



CANS

NEWSLETTER

California Association of Neurological Surgeons

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Politics—stuff like this fits well with Halloween

Randall W. Smith, M.D., Editor

It is noted that the Congressional Budget Office has estimated that tort reform, in its various forms, could save the Feds about \$40 billion over ten years. They base this estimate on some research regarding general use of medical services before and after a state adopted some malpractice reform. I can't argue against legitimate research but I can question the extrapolation of limited investigation over a time frame (10 years) that is likely to include radical changes in the healthcare system. Maybe capping pain and suffering, abolishing joint and several liability, allowing collateral resources to be used in determining awards and changing the statute of limitations—one year for adults and three years for children—from the date of discovery of an injury (all of which were presumed by the CBO estimate and which has got to be very unlikely) would indeed reduce the Fed spending by the amount suggested. Seems to me that is a lot of presumption and so I remain very skeptical about any savings from tort reform as stated in last month's newsletter. (*See the Letter to the Editor by Dr. Abou-Samra in this issue.*)

It is also noted that the separate Senate Bill 1776 to kill the Sustainable Growth Rate concept was promptly embraced by the AMA and about as promptly was defeated by the Senators. The AANS/CNS opposed the bill because it didn't really establish a better system and included a 10 year freeze on Medicare reimbursement for docs. One guesses the AMA felt they could change the payment freeze over time but our team on the hill was more realistic. Good riddance to that one.

Finally, it is noted that the Senate, in an attempt to garner the 60 votes they need to approve a public health insurance option (Medicaid for more of the less fortunate and Medicare for any who like the expected lower premiums) has come up with a trick to get those votes. They propose that states can opt out of offering the plan if they prefer their own solutions. This has got to be bogus in the huge majority of states that have no plan and no likelihood of creating one with California being a prime example. They all will opt in. Even Massachusetts, which does have a state public option plan (which is nearly bankrupt), will get in line and get out of the healthcare business and leave it to Uncle Sam. No wonder the private insurance industry is attacking. ❖

CANS Annual Meeting

HEALTH CARE REFORM 2010 - CHAOS OR PROGRESS?

January 15, 16, 17 2010, Anaheim, CA



Meeting schedule and registration forms are included at the end of this newsletter.

Room reservations (\$209 per night) as well as discounted tickets to Disneyland@Resort can now be made by accessing

<https://resweb.passkey.com/go/CANS>.

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Letter to the Editor

(Editor's Note: Arthur Relman, M.D., from Harvard Medical School and of NEJM fame, in an op-ed posted by the Journal on September 23rd, opined that as long as fee-for-service exists, costs will never be brought under control and high income specialists will continue to dominate the medical marketplace to the detriment of primary care docs. He proposes universal tax-based insurance paid for by the Feds with the government giving a fixed amount of money to a national network of community-based, private, not-for-profit, multispecialty, doctor-managed group practices. These capitated group practices would pay their docs a fixed salary with bonuses for quality and insurance companies and employer provided medical insurance would no longer exist. The essence of his proposal is capitation: capitation by the Feds who will decide how much to spend per insured and capitation of docs who will now have no incentive to do more to make more. He further feels that his proposal would be resisted by "vested interests" which must constitute the understatement of the decade.)

Dear Editor:

I am aware of Dr. Relman's position through many sources, including my mentor, a professor of anatomy at the University of Arizona. I was 17 years old then and started as a lab tech in his neurophysiology lab in Long Beach (UCLA facility). I continue to do laminectomies and stereotactic surgery at about the same reimbursement rate!

There is much truth in Dr Relman's criticism of our current fee-for-service paradigm. As much as I have benefited from this system, I can't help but be dismayed in its excesses. Here in San Diego, I see gross excesses in pain therapy enterprises for spinal disorders. Thousands of dollars, even millions spent for absolutely useless care. We all see excessive spinal surgery being performed. Today I reviewed the images of the mother-in-law of one of our hospital administrators. She is 85 years old with osteoporosis. Following a C1-C2 posterior fusion by my partner for an odontoid fracture last year she did well, but developed a strange head lateral tilt. She was operated on by another surgeon last week...an occipital to T3 posterior fusion and anterior corpectomies with cages. Now she can't swallow. I hope she makes it out of the hospital with her life and head not tilting. Cost to society...much. Cost to family...anguish. Cost to patient...hopefully not her life.

The new cash paradigm in San Diego is operating on accident victims (captured through the ED), charging many thousands of dollars and testifying for the inevitable plaintiffs attorneys in the inevitable law suit against the other motorist. A huge cash cow. It has become the answer to the loss in revenue from WC. Can you believe we have surgeons whose specialty is caring for WC patients? What does this tell us as a profession? Specializing in an insurance program!

Even more disturbing is the development of spinal implant distributorships in San Diego. A couple of spine surgeons get together buy implants from spinal implant companies on the cheap (a few hundred a screw) and bill the insurance from the distributorship for thousands. I am told these surgeons recover \$20,000 to \$50,000 each month...each! I was told a county neurosurgeon generated \$600,000 in implant costs alone last month. Small wonder we are under the microscope!

The Massachusetts plan predicts the future of health care in America. Capture all citizens. Mandatory insurance for all. Costs go up in a fee-for service environment...7 to 9 percent per year which will bankrupt the state. ER visits go up 9% since residents have insurance but can not find a primary care physician. Why not go to the ER for an ear ache when one will not be billed for services? The solution is obvious and ominous...denial of care and rationing. The Commonwealth has decided to stop paying for foreign legal residents (non citizens). Next, of course is to make the Commonwealth a capitated HMO...physicians will be paid a capitated salary.

This is our future. I think a 20% of GDP expenditure for health care is not excessive in our wealthy county. The benefits in terms of medical advances and the employment of a significant number of our citizens should not be discounted. More people are employed in the health industry in Detroit than in the automobile industry!

What is the solution? It will be decided by politicians and hopefully can be muted by our profession for the benefit of our patients and coming generations of physicians and surgeons. I wonder if the Kaiser model will be our future. The next 10 years will form medicine for the future of our specialty. ❖

Kenneth Ott, MD, FACS
CANS President-Elect

(Dr. Ott has his dander up. Another letter.)

Dear Editor:

*This is the way the world ends
This is the way the world ends
This is the way the world ends
Not by a bang but with a whimper*

TS Eliot: "The Hollow Men."

Recently the New York Times capitulated in their advocacy of health care reform. This occurred after an extensive review of the current legislative process...an ever moving target of special interests (NYT, Sunday October 11, 2009, page wk 9). The editors agree that the current bills will do little to reform health care. ". . . we remain optimistic that – with sustained attention- Congress and the executive branch can find ways to reform the delivery of medical care." Certainly a dream.

Additionally a new commission "insulated from political lobbying" will find a way to limit costs of Medicare and improve spending. How naïve is this?

In fact, the special interests have co-opted the legislation. The American Hospital Association and device manufacturers have lobbied to reform the reform to their benefit. Unhappily our position has been undercut by our own AMA. Lesser forces such as CANS continue to fight the Barbarians at the Gate.

My metaphor for this process is a popular roach killer--the Roach Hotel. Remember the advertisements for the Roach Hotel..."you can check in but you can't check out!" Hey, call your friends in Massachusetts. Their health plan covers virtually all state residents. The surgeons checked in...not voluntarily...now they can't check out. The plan is bankrupting the state. The solution is to make the state health plan a HMO, and salary all physicians. Such as it is with the national, universal health plan. We will be checked in, but we can't check out.

*This is the way health care ends
This is the way health care ends
This is the way health care ends
Not with a bang, but hopefully with our power to manage our future
And continue quality care of our patients ❖*

Kenneth Ott, MD, FACS

NEUROSURGEON WANTED

Well established and respected Northern California Neurosurgical practice is seeking a new associate to take over retiring surgeon's practice in Sacramento. Candidate will have ample opportunity to grow an already robust referral-only practice. Candidates must be interested in both intracranial as well as spinal procedures. BC/BE (Board Certified or Board Eligible) applicants may send resume to: cgriswold.capneurosurgeons.com. ❖

Dear Editor:

In your editorial "Defensive Medicine Won't Go Away", September 2009 issue, you made some accurate observations, but I am afraid that I don't agree with your premise; in fact, I think you missed the real meaning of "tort reform."

I agree that an emergency room physician in LA is as likely as his colleague in Miami to order an unnecessary CAT scan in order to protect his "rear," thus participating in and propagating the defensive medicine habit and mentality. Additionally you are absolutely right that no practicing physician can ignore the real threat of being named as a defendant in a malpractice law suit.

I also agree that MICRA was and continues to be helpful in making buying malpractice insurance possible and even "affordable," therefore it has been financially helpful to physicians. However, MICRA was not designed to "solve" the medical malpractice problem. Simply put: it was designed to address one aspect of the malpractice problem and one aspect only-the runaway pain-and-suffering awards.

There are many more aspects to this problem: the contingency system that plaintiff lawyers use, the trial by jury of "our peers," the litigious society in which we practice ... are but a few of the problems we face. No tort reform can be considered a serious reform unless this entire system is changed. Only then will we alter significantly our habit of practicing defensive medicine, and only then, will we reap as a Nation-not only practicing physicians-the financial benefits of such reform.

There is a raging debate now about how much saving will tort reform generate. It was recently estimated by the CBO to be 54 billion dollars. But, seriously, how can we know with any certainty if we have not yet changed our "ordering of tests and imaging studies" habits? I'd say that \$ 54 Billion is the minimum savings. I imagine that the real savings are substantially higher.

Yes, we need tort reform, not because it is good for "docs and the nearly 10 billion dollars med mal industry," but because it will actually improve the delivery of health care in America; because it will be an integral part of any real comprehensive health care reform; and because it is the right thing to do. ❖

Moustapha Abou-Samra, M.D., CANS Past President

Tidbits from the Editor

Randall W. Smith, M.D.

CANS the only help for Medicare Intermediary Problems

Last month we noted that the Medicare Intermediary for California, Palmetto GBA, would be happy to have those of us who encounter problems with Medicare claims "utilize Palmetto's Ombudsperson program by contacting Melissa Robinson (Melissa J. Robinson@PalmettoGBA.com) who will assign one of their four ombudspersons to work with you." Turns out that is not true as Palmetto indicates they don't have the personnel to handle all the expected moans and groans. So any CANS member who has a hassle with Palmetto about anything that is not reasonably solved should contact Philip Lippe, M.D. (pmlippe@att.net) who is our man who interacts with them on a regular basis as a CANS consultant. He will run interference. Not a member of CANS? Good luck. ❖

Red Flags will actually fly

The Federal Trade Commission's (FTC's) "Red Flags Rule" finally becomes effective November 1 after being postponed from May implementation. This regulation requires creditors (they who issue invoices or defer payments for services) including hospitals and physicians, to have a plan for avoiding identify theft of patients and helping them when theft has occurred. The ACS and the AMA helped get the delay from May but were unsuccessful in getting docs exempted from

the rule. Violations of the regulation will result in a penalty of up to \$2,500 per "knowing violation." As we noted previously, the AMA has prepared a guidance document, along with sample policies, to assist physicians in bringing their existing HIPAA security and privacy policies into compliance with the Red Flags Rule. *That document is again attached to the E-mail you received that included this newsletter.* ❖

Old neurosurgeons and the JNS

The AANS has decided that old geezers like this writer who are Lifetime members will no longer be provided with the printed journals it publishes (*Journal of Neurosurgery; Pediatrics; Spine*) unless a \$200 subscription is elected. For the \$105 annual dues charged to Lifetime members, that seems fairly reasonable considering the cost of paper, printing and postage and considering that we still get access to the on-line versions. The question now arises as to how long the AANS will actually print the journals at all. The day will come when these publications will be on-line only with those of us who still like to hand/lap read getting the electronic version downloaded to our E-reader. ❖

CSNS Meeting in New Orleans

The Council of State Neurosurgical Societies (CSNS), the socioeconomic arm of the AANS/CNS, held its autumn meeting on October 23-24 in the Big Easy. It was attended by 48 delegates from the various states (8 from CA), 21 delegates appointed by the AANS and CNS and 14 residents including two from California, Paul Kalanithi, M.D. from Stanford and Vincent Wang, M.D. from UCSF.

Items of interest:

1. **Peter Carmel**, a neurosurgeon from New Jersey, currently serving a second stint on the AMA Board, is running for AMA president. He will be up against an Ob/Gyn and a family doc. There have been surgeon AMA presidents but never a neurosurgeon. He asked for help from the CSNS and the state societies and all pledged to give him a hand which will be calling your local members of the AMA House of Delegates. More about how you can help in the future. He fielded a question as to why the AMA seems to be at continual odds with specialty groups about embracing Congress' reform bills. He indicated that the AMA needs to follow the policy set by the House of Delegates who are predominantly generalist delegates and who do favor a lot of the legislation being considered.
2. The CSNS delegates approved revisions to the Council's **Rules and Regulations** which essentially add some additional committees to improve developing future leaders, improving relationships with state societies and more formal cultivation of residents in the CSNS.
3. The AANS and CNS requested a **16K reduction** in CSNS operational expenses which they pay for each year. The reduction will be met by reducing some Executive Committee food items (2K) and by holding the spring Executive Committee meeting via conference call (14K). The voluntary contribution account is about 100K which is used for paying for some of the studies and programs of the CSNS which the AANS/CNS approve but can't fund. The account is supported by a voluntary contribution from state societies; \$250/delegate. About 20 states make such contributions each year and CA always has done so since the inception of the contribution program.
4. **Mick Perez-Cruet** from Detroit reported on a survey of US neurosurgeons by the CSNS about how organized neurosurgery handles socioeconomic (SE) issues. Turns out of the 1155 responders, 37% had never heard of the CSNS but 46% were interested in participating and 25% felt the CSNS had actually helped their practice. 65% felt their state neurosurgical societies had helped their practices. Regarding socioeconomic education, 33% got it best from attending the national meetings, 17% got it best from state society meetings and 51% indicated the best publication to get good SE info was the AANS quarterly *Neurosurgeon*.

5. **Nick Bamabakidis**, chairman of the Medical Legal committee, announced an extensive study of Conflict of Interest information, practices and laws. It will be posted on the CSNS Web site as a Power Point presentation for study or use by CSNS members.

6. **Stacey Wolfe** reported for the Medical Practices committee on the Medical Device Registry which was urged to be formed in a resolution from the spring CSNS meeting. The concept is that when a device is implanted, there should be a

registry where the patient and manufacturer information is maintained so that when a problem is encountered or a recall issued, patients who received the material can be identified and located. The registry is a work in progress complicated by identifying who would manage the database involved and who would be responsible for data entry. She indicated the FDA has been tasked with answering some of these issues.



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7. **Shelly Timmons**, chair of the CSNS Neurotrauma committee (and who is on the ACS Trauma Committee) gave the report of the neurocritical care survey conducted by her committee. 741 neurosurgeons responded with an equal distribution of academic and private practice docs. One fourth of respondents reported that they had to have a consultant when managing an ICU patient and very few reported managing every patient's every need. 80% of those that don't manage the whole show reported a congenial collaboration with colleagues and one-third indicated they didn't have the time to manage everything anyhow. Only 3% of docs reported that cerebral monitoring devices were placed by non-neurosurgeons with 1/3 of those by PAs/NPs and another third by neurologists. Only 7.6% reported not being allowed to do some aspect of critical care. She noted the ongoing activities of the Neurocritical Care Society in pushing for limiting neurocritical care delivery only to those who have completed their certification which includes specific training and passing an exam. Neurosurgeons should know that the Neurocritical Care Society is not recognized

by the ACGME or the American Board of Medical Specialties and that the well articulated position of the AANS/CNS on this issue is posted on the AANS Web site under Policy Statements. She further noted that neurosurgery training programs would be wise to document the hours spent by residents doing neurocritical care to combat those that think that only docs who do critical care full time are qualified to render this kind of care.

8. **Bob Harbaugh's** AANS/CNS Washington Committee report was highlighted by his opinion that there will be a public insurance option come out of both the House and Senate healthcare reform bills. He reiterated the continuing opposition to that option by the AANS/CNS as well as our positions for repealing the Sustainable Growth Rate formula, including tort reform in any legislation and opposing the clinical effectiveness research concept which he feels will surely lead to rationing.

9. **John Wilson**, chairman of the CSNS Coding and Reimbursement Committee, reported that 63075 almost surely will be revalued to include an arthrodesis but there is no plan to bundle taking an autograft or utilization of plates.

10. **Rick Boop**, chairman of the Neurosurgery Political Action Committee, reported that as usual about 10% of America's neurosurgeons contribute to the PAC while 90% sit on the sidelines and their wallets. He made the plea for more of us to contribute particularly in light of the current reform debate where we can have some impact but it takes money for access to legislators. He awarded a trophy to California (accepted by CANS president Bill Caton) whose neurosurgeons have contributed the most this year.

11. House of Representatives member from Louisiana's 6th district, **Bill Cassidy**, who is a doc practicing GI medicine in his spare time, gave a luncheon address in which he felt, like the good Republican he is, that the health insurance public option was not the way to go. He expressed his preference for reducing administrative costs in commercial insurance policies to make them more affordable and to encourage people to adopt healthier life styles to reduce disease and the cost of treating it. He was strongly in favor of Health Savings Accounts for all which would put the patient in control of the first thousands of dollars spent on healthcare each year. He trusts patients to research and choose wisely when it's their money on the line.

12. The CSNS took the following actions on the eight resolutions submitted for the meeting:

RESOLUTION I – Neurosurgeons as Spine Care Specialists. This resolution wanted the AANS/CNS to embark on an educational campaign aimed at referring physicians, work comp carriers and the public that neurosurgeons are spine docs. The assembly chose (on a fairly close vote) to defeat this resolution as it was essentially the same as resolution V adopted in September of 2008 and that the AANS/CNS were already doing what was asked.

RESOLUTION II - Mandatory Advanced Directives For Medicare Participants. This resolution wanted to make it mandatory to complete an advanced directive upon enrolling in Medicare. The assembly could not bring itself to pursue this concept in light of what spin doctors would do to a "pre-death" directive even if it were voluntary rather than mandatory and voted to table the resolution which effectively killed it for this meeting. It could be reintroduced in the future.

RESOLUTION III - CSNS Speaker's Bureau. This resolution would create a posse of CSNS Executive Committee members willing to travel to individual state neurosurgical society meetings to extol the virtues of the CSNS and help the societies to disseminate and discuss socioeconomic information. The assembly approved this resolution and \$5000 from the voluntary account to support travel and lodging of the speakers if not covered by the state societies.

RESOLUTION IV- Transparency to Health Care Cost. This resolution would create a pilot program to have some hospitals supply a detailed breakdown of their costs/charges in providing their aspect of the care of our hospitalized patients in order to allow us docs to identify costly items we could do without and be able to assist in cost reductions. The assembly chose to refer this resolution and its 5K price tag to the Coding and Reimbursement Committee for an implementation plan to be reported upon at the spring meeting in Philadelphia.

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RESOLUTION V - The Abuse of Neurosurgical Resources by Emergency Rooms and Acute Care Facilities. This resolution was aimed at creating consultative guidelines to combat what is perceived as abuse by ED's of neurosurgical consultants as part of the ED docs practice of defensive medicine. The assembly felt there was too much variability in the ED/consultant interaction for a national guideline and rejected the resolution as unworkable as written.

RESOLUTION VI - Exploring the Need for Disclosures of Neurosurgeon-Owned Hospitals. This resolution reflected the author's suspicion that doc owned specialty hospitals may lead to abuse and we should try to indentify the scope of the problem and recommend ways of avoiding conflicts of interest. The assembly felt the need for more detail on how to potentially proceed and referred the resolution to the Medical Practices Committee for study and possibly a clearer resolution in the future.

RESOLUTION VII - Simplified Conflict of Interest Reporting in Organized Neurosurgery. This resolution would create a universal conflict of interest disclosure form that once completed by the doc could be used to satisfy the many requirements for completion of various such disclosure forms by speakers at the annual AANS and CNS meetings. The assembly approved the resolution and the AANS/CNS will be approached regarding this issue.

RESOLUTION VIII – Use of Guidelines in Determining Reimbursement for Neurosurgical Care. This resolution was submitted by the Neurosurgical Society of Alabama because the predominant medical insurance carrier in that state planned to unilaterally reduce physician reimbursement rates unless care rendered conformed to unspecified "guidelines." The Society wanted help in dealing with this issue and the resolution called for the AANS/CNS to develop policies/procedures and a guideline clearing house that would assist state societies in dealing with such carrier maneuvers. The resolution was adopted and the CSNS Executive Committee will consult with the AANS/CNS to pursue the issue. ❖

THOUGHT OF THE MONTH:

Harold Slumberg, a retired engineer, was asked "What do you old folks do now that you're retired?" He replied, "Well, I'm fortunate to have a chemical engineering background, and one of the things I enjoy most is turning beer, wine, Scotch and margaritas into urine." Where do I sign up? ❖

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). ❖

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.

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. 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, (916-457-8202) with the word "unsubscribe" in the subject line.

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AMA identity theft prevention and detection and Red Flags Rule compliance: Sample policy

Please note: The information provided in this document does not constitute, and is no substitute for, legal or other professional advice. Seek consultation from legal or other professional advisors for individualized guidance regarding the application of the law to your particular situation or regarding other compliance-related concerns.

To customize this template document, replace the text in brackets (e.g., [text in brackets]) with text that is appropriate to your practice and circumstances. After customizing this document, it is advisable to have it reviewed by an attorney who is familiar with health privacy laws and regulations in the state(s) in which your practice is located and who is in a position to provide your practice with legal counsel.

To the extent possible, you should reword each section to reflect the specific procedures to be followed in your practice, and be sure to incorporate applicable state laws. In addition, you may decide that certain functions may only be performed by certain personnel, within certain departments or with a certain form of management approval. When appropriate, you may wish to include sanctions provisions. Sanctions are the disciplinary measures to be taken in the event of careless disregard or deliberate violation of any of these provisions. You may also wish to keep the documentation of sanctions in a separate sanctions policy.

***[Physician practice name]* Policies and procedures Identity theft prevention and detection and Red Flags Rule compliance**

Policy

It is the policy of *[physician practice name]* to follow all federal and state laws and reporting requirements regarding identity theft. Specifically, this policy outlines how *[physician practice name]* will (1) identify, (2) detect and (3) respond to “red flags.” A “red flag” as defined by this policy includes a pattern, practice, or specific account or record activity that indicates possible identity theft.

It is the policy of *[physician practice name]* that this Identity theft prevention and detection and Red Flags Rule compliance program is approved by *[physician practice name Board of Directors or appropriate committee/representative]* as of May 1, 2009, and that the policy is reviewed and approved no less than annually.

It is the policy of *[physician practice name]* that *[specify title here]* is assigned the responsibility of implementing and maintaining the Red Flags Rule requirements. Furthermore, it is the policy of this *[physician practice name]* that this individual will be provided sufficient resources and

authority to fulfill these responsibilities. At a minimum, it is the policy of [*physician practice name*] that there will be one individual or job description designated as the privacy official.

It is the policy of [*physician practice name*] that, pursuant to the existing HIPAA Security Rule, appropriate physical, administrative and technical safeguards will be in place to reasonably safeguard protected health information and sensitive information related to patient identity from any intentional or unintentional use or disclosure.

It is the policy of [*physician practice name*] that its business associates must be contractually bound to protect sensitive patient information to the same degree as set forth in this policy. It is also the policy of this [*physician practice name*] that business associates who violate their agreement will be dealt with first by an attempt to correct the problem, and if that fails by termination of the agreement and discontinuation of services by the business associate.

It is the policy of [*physician practice name*] that all members of our workforce have been trained by the May 1, 2009 compliance date on the policies and procedures governing compliance with the Red Flags Rule. It is also the policy of [*physician practice name*] that new members of our workforce receive training on these matters within a reasonable time after they have joined the workforce. It is the policy of [*physician practice name*] to provide training should any policy or procedure related to the Red Flags Rule materially change. This training will be provided within a reasonable time after the policy or procedure materially changes. Furthermore, it is the policy of [*physician practice name*] that training will be documented, indicating participants, date and subject matter.

Procedures

I. Identify red flags. In the course of caring for patients, [*physician practice name*] may encounter inconsistent or suspicious documents, information or activity that may signal identity theft. [*Physician practice name*] identifies the following as potential red flags, and this policy includes procedures describing how to detect and respond to these red flags below:

1. A complaint or question from a patient based on the patient's receipt of:
 - A bill for another individual;
 - A bill for a product or service that the patient denies receiving;
 - A bill from a health care provider that the patient never patronized; or
 - A notice of insurance benefits (or explanation of benefits) for health care services never received.
2. Records showing medical treatment that is inconsistent with a physical examination or with a medical history as reported by the patient.
3. A complaint or question from a patient about the receipt of a collection notice from a bill collector.
4. A patient or health insurer report that coverage for legitimate hospital stays is denied because insurance benefits have been depleted or a lifetime cap has been reached.
5. A complaint or question from a patient about information added to a credit report by a health care provider or health insurer.
6. A dispute of a bill by a patient who claims to be the victim of any type of identity theft.

7. A patient who has an insurance number but never produces an insurance card or other physical documentation of insurance.
8. A notice or inquiry from an insurance fraud investigator for a private health insurer or a law enforcement agency, including but not limited to a Medicare or Medicaid fraud agency.
9. *[Insert other relevant practice-specific items here.]*

II. Detect red flags. *[Physician practice name]* practice staff will be alert for discrepancies in documents and patient information that suggest risk of identity theft or fraud. *[Physician practice name]* will verify patient identity, address and insurance coverage at the time of patient registration/check-in.

Procedure:

1. When a patient calls to request an appointment, the patient will be asked to bring the following at the time of the appointment:
 - Driver's license or other photo ID;
 - Current health insurance card; and
 - Utility bills or other correspondence showing current residence if the photo ID does not show the patient's current address. If the patient is a minor, the patient's parent or guardian should bring the information listed above.
2. When the patient arrives for the appointment, the patient will be asked to produce the information listed above. **This requirement may be waived for patients who have visited the practice within the last six months.**
3. If the patient has not completed the registration form within the last six months, registration staff will verify current information on file and, if appropriate, update the information.
4. Staff should be alert for the possibility of identity theft in the following situations:
 - The photograph on a driver's license or other photo ID submitted by the patient does not resemble the patient.
 - The patient submits a driver's license, insurance card, or other identifying information that appears to be altered or forged.
 - Information on one form of identification the patient submitted is inconsistent with information on another form of identification or with information already in the practice's records.
 - An address or telephone number is discovered to be incorrect, non-existent or fictitious.
 - The patient fails to provide identifying information or documents.
 - The patient's signature does not match a signature in the practice's records.
 - *[If your practice collects Social Security number]:* The Social Security number or other identifying information the patient provided is the same as identifying information in the practice's records provided by another individual, or the Social Security number is invalid.

III. Respond to Red Flags. If an employee of *[physician practice name]* detects fraudulent activity or if a patient claims to be a victim of identity theft, *[physician practice name]* will respond to and investigate the situation. If the fraudulent activity involves protected health information (PHI) covered under the HIPAA security standards, *[physician practice name]* will also apply its existing HIPAA security policies and procedures to the response.

Procedure

If potentially fraudulent activity (a red flag) is detected by an employee of [*physician practice name*]:

1. The employee should gather all documentation and report the incident to his or her immediate supervisor [or designated compliance officer/privacy official, if applicable].
2. The supervisor [or designated compliance officer/privacy official, if applicable] will determine whether the activity is fraudulent or authentic.
3. If the activity is determined to be fraudulent, then [*physician practice name*] should take immediate action. Actions may include:
 - Cancel the transaction;
 - Notify appropriate law enforcement;
 - Notify the affected patient;
 - Notify affected physician(s); and
 - Assess impact to practice.

If a patient claims to be a victim of identity theft:

1. The patient should be encouraged to file a police report for identity theft if he/she has not done so already.
2. The patient should be encouraged to complete the ID Theft Affidavit developed by the FTC, along with supporting documentation.
3. [*Physician practice name*] will compare the patient's documentation with personal information in the practice's records.
4. If following investigation, it appears that the patient has been a victim of identity theft, [*physician practice name*] will promptly consider what further remedial act/notifications may be needed under the circumstances.
5. The physician will review the affected patient's medical record to confirm whether documentation was made in the patient's medical record that resulted in inaccurate information in the record. If inaccuracies due to identity theft exist, a notation should be made in the record to indicate identity theft.
6. The practice medical records staff will determine whether any other records and/or ancillary service providers are linked to inaccurate information. Any additional files containing information relevant to identity theft will be removed and appropriate action taken. The patient is responsible for contacting ancillary service providers.
7. If following investigation, it does not appear that the patient has been a victim of identity theft, [*physician practice name*] will take whatever action it deems appropriate.

2010 CANS Annual Meeting

“Health Care Reform 2010: Chaos or Progress?”



Disney's Grand Californian Hotel® & Spa

January 15-17, 2010, Anaheim, California

CONTACT INFORMATION

California Association of Neurological Surgeons (CANS)
5380 Elvas Avenue, Suite 216, Sacramento, CA 95819
tel 916-457-2267; fax 916-457-8202
janinetash@sbcglobal.net; www.cans1.org



Disneyland® discount
tickets available
—see page 5—

President's Message

William L. Caton III, M.D.

“Health Care Reform 2010 Chaos or Progress”

I invite you to attend the annual CANS meeting to be held at *Disney's Grand Californian Hotel® & Spa*. We had an excellent meeting at this location two years ago and are returning to this wonderful site. Many of your fellow neurosurgeons brought their families for an enjoyable weekend. I hope you will join us at Disneyland.

CANS is committed to our neurosurgeons to put forth a program on healthcare reform. The title of this program is an indication of the current state of affairs in medicine. An excellent program has been arranged in an effort to gain further insight into this dynamic legislative process and its impact on California Neurosurgery.

As 2010 approaches, many questions remain as to what form the new Health Care Legislation is going to take. There are many current bills in discussion in the House and in the Senate. No one is certain which legislation will prevail. Indeed, the current Senate Legislation has over 500 amendments tagged on to it ranging from funding for walking paths to jungle gyms.

We shall have a series of speakers who will share their insight as to the state of the medical reform as of January 2010. Among the many distinguished guests will be former Congressman **Tom Campbell**, a current Republican gubernatorial candidate in California. Mr. Campbell is currently on the faculty at the Chapman College. He is the former dean of the Business School at University of California at Berkley and served many years as a Congressman representing the Bay Area. Mr. Campbell has significant expertise in Health Care Legislation. He has been a firm proponent of physician rights including authoring several bills in an attempt to allow physicians to participate in collective bargaining.

Also speaking will be **Congressman Adam Schiff**. Congressman Schiff is a Blue Dog Democrat who has been very active in the Democratic Party in legislation including Health Care. He shall speak on the state of the Health Care Reform Package offered up by the Democratic Party and will discuss its impact upon us.

Another guest will be **Jack Lewin, M.D.** Dr. Lewin is the former Medical Director of State of Hawaii, former Executive Director of the California Medical Association, and currently the Executive Director of the American College of Cardiology. Dr. Lewin has been very active in the health care planning in the Obama Administration and has been a frequent visitor to the White House. He will share his views about the new health care legislation and reorganization of Medicare.

Speaking on the economics of the governmental change and its impact upon the free markets and credit crises in the United States will be **James Rothenberg**. Mr. Rothenberg is the Chief Executive Officer of the Capital Resources and Management Group. He also serves as the treasurer of Harvard University. He will share his insights as to the role of the changing economic and credit crisis in relationship to health care and its future.

Representing our national organization, **Troy Tippett, M.D.**, AANS president, shall give us an update on the American Association of Neurological Surgery's input on the Health Care Legislation. Dr. Tippett shall discuss his activities and that of the board of the AANS in our behalf on the national scene.

A series of panel discussions is also planned including several of our California neurosurgeons discussing the pros and cons of the health care legislation as of January 2010. Certainly this legislation remains a moving target!

Another panel has been organized to discuss the impact of the new legislation on hospitals, managed care, physician contracting. This panel shall try to give some insights to the audience as to the answers of the dilemmas facing the neurosurgeon in this changing arena of health care reforms.

I look forward to the members of CANS and spouses joining us on the Martin Luther King holiday weekend of January 16, 2010 and January 17, 2010. On January 17, 2010, a course on QME is planned to update the current CME hours necessary to maintain the QME certification.

I am going to Disneyland. How about you?

Schedule of Events - January 15-17, 2010

FRIDAY	Welcoming Reception (Light refreshments/no-host bar), Wisteria Room 6:30 p.m.
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SATURDAY MORNING (Sequoia Ballroom)
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7:30-8:15 *Continental Breakfast/Visit Exhibits*

8:15-8:30 **CANS Business Meeting**

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

PROGRAM: Medical Reform 2010/Chaos or Progress?

8:30-9:00 **Chaos or Reform—Hollywood on the Potomac**

Jack Lewin, M.D., Chief Executive Officer, American College of Cardiology

9:00-9:10 Q/A

9:10-9:40 **Economic/Credit Crises and their Impact on Health Care**

James F. Rothenberg, Chairman and Principal Executive Officer of Capital Research and Management Co./Treasurer of Harvard University

9:40-9:50 Q/A

9:50-10:20 *break/visit exhibits*

10:20-10:50 **Neurosurgery and Health Care Reform**

Troy Tippett, M.D., President, American Association of Neurological Surgeons

10:50-11:00 Q/A

11:00-11:30 **Health Care Reform, Legislation and Physician Bargaining**

Tom Campbell, Candidate for Governor of California

11:30-11:40 Q/A

12:00- 1:00 **Luncheon**

1:00-1:30 **Current Congressional Legislation on Health Care Reform and Its Impact on California Citizens and their Doctors**

Congressman Adam B. Schiff—California's 29th Congressional District

1:30-1:40 Q/A

1:40-2:30 **PANEL DISCUSSION**

2:30-2:40 *break/visit exhibits*

2:40-3:30 **PANEL DISCUSSION**

*****CONTINUED ON NEXT PAGE**

Schedule of Events - January 15-17, 2010

SATURDAY EVENING (Trillium Room)



7:00 p.m. Cocktails
7:30 p.m. Dinner
Award Presentation

SUNDAY (Sequoia Ballroom)

QME Seminar

8:00 a.m. Continental Breakfast/Visit Exhibits

9:00-noon **Ethics in Workers' Comp for Physicians**
Jeffrey Adelson, Esq., Counsel, Adelson, Testan and Brundo

Recent case law of importance to physicians including Almarez/Guzman
David Kizer, Esq., Counsel, State Compensation Insurance Fund;
Former Counsel, Industrial Medical Council

This seminar is presented by **Livingstone-Lopez Consulting**.
(California Workers' Compensation & Report Writing Consultant,
DWC Certified Education Provider # 2 & # 470)

The course fulfills 3 of the 6-hour annual requirement for QME continuing education for current QMEs. This class also offers a home study option for the remaining 3, 6 or 9 credits you may need. Contact Dana Livingstone-Lopez directly for this option (760 944-6769 or dana@teachqme.com).

HOTEL RESERVATIONS



Preferred method for making room reservations is via E-mail:

<https://resweb.passkey.com/go/CANS>. Call 714 520-5005 (M-F 8-5pm) for phone reservations.

*A link to **Disneyland® Resort** discount tickets is available if you reserve your room on line.*

Questions about reservations can be directed to: DLR.Convention.Groups@Disney.com

ROOM RATE: \$209.00. There will be a \$12.00 daily resort fee to cover overnight parking, local telephone service, fitness center and Internet access; all rooms are equipped with DVD players, safes and cribs.

Rates are subject to prevailing City Bed Tax. Check-in time is 3:00 pm, check-out time is 11:00 am.

The convention rate of **\$209.00** is available until **January 4, 2010**, or until block is filled.

A credit card is required to secure the reservation; payment will be processed upon arrival. The hotel requires 72 hours notice of cancellation or date change. In addition, a cancellation number must be issued by the Hotel for refund of deposit or for release of guarantee, no matter the cause for cancellation. If canceling or changing within 72 hours of arrival, deposit will be forfeited or the Credit Card will be charged for the first night's room rate plus 15% Anaheim Bed Tax. Children under 17 stay free when utilizing same room as an adult or parents.



Dinner Menu

*Trillium Room and Terrace, **Disney's Grand Californian Hotel® & Spa**
Saturday, January 16, 2010, Reception 7:00 pm; Dinner 7:30 pm*

CHOICE of ENTRÉE (Salad, dessert and wine included)

- ◆ *Point Reyes Crusted Angus Beef Filet/Garlic Gold Potato Puree*
- ◆ *Loch Duart Salmon Filet/Shrimp Risotto*
- ◆ *Vegetarian*

Children's Dinner Menu (ages 3-9)

Green salad, Chicken Filet Tenderloins with BBQ sauce, macaroni & cheese and corn on the cob; cookie; apple juice or milk.



CANS ANNUAL MEETING 2010 REGISTRATION FORM

Disney's Grand Californian Hotel® & Spa, Anaheim, CA, January 15-17, 2010

Name (please print) _____

Neurosurgeon ___ other (please specify) _____ Telephone _____

Address _____ Fax _____

City, State, Zip _____ E-mail _____

1. Saturday Meeting Registration January 16

(includes opening reception on Friday for everyone and lunch for registrants on Saturday)

CANS Members	\$ 300	<input type="checkbox"/>	Senior Members	\$250	<input type="checkbox"/>	<input type="checkbox"/> lunches
Non-Members	\$ 350	<input type="checkbox"/>	Residents	no charge	<input type="checkbox"/>	

* Please indicate if you will attend luncheon (there is a \$50 lunch fee for guests, spouses and residents)

2. Saturday Banquet, January 16 Cocktails 7:00 pm; Dinner 7:30 pm (includes salad, wine, dessert)

Per Person	\$125	<input type="checkbox"/>	Name _____	Filet _____	Salmon _____	Veg _____
Guest	\$125	<input type="checkbox"/>	Name _____	Filet _____	Salmon _____	Veg _____
Child (3-9)	\$ 35	<input type="checkbox"/>	Name (s) _____			
	\$35	<input type="checkbox"/>	_____	<input type="checkbox"/> dinners		

3. Sunday QME Course January 17 9:00- noon (includes continental breakfast)

Per Person \$125

TOTAL AMOUNT DUE by December 15, 2009

\$

No refund requests (including no-shows) will be accepted after January 1, 2010 so that quantities can be guaranteed to the hotel.

Payment Information:

1. Check enclosed (payable to CANS) _____
2. Please authorize use of VISA _____ or MasterCard _____

Card number _____ Expiration Date _____

Name on card _____ Signature _____

Address if different from above _____

CANS office use only:

log	_____
conf sent	_____
pgm book	_____
name tag	_____
check #	_____
date	_____
cc settled	_____
QB ledger	_____

Rooms: Log on to <https://resweb.passkey.com/go/CANS> or call Disney's Grand Californian Hotel® & Spa (714 520-5005) M-F 8-5 by January 4, 2010 to ensure a room at the group rate of \$209.00.

Please check here when you have made your hotel reservations.

Return registration form to CANS, 5380 Elvas Ave., #216, Sacramento, CA 95819 or fax to 916 457-8202.

Contributions to the California Association of Neurological Surgeons are not tax deductible as charitable contributions; however, they may be tax deductible as ordinary and necessary business expenses.