



CANS

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President's Message: Our Social Contract - Does it exist? Do we want one?

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I am writing this column from Chicago as I reflect on today's discussion, a discussion that took place at an AANS sponsored course titled: "Neurosurgeon as CEO-the business of neurosurgery."

Three weeks ago I attended an ethics seminar at the University of California Irvine. "The Role of Industry and Academia" was discussed. The seminar was sponsored by the association of Ethics in Spine Surgery, a young group that is trying to expose abuses in spine surgery and whose founder, Dr. Charles Rosen, has his heart in the right place, but who, sometimes, gives the impression that he is too idealistic.

Today's discussion emphasized that neurosurgeons must become business savvy and proactive in their discussions with hospitals and insurance companies. I learned that the days when we made our income from direct patient care are over; 40-50% of a successful groups' income is indirect: imaging studies, surgery centers and all what goes with them including commission on implants, physical therapy programs, pain management, etc. Why not? Since we control the ordering of these studies and various modalities of therapy, why not benefit from them. Someone even suggested having an in-house pharmacy service.

Please look up two articles from the NY times:

- "Paying Doctors to Ignore Patients" was an Op-Ed that was published on July 24, by Peter B. Bach a physician at Memorial Sloan-Kettering Cancer Center who was a senior adviser to the administrator of the Centers for Medicare and Medicaid Services from 2005 to 2006. He corroborates the point that doctors do not make money taking care of patients anymore, so they spend as little time as possible with them. Instead, they resort to owning their own lab and imaging equipment because they can charge for them, and the income generated is lucrative. He also quotes a study done at the University of South Carolina in 2002 that found that physicians who own their imaging centers order 2 to 8 times more the number of studies than those who don't. The study also showed that \$40,000,000,000.00 is spent on unnecessary imaging in our Country, therefore accounting for 2% of all American health care spending!
- "Weighing the Costs of a CT Scan's Look Inside the Heart" is the other article. It was published on June 29, 2008. The authors, Alex Berenson and Reed Abelson, did an exhaustive research about the subject. They reached this conclusion: despite the fact that this imaging modality is unproven as an effective way to prevent major myocardial infarctions, the financial incentives for physicians that own the technology and the insatiable appetite of Americans for all things "cutting edge," makes the widespread use of such a technology almost unstoppable under our present compensation system. Disc replacements, in the lumbar and cervical spine, are procedures not too dissimilar, as they are in search of real clear cut indication.

It is always good to remember that we are our patients' advocate and should not become procedures' advocate, a real temptation in our system today!

Most of the speakers at the ethics seminar emphasized that Physicians are "professionals" and therefore they should put the interest of their patients ahead of their own. I agree. But for this to work, we must have a real "Social Contract." We must be treated as professionals, and in return we should act the part.

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The speakers at the “*Neurosurgeon as CEO*” meeting emphasized that in a sense, each of us is leading a multi-million dollar business and that we should apply sound business principles to our practices. No one can argue such sound advice.

The government wants to treat us as business owners and impose on us all the restrictions that apply to business, but at the same time, wants us to behave as professionals with all the altruism expected of professionals.

Presently, we are intentionally treated by the government and insurance companies as providers, and unfortunately, we frequently behave in a way that fulfills the role assigned to us. In the final analysis, we must decide as physicians and neurosurgeons what is more important to us: being professionals or being business owners?

Whatever the answer, we must reclaim our well deserved position at the helm of the health care system. First, we should care for the patients. Second, we should oversee the system. And third, we should direct the expenditure. As we do that, let us not forget that the billions of dollars spent on health care is our money and the money of our fellow Americans, so let us spend it wisely as we would our own. ❖

When you not being you is OK

Randall W. Smith, M.D., Editor

For those of you out there who work with Physicians Assistants (PAs) and Nurse Practitioners (NPs), the question arises as to when a response by one of these Allied Health Professionals (AHPs) under your direction to a request for ED consultation will not run afoul of EMTALA regulations. As you know, when you are a named on-call neurosurgeon for the ED and are requested by the ED doc to see a patient, you must respond or risk prosecution by the Feds as well as the State. To paraphrase Bill Clinton, the issue is when is it acceptable for you not to be you?

Previously the Feds felt it was OK for an Allied Health Professional (AHP) to respond as long as that practice was acceptable under state scope of practice laws. California state law limits the abilities of NPs and PAs to perform what would otherwise be the practice of medicine absent applicable standardized procedures and delegation agreements. On-call physicians who send non-physician representatives to perform medical screening examinations, therefore, must ensure that the practitioner has such authorizing documents in place, that such documents govern examinations of the type requested, and that the non-physician practitioner has been credentialed and privileged by the hospital’s medical staff prior to appearing to do the evaluation. All that documentation, those protocols and the hospital credentialing is a pain but it is entirely required.

The CMS has recently narrowed the circumstances under which a non-physician representative may respond for the on-call physician. In essence, the new rule requires you to personally respond if specifically requested. If the ED doc is OK with you sending the AHP, no sweat but "In the event that the treating physician disagrees with the on-call physician's decision to send a representative and requests the appearance of the on-call physician, then both the hospital and an on-call physician who fails or refuses to appear in a reasonable period of time may be subject to sanctions for violation of the EMTALA statutory requirements . . .”.

In light of the above, take your ED doc to lunch from time to time.

The official CMS document showing the changes can be found at

<http://www.cms.hhs.gov/surveycertificationgeninfo/downloads/SCLetter08-15.pdf>.

(The editor acknowledges the excellent, succinct article by Lowell C. Brown, Sarah G. Benato and, Patricia Kosich of Arent FOX, LLP (<http://www.arentfox.com>), a Los Angeles law firm, in the preparation of this newsletter item.) ❖

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). ❖

More News from the Editor

Big Brother trying to play Mother-May-I

The Feds are considering a requirement for pre-authorization for imaging studies in an attempt to control what they consider runaway costs for imaging in Medicare. They really are worried about those of us who have imaging capabilities in our offices with the implied fraud we inflict by ordering studies so as to improve our bottom line. The AANS/CNS, along with a group of impacted specialties, has submitted a rebuttal for those rules citing the usual arguments against such pre-authorization including diagnostic delays. The rebuttal politically avoids the best argument that pre-authorization contracts are usually let to those who make more bucks by more denials. That said, neurosurgery would do better by claiming a partially exempt status considering that we should not be lumped with the GPs and the Internists but rather constitute a select group who does not need pre-authorization unless we demonstrate a 2 standard deviation from neurosurgical peers (a 1 standard deviation if we own an in office imaging capability). Why lump the huge majority of work-a day neurosurgeons in with the amateur PCPs or the neurosurgical entrepreneurs? ❖

The Keyboard is Mightier than the Pen

As part of the recent Medicare legislation which postponed the physician pay cut, the Feds are pushing for electronic prescribing which they claim would save 156 million dollars over 5 years, save lives and prevent 150 million phone calls by pharmacists each year to doctors for help in deciphering a hand written script. As with the PQRI program, CMS will pay a bonus (2%) to docs who E-prescribe in 2009 and 2010. As usual, there are a few flies in this behavioral modification ointment. First, it is estimated it will cost the doc about 3K to get the software up and running to E-prescribe, many pharmacies don't accept electronic prescriptions and some controlled substances are prohibited from the electronic game. It is a little unclear how much E-prescribing will qualify for the bonus and what the bonus will be calculated upon. If the 1.5% PQRI bonus (going up to 2% for 2009 and 2010) is any bellwether, each doc can anticipate about \$1000 annually for playing the E-prescribing game in 2009 and 2010 followed by lesser amounts in 2011-13 which means you might, just might, get the bonus to eventually pay for the software. One wonders just why the Feds persist in these half a carrot programs funded up front by docs. Maybe it's because they can. What they certainly can do is reduce your Medicare payments if you don't E-prescribe, which is planned for 2012. Yikes! ❖

Overpayments a Fertile Field

A couple of interesting reports about overpayments (translation=fraud) have surfaced recently. The Feds reported on a three year demonstration project in 6 states that concluded that just over a billion dollars had been improperly paid out to Medicare providers. The great majority (828 million) was overpayments to hospitals. The good news is that only about 2% (20 million dollars) of the total was overpayments to docs. The bad news is that they plan to go after every dime and the hospitals and Feds have more accountants and attorneys than we do.

On the Work Comp front, the Department of Industrial Relations (DIR) apparently paid a million bucks for a study the intent of which is to use the information to evaluate the scope of medical provider fraud in California. Based on a protocol created by Dr. Malcolm Sparrow, professor of practice of public management at the John F. Kennedy School of Government at Harvard University (these Harvard guys can be a pain; remember Dr. Hsiao and RBRVS?), and thoroughly analyzing just 97 claims, the study found a 22-28% billing error rate that would extrapolate into annual improper payments of 500 million to over a billion dollars. A majority of the overpayments were due to the comp carrier incorrectly paying for stuff that was not medically necessary according to statute or ACOEM guidelines, but a significant amount was spent on services that were not actually provided. They mostly discovered the latter category by interviewing the injured workers as to what they actually received and felt the category was obviously fraudulent billing by the provider.

Just what the above portends for us docs in the near future is at present not totally clear but it is hard to believe that those with the money (the comp insurers with the DIR as watchdog) are going to let this just lie around as interesting information. For those of you that might be pushing the envelope, remember that there are ways to prove impropriety (like charging for 6 hours to review records less than an inch thick when it would at most take 90 minutes if they were in Braille or claiming an hour of face-to-face time with 10 patients in a four hour office afternoon). Remember, when there are big bucks at stake, the bean counters really hit their stride and the attorneys can't be far behind. ❖

The Buck Begins Here

With apologies to our doc readers, the following information is important for your office billing staff since Palmetto (wasn't that a candy bar?) will become the California Medicare Administrator (translation—to whom you send Medicare bills) in September rather than NHIC who we have all been billing for years. Good luck and ignore at your collective peril.

Essentials on PalmettoGBA, the Medicare Administrator Starting On 9/02

(prepared by the Alameda-Contra Costa Medical Association - 7/14/08)

Website and E-mail Alerts are the Primary Source of Communication

Go to: www.PalmettoGBA.com/J1

- Sign up for e-mail updates by clicking on “E-mail Updates” in the upper left corner of the page.
- Scroll down the opening page to find recent announcements, a resource checklist, an implementation timeline, and other important information.
- Navigation guides on the left side of the page:
 - EDI - links to information on electronic claims submission
 - EFT – information on receiving electronic payments from Medicare
 - FAQs – essential information on many issues
 - LCDs – information on local coverage policies
 - Learning and Education – information on educational programs (education is primarily via webinars, conference calls, and listservs).
 - Publications – links to documents containing essential information
- E-mail inquiries may be submitted to j1mac@palmettogba.com.

Key Actions to Be Taken by Physicians – (find info. on website)

Electronic Claims Submission:

- **Electronic Data Interchange Enrollment Form** (also referred to as the EDI Agreement) – All physicians submitting claims electronically must complete this form and return it by 8/29/08. Palmetto is encouraging physicians to enroll as soon as possible to begin electronic submissions
- **EDI Application Form** – All physicians, billing services, clearinghouses who transmit (not applicable to physicians who send their claims via a clearinghouse or billing service) claims directly to Medicare should complete this form immediately.
- **EFT Agreement** – All physicians receiving electronic fund transfers from Medicare must complete and submit this form by 8/15/08.
- **Physicians using a low-cost software offering from NHIC** should consult Palmetto's website at <http://www.palmettogba.com/J1?Open&cat=EDI~General>, and click on “EDI,” then “General” to facilitate connectivity to Palmetto's EDI Gateway.

Paper Claims Submission and Other Key Information:

- Other than the enrollment requirements listed above, the conversion to Palmetto does not trigger a requirement to re-enroll in the Medicare program. Any pending re-enrollment processes prompted by the recent NPI implementation problems will transfer to Palmetto for completion on 9/02.
- 9/02 is the “cutover” date when claims (electronic and paper) must be sent to PalmettoGBA.
- Paper claims submitters must have a waiver (to file by paper) on file prior to the cutover date.
- Palmetto consolidated local coverage determinations (LCDs) for all the Western states into 88 LCDs. There will be 33 new LCDs for California effective 9/02. (see website)
- Levels of appeals have not changed, but forms and addresses for appeals have changed and there have been a few changes in claims completion instructions as well as where to submit claims (see website).
- Telephonic customer service will be via an “Interactive Voice Response System” – 866-931-3903
- Telephonic customer service for EDI and EFT issues: 866-749-4301. ❖



Visit beautiful Carmel, California for the CANS Annual Meeting

January 17-18, 2009

There are some sleeping rooms available for meeting attendees who want to arrive on Thursday, January 15th to do some touring and some rooms on Sunday, January 19th for those who wish to take advantage of the Martin Luther King holiday weekend (see next page for reservation form). Please note that reservation deadline is December 15th, 2008.

Note to potential exhibitors: Rather than a full-day meeting and exhibits on Saturday as we have done in the past, we are planning two half-day morning sessions to allow free afternoons for golf at the resort or sightseeing. As always, your company name and product will be showcased in our program booklet. You are welcome to attend all the social functions, including the Saturday evening banquet at the Monterey Bay Aquarium.

Your participation is very much appreciated especially in light of the fact that our meeting is a small one in comparison to the national meetings. We like to think of our event as an intimate one where your company representatives can visit with current neurosurgical clients as well as form new relationships.

Please contact janinetash@sbcglobal.net to receive the exhibit registration material. ❖

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

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 Moustapha Abou-Samra, 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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