



CANS

NEWSLETTER

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CALIFORNIA ASSOCIATION OF NEUROLOGICAL SURGEONS, INC.

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President's Message

Patrick J. Wade, M.D.

2007 has kicked off an early silly political season, not just in California, but nationally as well.

In California, the Governor proposed a plan for Health Insurance for all. His ideas contained something for everyone to love and to hate simultaneously. Taxing the providers who are already on their knees financially made little fiscal sense but it sure got the attention of Doctors, other providers of care and Hospitals. It peaked their interest at being at the table. Business too got hit but where was the carrot to labor? Could a raise in state sales tax get the Unions' attention? It would spread the cost more evenly. Maybe the threat of lost jobs due to costs causing increased personnel cuts for business is enough of a stimulus.

So far, little of substance is happening - multiple bills in the hopper, but not the Gov's. There is a coalescence of interest groups occurring. Watch Senator Kuehl's single payer... again! There are murmurings of attacking MICRA with a raise of the Non-economic cap to be introduced by the "let's stop spanking" Sally Lieber. The legislature is trying to sneak by a term limit extension calling it a "needed reform." Californians will decide. Nationally AMA President Bill Plested (former CMA Pres.) Denounced "Pay for Performance" for exactly what it is a sham and another method to deny those who provide care to be paid for their services. We ask you all to call upon the CMA Board of Trustees to reverse their support of "P4P."

Do you have a colleague who does not belong to CANS? Put the arm on him to join us. In unity and numbers we can best preserve the practice of Neurosurgery. We must fight for Access to care and adequate reimbursement to attract the best and brightest to come to and remain in California.

The 2008 Presidential show has begun, so enjoy the silliness. In 2008, 22 of 33 Republican Senators are up for election and must defend their seats. This is worth watching. The Republican Congress curtailed Medicare cuts. We'll see what happens in the next 2 years. Will the Democrats be as helpful? Most predict gridlock, which has some advantages.

The CANS Board meets in Los Angeles 5 May 2007 and the AANS meets in DC April 14th to 19th. Plan to be at the CANS annual meeting held at Disney's Grand Californian Jan 18th-20th, 2008. Stay through the MLK Holiday Monday the 21st and bring the family to enjoy Anaheim and the Disneyland Park. ❖

CORRECTION

In the annual meeting article in the January 2007 issue of this newsletter, I incorrectly listed the Web address of the company that CANS member Kimberly Page uses for her electronic medical record system. The company is Medinotes and their Web address is www.medinotes.com. We regret the error (that is what you are supposed to say when you screw up).

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Pay for Performance - the Good, the Bad and the Ugly

Randall W. Smith, M.D., Editor

The CMS has released early results of its Pay for Performance pilot hospital program designed to reward institutions if they improve in their ability to comply with government chosen parameters in the treatment of acute MI, CABGs, heart failure, pneumonia and hip and knee replacement. The feds claim an across the board 11.8% improvement among the hospitals participating with those institutions finishing in the top 10% getting a 2% bonus and those in the 11-20% group getting 1%. Needless to say, hospital administrators in the bonus groups think it's a Good idea. On the down (Bad) side is the plan by CMS to institute a program for docs. Those docs who register for the program which requires 6 months of reporting on how well one did on at least three quality measures chosen by the feds will get a 1.5% bonus no matter how well the participating doc performed. AMA President William Plested has expressed his view (AMNews—2/19/07) that this doc P4P is cost control dressed up in new clothes and at the very least could run afoul of our ethical duty to do what we think best for an individual patient, general guidelines notwithstanding. The mischief (Ugly) is how the feds characterize P4P non-participating docs or those that fail to improve (?substandard), the potential for litigatory machinations by the plaintiff's bar if you don't get a federal reward and the final hooker—that since all this maneuvering is supposed to be cost neutral, the good performance bonuses are funded by a poor performance or non-participant tax (the bottom 20% of hospitals in the pilot program will have to pay a penalty). Just how neurosurgeons would fit into this scenario considering how few procedures we really do in the trillion dollar medical picture is unclear but I smell the odor of a reimbursement reduction to help fund this experiment. See page 4 for the complete text of Dr. Plested's rather lengthy and detailed opinion, which he addressed to all physicians. ❖

Executive Office Report

Janine Tash

Dues

If you have not already returned your dues statements, please make careful note of our inquiry about the type of information you want listed on the CANS website. We are in the process of updating your contact information so that it agrees with our member database which is only as accurate as the information returned to us when dues are remitted.

Peer Reviewers Needed

Dr. Marc Vanefsky, one of the CANS Directors, spoke with a physician from Lumetra, the Quality Improvement Organization for Medicare, who said that Lumetra is looking for physicians to do peer reviews. Cases usually involve a complaint about quality of care or a utilization management issue. Lumetra will prepare questions based on the complaint and will send those questions, along with pertinent medical records, to the reviewer who will answer in writing. Peer reviewers remain anonymous outside of Lumetra and will not be involved in any litigation that may follow a review. Reviewers must be board-certified physicians actively practicing in California with hospital privileges. Reimbursement is \$90 per hour. If you are interested, contact Edward M. Lukawski, MD, Associate Medical Director, Lumetra, at 415 677-8408.

Please contact me at janinetash@sbcglobal.net with your input on any of the above items. ❖

Other News

Randall W. Smith, M.D., Editor

Work Comp Docs Not Happy—Except for Orthopaedics

The Division of Workers' Compensation has released a study they conducted on satisfaction of docs and workers with the present system. The workers were generally pretty satisfied with the speed and quality of the care they received but the providers were less satisfied. The report found evidence that some providers have dropped out of the system since the 2004 reforms. Family practice and internal medicine doctors were 32% of providers before the 2004 bill passed, compared to 25% of current providers. Non-surgical specialists were 31% of pre-reform providers, but only

22% of providers now. Orthopaedic surgeons were 14% of pre-reform providers, but 28% of current providers. (One can speculate that the increase in orthopods is in the spine surgery group who recognize the relative good pay for their services in the Comp system.) The same study noted that 55% of current orthopaedic docs have experienced a decline in the volume of their workers' compensation patients since 2004 which may well be due to new regulations and authorization/utilization-review issues. More than one-third of providers reported they plan to quit workers' compensation entirely (14%) or to reduce their workers' compensation volume in the future (21%). Going forward, if a CANS member can tolerate the regulatory hassles unique to the Comp system, Comp carriers still pay the best for surgeries as compared to Medicare and commercial rates—at least until the new Comp fee schedule comes out later this year or in 2008. ❖

Inclination for a Cheaper Inclinometer

In a previous issue of this newsletter, it was pointed out that if you prepare Work Comp reports addressing permanent impairment using the AMA guides, the spine section often necessitates measuring spine motion using an inclinometer. The AMA Guides list some purveyors of said inclinometers and I chose one in Arizona and paid \$484 for a nicely cased product that included two inclinometers one of which connects to the other and the combined unit automatically subtracts the attached unit's reading from the main unit's reading giving you a net movement such as a true lumbar flexion after subtracting out the sacral movement associated with back flexion. As a very amateur woodworker, I recently bought two inclinometers (the second in order to pen this comment) from Wixey Corporation designed to measure the exact angle of a table saw blade. Turns out these inclinometers work just great on patients and since we all learned how to subtract in the 3rd grade, I could get a nice net measurement of motion using two of them when necessary. The punch line: The Wixey inclinometers cost \$40 per unit, shipping is free and they come with a spare battery. \$400 here, \$400 there can add up to real money. Go to www.Wixey.com and click on Digital Angle Gauge. ❖

CA Health Plan and the CMA

It would appear the Governor's plan still can't find a legislator to introduce it and a lot of posturing by the interested parties hasn't led to a workable alternative. The CMA has moved up from the rear to the middle of the pack by forming a coalition with some insurers and a hospital system to explore common interests. One hopes this is the beginning of the formation of an alternative health plan in which all parties (docs, hospitals, insurers, business, labor and the public) throw something in the pot to help achieve the laudable stew articulated by the Governor. The 2% tax on docs is onerous but if one broadened the base to include all providers who can bill Medicaid (chiropractors, psychologists, optometrists, various therapists, etc.) and reduce the percentage to less than 1% especially for GP's and physical therapists, get the insurers to cough up some money, get labor to contribute something, and have the hospitals and business buy into some significant contribution and then have this coalition recommend a small increase in the sales tax as the public's share—then there should be enough momentum to overcome the GOP resistance to these new taxes. Let's face it, it will take new taxes to come up with the billions to pay for this program and if everyone's ox gets gored just a little, there might be enough bloodshed for the transfusion our state needs to provide affordable health care for its less fortunate inhabitants. ❖

Neurosurgical Positions Available/Wanted

Any CANS member who is looking for a new associate/partner 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). ❖

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Letter to the Editor

Moustapha Abou-Samra, M.D., Ventura

This letter is written in the hopes of starting a conversation about Health Care. It is written by a Californian who is also a neurosurgeon in private practice. It does not reflect my official position as President Elect of CANS.

I am very impressed with our Governor's courage, vision and leadership. His willingness to tackle "Health Care," a complicated and difficult issue, signals his sincere desire to leave California and Californians in better shape. And where California goes, so does our Nation. The principle that each Californian should have access to Health Care is accepted by virtually everyone: in fact, every Californian has access to care one way or another; usually, uninsured individuals present to ER departments across the state, clogging the system and receiving a less efficient and more expensive brand of Health Care.

Providing insurance coverage for each Californian makes perfect sense; it will allow people to seek elective care from their own physicians, a cheaper and much better brand of Medicine. I gather that it will cost at least twelve billion dollars to accomplish such coverage and universal access; the real question is who should pay for universal access to health care? The Governor has several proposals that attempt to deal with this issue. One of his proposals will charge physicians 2% of their gross income for the privilege of taking care of their patients. Although I do not agree, in principle, with this notion-why not charge accountants for preparing our tax returns and lawyers for the pleasure of representing us? I am certainly willing to pay a fee to provide care to all Californians. And, like every physician I know, I do consider it a privilege to take care of my patients.

To be fair, however, everyone should be expected to pay a portion of this fee; if we recognize the need and if this is meant to take care of each of us, our neighbors and our children, then let us call it what it is and apply it to everyone. It is a Health Care tax!

Physicians have always paid more than their share, and this will not change. We have made ourselves available at all hours and provided care to the uninsured for years without any compensation. We have placed our own comfort and safety second to those of our patients, and I am sure that we will continue to do just that in the foreseeable future. Though to make their hard work more palatable and to encourage physicians to provide care to the uninsured, recognizing their efforts will be very helpful.

If, when a physician or surgeon provides a needed medical examination or procedure to an uninsured patient, he/she is allowed to deduct the accepted Medicare rate for such an exam or procedure from his/her income tax, physicians will feel that their time and effort are being acknowledged and appreciated. Many of us travel to other countries to care for the sick. And we do it because there is a need and because our services are welcomed with a minimum of red tape and because it is the right thing to do... Here in our Great State there is a great need and there are a lot of people that can use our help. I venture to say that if such a tax break is provided, with appropriate and strict guidelines, that many if not all physicians will be willing to volunteer their services, thus providing a significant part of the solution to our Health Care problem.

Perhaps the CANS' newsletter can be used as a forum to discuss this and other Health Care coverage related topics, and if we can reach a consensus, we may present our formal recommendations to our Governor for his opinion: it seems to me that Governor Schwarzenegger, by making his Health Care proposal, has signaled his desire to listen to Californians in general and physicians in particular. ❖

Pay-for-performance: It's about cost control, not quality

A message to all physicians from AMA President William G. Plested III, MD.(February 19, 2007)

I am always entranced when intelligent people become mesmerized by an idea that is patently stupid. Nowhere has this phenomenon been more in evidence than in the pay-for-performance (P4P) mania that is absolutely sweeping the nation. There is so much energy being expended in efforts to rush out these programs that there seems to be none left over for a calm, rational assessment of the whole idea. This is the incarnation of the wonderful children's story, "The Emperor's New Clothes." A delightful charlatan convinced the emperor that the "clothes" that he sold him were invisible to anyone who was unfit for his office or unforgivably stupid. The inevitable result was that nobody wanted to appear stupid or unfit, so they all complimented the naked emperor on his beautiful clothing.

It would appear that this whole thing was enabled by some papers written about the care that patients received from visits to their physicians. These papers were long on sensationalism and short on scientific rigor; however, that's what is

tailor-made for today's popular press. The qualifications of the reviewers can be questioned. What is not in question is their underlying bias.

The bottom line of the studies was the widely touted result that in only 50% of cases did the treatment meet the standards that had been preselected by the reviewers. It was then widely reported that the chance of obtaining proper treatment from American physicians was essentially random.

This, of course, is patently ridiculous, and even the most naive can poke innumerable holes in this argument. But this pronouncement was manna from heaven to employers, insurers and government agencies continually looking for any excuse to reduce physician reimbursement.

They all pounced upon these reports and in unison said, "Aha! We refuse to pay for poor quality care." And the concept of "pay for quality" or "P4Q" was born. This effort was short-lived for several reasons, the most significant of which was that nobody ever has been able to come up with an acceptable definition of "quality" health care. Also, physicians are ethically bound to achieve the best quality care possible for their patients. This means that if quality really could be defined, all physicians quickly would comply, and there would be no excuse for reducing payments to any of them.

The result was that the concept of pay for quality was scrapped before any programs were even designed, and "pay-for-performance" was born. Not only was this more alliterative, but performance standards also could be determined by anyone. As a matter of fact, this is exactly what has been going on at a furious pace.

The final touch was the development of "efficiency measures." The purveyors of P4P continue to insist that these programs are all about quality.

I flatly dispute that contention. Efficiency measures are cost-control measures, pure and simple. To even qualify to have your performance measures reviewed, you must first be a *very* low-cost provider. It would appear that in most P4P programs only those whose charges are in the lowest 15th to 20th percentile qualify.

Of course, you can enter a bidding war to see if you can become one of those "lucky" enough to be in the very low-cost group. That will qualify you to be measured against the insurers' or employers' performance measurers — at least until someone puts in a bid lower than yours. Anyone who can't see where this ends needs help.

Conscientious physicians, as usual, have tried to make a silk purse out of this sow's ear by developing performance measures that are scientifically based and peer reviewed and that truly measure quality. The AMA-convened consortium consists of volunteer physicians who do in-depth outcomes studies on a wide variety of treatment modalities to establish "best practices."

The preferred treatments are listed as performance measures. Many if not most P4P plans use some consortium measures to add an aura of respectability to their programs. But none use only consortium measures, and all include the efficiency measures that make a mockery of the entire process.

Unfortunately, it is impossible to review all of the fallacies and problems that are associated with P4P, simply because the list is so long. But I'll review just a few.

First, and really most important, is the fact that the underlying assumption that P4P programs will improve care and save precious health care dollars is totally unproven. Furthermore, such an assumption is simply illogical.

Next, let's consider medical ethics, the cornerstone of our profession. The decision by a physician to attempt to qualify for a bonus payment by participating in a P4P program that has been designed by nonphysicians is clearly a business decision. To base a patient's treatment upon a business decision rather than a medical and scientific one is unethical.

Today it is reported that literally hundreds of P4P programs are being rolled out. This means that if a physician decides to participate in P4P plans, when a patient is seen in the office, the specific P4P plan of that patient's employer or insurer first must be determined. To qualify for a bonus payment, the P4P plan then must dictate the treatment.

A busy physician who sees several patients with the same diagnosis, but with different insurers and P4P plans, will find himself prescribing treatments that will be different in each patient. Again, the treatment prescribed has become a financial decision rather than a scientific one. How can anyone defend such a practice?

Another basic principle of P4P is public reporting. This means that whoever devises the P4P program will rate physicians based upon their compliance with that program. It is assumed that only 15% to 20% of physicians ultimately will qualify for a bonus in a specific P4P program.

These physicians, then, will be very publicly reported as preferred, superior, quality or whatever appellation that plan chooses. Furthermore, the insurer will "steer" patients to those physicians by requiring lower co-pays or other inducements.

Again, remember that regardless of the volumes of rhetoric, P4P programs are all about costs, not quality. But the public will be told that the designated physicians are chosen based upon quality. With this being the case, most of the public might believe that quality is actually being measured. Eighty percent to 85% of physicians who contract with an insurer will be reported as not preferred, substandard or whatever.

This is patently absurd. But it gives rise to numerous opportunities for our “friends” in the trial bar. Is there liability for a physician who doesn’t notify a patient that he or she is nonpreferred? Is there liability for a physician who refers a patient to a nonpreferred physician? What about the hospital who has physicians who are nonpreferred for a patient’s plan but who are on-call in the emergency department? There is no end to the liability mischief that can be caused by this public reporting of highly suspect data.

Remember that hundreds of P4P programs are being rushed out by the Centers for Medicare & Medicaid Services and private insurers. These plans are proposed to cover all specialties. To start a program, some measures can be cobbled together, but what about tomorrow? Are we to assume that an insurer will do a better job of keeping up with the explosive pace of medical progress than our specialty societies do? Of course it can’t.

These are just a few problems with P4P that immediately come to mind. I’m certain that you can come up with many more.

It also would appear that an absolute prerequisite for all P4P programs is an electronic medical record. This means that mode of practice will be a decisive factor in qualifying for a P4P bonus. To date, EMRs are almost prohibitively expensive for most solo and small practices, the very practices providing about 60% of medical care today. All automatically will not comply and will be publicly reported as substandard or not preferred.

What a program!

The question I’m repeatedly asked is, “How can they do this to me?”

The answer is simple. You signed a contract with the insurer to become a participating physician. Several years ago, this seemed like a reasonable decision. But today, with sham negotiations, automatic reductions in reimbursement, payment denials, silent PPOs and now P4P with public reporting, signing a contract with anyone seems to be terminally stupid.

I can’t for the life of me see why I would sign a contract that allowed me to be treated so shabbily. What do you think?❖

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 Patrick Wade, M.D. 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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