Progress notes and orders must be legible and signed. If the signature appears illegible, the office can create a signature page identifying the usual signature of the physician and attach it to the materials sent. If the signature is missing, the physician can send an attestation stating he or she actually saw the patient on the date of service in question

Denial Reason #3: No time documented on timed codes

Resolution: When service time is part of a particular code (e.g., for some therapy, mental health claims, infusions, critical care, etc.), the time must be documented on the chart either in the format of 'from-to' or total time.

Denial Reason #4: No record of medications given when medication billed on claim

Resolution: When medications or lab tests are billed, there must be some documentation (or order) to show the medication was administered and the test was wanted or needed.

Denial Reason #5: Incorrect place of service on claim and incorrect use of new patient versus established patient

Resolution: The distinction between a new and an established patient is whether a patient was seen face to face by the provider within the last three years. Since some E/M codes are the same for 'office or other outpatient services', the correct place of service must be on the claim and match the documentation. ❖

Kudos to North Carolina

On July 25, 2011, the North Carolina General Assembly overrode a gubernatorial veto and passed a bill limiting malpractice awards that should improve North Carolina's medical liability climate for both physicians and their patients. The bill includes a cap on non-economic damages for medical liability actions that cannot exceed \$500,000. The cap will be indexed for inflation every 3 years. Though not as good as California's MICRA (\$250,000 cap; no inflation index), it should go a long way to stem the exodus of docs from North Carolina just as similar caps in Texas and West Virginia basically changed doc emigration to immigration. ❖

Truth for the month

Junk is something you throw away three weeks before you need it.



ATTENTION: Exhibitors

Exhibit registration for the CANS Annual Meeting is now available. Please contact janinetash@sbcglobal.net to receive an exhibit registration packet and reserve space.

The meeting will be held January 14-15, 2012 in Anaheim at Disney's Grand Californian Hotel.

Meetings of Interest for the next 12 months:

Western Neurosurgical Society: Annual Meeting, September 10-13, 2011, Kauai, HI

CANS Board of Directors Meeting: September 24, 2011, Oakland, CA

CSNS Meeting, September 30-October 1, 2011, Washington, DC

Congress of Neurological Surgeons: Annual Meeting, October 1-6, 2011, Washington, DC

North American Spine Society: Annual Meeting, November 1-5, 2011, Chicago, IL

Cervical Spine Research Society: Annual Meeting, December 7-10, 2011, Scottsdale, AZ

CANS: Annual Meeting, January 13-15, 2012, Anaheim (Disney Grand Californian Hotel), CA

Southern Neurosurgical Society: Annual Meeting, March 28-31, 2012, Amelia Island, FL

CSNS Meeting, April 13-14, 2012, Miami, FL

AANS: Annual Meeting, April 14-18, 2012, Miami, FL

Neurosurgical Society of America: Annual Meeting, June 10-13, 2012, Park City, Utah

Rocky Mountain NS Society: Annual Meeting, June, 2012, Maui, HI

New England Neurosurgical Society: Annual Meeting, June, 2012, TBA

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 **two-month 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: To place a newsletter ad, 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. Marc Vanefsky 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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