



CANS

NEWSLETTER

California Association of Neurological Surgeons

Volume 37 Number 6

June 2010

President's Message: Is Cost Effective Surgery Possible?

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

An important element in the new health care bill are provisions to reduce the overwhelming cost of health care in our country. One idea is to eliminate health care fraud...surely we are all for that. Another idea is to make our health care more cost effective...surely we are all for that. More heal for the buck, so to speak.

Within the health care bill is a provision to create the Health Care Comparative Effectiveness Research Institute. This bureaucracy will review evidence and produce new information on how diseases, disorders and other health conditions can be treated to achieve the best clinical outcome for patients.... more heal for less buck.

But common sense and experience cast a doubt on this experiment. Level 1 clinical trials are uncommon and most of our clinical decision making is based upon retrospective, uncontrolled, unrandomized studies. As an example, two studies published last year in the NEJM* compared vertebroplasty to a sham-operated control group of patients. After one month, no significant difference was found in the pain outcome of the two groups. Yet the acceptance of these results has been minimal in my experience. Those who perform the procedure are critical of the studies' design and conclusions, and most referring physicians are unaware of the studies. I doubt there has been any reduction in the number of vertebroplasties carried out in the U.S. since last summer when the results were published. It seems more likely that insurance companies (Blue Cross for example) will simply stop funding vertebroplasties in the future, similar to the response of insurance companies to EC-IC bypass surgery decades ago.

Reliance on lesser powered clinical studies leads to the development of treatment protocols and guidelines. These seem to arise from a consensus of "experts" who may have their own agendas ranging from personal prejudices to industry bribery. As an example the American Academy of Clinical Endocrinologists recently released guidelines for blood glucose control in Type 2 diabetes mellitus. These were based upon the assumption that newer oral hypoglycemic drugs are more effective than older generations of similar drugs (no evidence). . The next assumption is that cost of medication does not matter (not true). The chairmen of the committee who formulated the guidelines are highly compensated consultants for the drug firms who manufacture the newer agents. Prior guidelines were later found to actually harm diabetic patients.

With the failure to reduce the cost of medical care through the embrace of cost effective medicine by our profession, cost reduction will be forced on us by insurance carriers and the federal government. The Cato Institute has suggested a free market approach: allow health care recipients the freedom to control their own healthcare dollars and allow an open market to drive down costs. Seems unlikely.

Then there remains the most draconian possibility: rationing of healthcare, up to and including the death committees, a brilliant term of political theater by Governor Palin. Here are three chilling paragraphs I found on the Web about Dr. Donald Berwick, an outspoken admirer of the British National Health Care Service:

"I am romantic about the National Health Service. I love it," he has said about the British health care system. His favorite part of British health care seems to be its rationing arm, the National Institute for Clinical Effectiveness (NICE). NICE is responsible for determining whether or not the life-extending benefits a patient receives are worth the cost to the government. Dr. Berwick calls this institution a "global treasure."

INSIDE THIS ISSUE:

Red Flags Rule- Act V - page 2

Annual Meeting 2011 - page 2

CANS Nominations - page 2

Letter to Editor: Ready for More Regs? - page 3

Medicare Fix - page 3

Organized Med, Patient Care & the Profession - page 4

GME and Regionalization of ER Care - page 4

Quality Patient Care - page 5

Neurosurgeon as AMA Pres? - page 5

EHR Vendor Certification - page 5

Medicare PECOS Deadline- page 5

Quote of the Month - page 5

Brain Waves: Meandering Thoughts - page 6

Calendar - page 7

How much is a human life worth? About £30,000 per year, according to NICE. Anything more than \$44,000 per year of extended life, and NICE is likely to deny treatment. Important drugs that prolong the life of cancer patients, such as Lapatinib and Sutent, are not allowed. Alzheimer's drugs are also heavily restricted for those in the early stages of the disease despite the fact that the early stages are when treatment can provide the most benefit. Originally pitched as nothing more than a board to promote "best practices," NICE has become a rationing death panel machine.

Dr. Berwick thinks this system is so wonderful, we should implement it right here in America. "It's not a question of whether we will ration care," he explained in a magazine interview, "It is whether we will ration with our eyes open." His idea of rationing with eyes open is when "collective action overrid[es] individual self-interest." The individual he is referring to here, whose interests should not matter, is the patient. The collective action is the death panel."

In April President Obama nominated Donald Berwick to be administrator of the Centers for Medicare and Medicaid Services.

**NEJM* 361:557-568, 569-579, August 6, 2009 ❖

The Red Flags Rule--Act V

Randall W. Smith, M.D., Editor

As might have been anticipated, the Federal Trade Commission has pushed back the implementation date for the ID theft prevention program, the Red Flags Rule, until January 1, 2011. Interestingly, the delay was due to the request of lawmakers in light of pending legislation passed by the House of Representatives in October of 2009 with a companion bill pending in the Senate which would exempt medical practices with fewer than 20 employees. That legislation came as a result of some AMA and other medical group's lobbying for which a large number of us should be grateful.

It is to be recalled that the lawyers were exempted by a Federal court ruling which is being appealed by the Feds so it is not necessarily a done deal. The AMA and many other medical groups also have filed a suit with the same Federal court to get all docs exempted as well which has yet to be ruled upon and may or may not stand considering that appeals also could be involved. The legislative fix has the advantage of not allowing the FTC to gripe or challenge and the drawback of only applying to smaller practices. It is a sort of guaranteed half-a-loaf versus the judicial potential for a full loaf. As this publication has repeatedly recommended, do nothing for now as we await the outcome of the machinations noted above. ❖

Executive Office Report

Janine Tash, Executive Secretary

Annual Meeting

The Ritz-Carlton in San Francisco is now taking reservations for the CANS Annual Meeting which will be held the weekend of January 14-16, 2011. You may telephone the reservations department at 1-800-241-3333 or link <https://www.ritzcarlton.com/en/Properties/SanFrancisco/Reservations/Default.htm?gc=cnsensa&nr=1&ng=1>.

The contracted group rate of \$225 is available from Thursday January 13 through Monday January 17. CANS opening reception will be Friday evening followed by the weekend program which is still in the planning phase.

Nominations for 2011

You will soon receive a request for nominations for various positions on the CANS Board of Directors. Please take some time to carefully consider who you wish to represent your interests on the Board. For those of you who indicated in the recent survey that you wanted to be more active in CANS, this would be a good opportunity to submit your name for consideration by the Nominating Committee who will prepare the 2011 slate of officers for vote by the membership. ❖

Letter to the Editor: Are We Ready for More Regulations?

Moustapha Abou-Samra, M.D.

Recently, I attended the annual meeting of the International College of Surgeons-US Section in Denver, CO. It was a particularly good meeting, the emphasis of which was volunteer medical work in areas of devastation such as Haiti, Iraq and various part of Africa. There was also an ethics session that I found particularly compelling. One of the issues discussed was: should we tell our patients “everything”?

While I firmly believe that patients should be fully informed, and that my own communication with them should be open, frank and honest, I do not think that providing them with needless details serves any purpose; in fact, it can be harmful.

A young general surgeon from West Texas shared with us the following experience:

At the end of a long and complex laparotomy, during which he was the assistant surgeon, the primary surgeon began the closure before the lap, sponge and needle count was completed. The fascia was closed, but the skin was not yet closed, when the circulating nurse advised that a single lap-pad was missing. The surgeon re-opened the fascia and found the missing “lap”. He went on to dictate in his operative report that the “count” was correct. The patient did well.

The administration of the hospital called the surgeon to task and opined that his operative report was not correct and that since the first count, completed after the closure of the fascia, was not accurate, he MUST re-dictate his operative report acknowledging this fact. He ... did! Imagine that!

There are so many ethical and medical issues here; I don't know where to start. But since my focus here is on regulations, I will adhere to this one point only. If a hospital is capable of regulating what a surgeon includes in his operative report, what else will they regulate?

And if a hospital feels compelled to dictate to physicians what they can or cannot do, to such a ridiculous extent, can you imagine what will the Federal government do, now that we have “Obama-care”? Scary, wouldn't you say?

Let me point out that the reviewers that found the discrepancy in this instance barely have a high school degree. And “your” reviewer from the Federal government will very likely not be more qualified.

And in the case I just described: NO, I do not see any logical reason to indicate anywhere in the operative report, nor do I think that I should tell the patient that the “count” was not correct at some point during the procedure.

Have we lost every semblance of common sense? May be it is time to start looking for something else to do ... ❖

Summer Wanderings

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

The Fix is in: Medicare ‘Fix’

When I originally wrote this article, the Medicare fee patch had not yet passed; but then the Medicare fee fix was separated from the failed jobs bill and passed almost unanimously (only George Miller from California dissenting) on June 24 and signed by President Obama on June 25. But this is only a 2.2% payment update extending through November 2010, not the permanent fix so much needed. The details of the fix and its possible future vary notably, so this is why the following information may appear not to correlate well, and conflict.

Even with restoration to last year's fee schedule, anything less makes it unlikely many physicians will see, or can afford to see, Medicare patients. Restoration by Congress to last year's fee level, a physician-favorable move, may not be so physician-favorable in the long run. Some sources say this will only be a six month fix, with rates frozen for six months. Others say the fee freeze will be for five years, the latter would be especially untenable for continuation of patient care and financially an economic burden to any physician who continued to participate in Medicare. Those of us at Medicare age, or approaching such, find this a great concern for personal future medical care. The present payment cut was to be 21.2%, increased to 23% in December, and nearly 30% in January, an intolerable level of cut. The major problem in restoring the fee cut is that, despite what some state, the increase would significantly increase the national debt if corresponding budget cuts are not made elsewhere. This evidentially is why the Medicare fee fix was eliminated from

the Obama Health Plan, to make the plan appear more fiscally acceptable, delaying such critical medical care delivery aspects and their fiscal impacts to later, after the plan was passed.

Organized Medicine, Patient Care and the Profession

I believe in organized medicine; I just wish that others would as well. Those of us who belong to the CMA and AMA, unfortunately a progressively decreasing number, have been disappointed with their ineffective action during the implementation of the new federal health care plan, HR 3590, but have noticed a new interest in physician membership concerns, somewhat late but promising. I would suggest that all read the inaugural address of Cecil B. Wilson "A Prescription for America's Health Care System", Chicago, AMA Annual Meeting, June 15, 2010. It indicates a more friendly membership orientation, especially his intention for mending divisions in medicine. Unfortunately he gives vague solutions, superficial approaches, and some of us would refer to these as pious platitudes.

Dr. Wilson does point out that the common ground we share is vast; what divides us is not (which I would agree with). But then he later states that the AMA kept its hand "on the wheel during the storms of the reform debate," where many of us feel that the AMA was used and abused during the process, not to the benefit of physicians or our profession.

Dr. Wilson also suggests in view of the fee basis crisis in Medicare to scrap the SGR, replacing it "with a payment structure that reflects the true costs of providing care in the 21st century" certainly a laudable goal, but does not suggest how this is to be accomplished. We must remember to be careful what we wish for: as it may turn out to be more onerous than what we have.

I certainly agree that physicians must unite to advance the concerns of our patients and the profession, and that is why I still belong to my local medical society (FMMS), CMA, AMA, CANS, WNS, AANS, and CNS (the dues themselves become an issue, just ask my wife Romona; I did in the past drop the Missouri Medical Association), but hope that the CMA and AMA will act in such a fashion to justify our continued participation. (The recent Journal of the American Medical Association (JAMA) issue of June 23-30, 2010, pps. 2521-2522 contains an article concerning the Health Care Reform that is quite favorable to it, and bemoans the lack of a public option feature. JAMA should be more balanced and accompany this article by one that also points out the faults of the Obama Plan).

The American College of Surgeons did in the end oppose the Obama Health Care Plan (See Bulletin of the American College of Surgeons June 2010, pps. 21-22) and, specifically, I do believe that the Independent Medicare Commission opposed by the American College of Surgeons should also be opposed by us. Nonetheless, the ACS does support some features of the program that I have concerns about, such as the proposed regionalization of emergency care and redistributing graduate medical education.

Graduate Medical Education and Regionalization of Emergency Care

The effort to redistribute graduate medical education slots (using an approach that they are "unused") to states with the lowest resident physician-to-patient ratios may place these positions where there is less quality of training, tending to water down the proficiency of the graduate. Well-staffed high quality training programs are still the best policy and these products (graduates) can be enticed to areas of physician need.

Additional regionalization of emergency care is also a feature of the new federal health plan, both by federal determination of centers and contracting. While most of us agree with rational regional care, this federal program may result in an interference with local care and provide a federally funded noncompetitive situation for Neurosurgeons ready



and able to deliver trauma care. This new federal program contains a number of such controversial and perhaps untenable policy issues.

Quality Patient Care

Patients want physicians to give more personal care. I hear this often from my neighbors. Many will not tell you that they feel slighted or degraded by having their visit primarily provided for by the Nurse Practitioner or Physician's Assistant, most often not seeing the physician, or if they do, noting the physician visit was perfunctory and often more social than professional. Unfortunately, referrals for specialty consultation often do not include physician encounters. We physicians must improve patient care and patient relationships. ❖

TIDBITS from the Editors

A Neurosurgeon as AMA President—not likely (by R. Smith, M.D.)

At least that is what this writer thought upon hearing that Peter Carmel, a New Jersey neurosurgeon, was running for the AMA Presidency. Not that Dr. Carmel wasn't qualified as he surely was what with his two terms on the AMA Board of Trustees and endeavors on many committees. But he was running against an Indiana family physician and a Massachusetts OBGYN. Considering the makeup of the AMA House of Delegates, it was not anything approaching a slam-dunk for Peter. This writer knows Dr. Carmel and has always been impressed with his being pretty straight forward in conversation and very good at reporting to the Council of State Neurosurgical Societies as to what the practice problems are and what the AMA was attempting to do about it. Like any good politician, he rarely answers a question with a yes or a no but he holds BS to a minimum. We will probably never know what convinced the HOD to elect a surgical specialist to the Presidency, which they did earlier this month, but the strong support he got from the AANS/CNS and other surgical and specialist interest groups in the HOD probably played an important role. Now comes the question of what did we get? In his candidacy statement, Dr. Carmel recognized the failure of the AMA to accomplish most of its goals in the Healthcare Reform debate, blaming it on poor tactics and he espouses new tactics of greater firmness when dealing with Congress and a switch of focus to physician issues now that patient issues have been improved by Obamacare. This writer is sure that we all wish Dr. Carmel well and stand ready to support him in his declared approach. Let us hope we got a Churchill (we will never give up) and not a Chamberlain (peace in our time). ❖

EHR vendor certification regulation published (by R. Smith, M.D.)

The Feds have just published regulations detailing the process that electronic health record (EHR) vendors need to satisfy in order to qualify for certified status. Any neurosurgical practice involved in converting to EHR and wishing to qualify for the EHR incentive program, that can pay as much as 44K to each physician converting, needs to use a certified vendor. There is no grandfathering so if your practice has converted or already is in the process, your vendor needs to get certified. CMS is also very close to releasing the final regulation on the criteria for qualifying for the EHR incentives. ❖

Medicare PECOS Deadline Moved to July 6 (by D. Henry, M.D.)

With the passage and signing of the Patient Protection and Affordable Care Act, PECOS, (The Provider, Enrollment, Chain and Ownership System), deadline for enrollment is now JULY 6, 2010 instead of the prior January 2011 date. CMS is requiring any doctor who orders or refers durable medical equipment, orthotics, home health services as well as imaging, laboratory or specialist services to Medicare patients to be enrolled by July 6, 2010. Since neurosurgeons treating Medicare patients almost assuredly at least order imaging, some orthotics and some labs, we need to enroll in PECOS.

Neurosurgeons who have not opted out of Medicare and those who signed up with Medicare prior to 2003 (the year PECOS was launched) will need to sign up with PECOS. Also, any neurosurgeon

Quote for the month:

"He uses statistics as a drunken man uses lamp-posts--for support rather than illumination."

- Andrew Lang (1844-1912)

who has not updated his/her enrollment in the past five years may need to fill out an updated application. Those who are not enrolled by the July 6th deadline face denial of their Medicare claims. In addition, NPI numbers must now be included on Medicare claim requests.

Federal law also requires physicians who enroll in PECOS or who are revalidating their enrollment **sign up for electronic funds transfer** by filling out CMS form 568. There is no opting out of the electronic funds program.

According to the American Medical News, in order to enroll in PECOS, the provider must have a NPI number and system ID and password. The ID and password are the same ones the provider used to sign up for a NPI number. The provider then needs to complete an application on the PECOS website at <https://pecos.cms.hhs.gov/>. The two-page certification should be printed, signed and dated, then mailed with supporting paper documentation to the local Medicare contractor within seven days.

To find out if you are on the PECOS provider ordering list, the web address is http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp and the location on the site is in the drop down box on the left under OrderingReferringReport. It is a huge file.

Sources:

- 1.) [amednews.com](http://www.amednews.com) at <http://www.ama-assn.org/amednews/2010/06/14/gv110614.htm>
- 2.) "PECOS Enrollment Moved Up". *Southern California Physician*. June 2010 p. 12. ❖

BRAIN WAVES: Meandering thoughts of a neurosurgeon

Deborah Henry, M.D., Associate Editor

The *Essential Wooden: A Lifetime of Lessons on Leaders and Leadership* sits on my night table, unfinished, along with perhaps a dozen more books. I never heard of John Wooden until I moved to southern California. Then, every once in awhile, his name appeared in the paper, or a sound bite from him sprouted from the radio, or Bill Walton expounded his mentor's virtues on national TV. So quietly, I became a fan of Mr. Wooden. His death was not unexpected. To live a treasured life until 99 and then die peacefully is a blessing we would all wish to have. But I tear at reading his obituary more so because of whom he was: a soft-spoken, humble man who changed lives in the best way possible-leading by example.

As the Professionalism of the Medical Doctor slowly erodes, often due to factors beyond our control, it is helpful to look at a true giant in the field of leadership. John Wooden knew instinctively that to lead by example is one's most powerful teaching tool. I have learned this as a parent. My son teaches me to be a better person as he learns from what I do and not necessarily what I say. As medical doctors and as neurosurgeons, who many still consider to be the epitome of all medicine, we need to be vigilant in our actions, advocates for our patients, and supporters of each other. The demands of medicine constantly beat against us, the never-ending surf of paperwork and politics pounding us daily. It can easily wear us down.

As physicians, we are all teachers. John Woodmen's greatness in basketball came from his ability to mold his players to be the best they could be. Our goal as physicians is to make our patients as healthy as they can be. Both require the willingness of the player-patient and coach-doctor to work at their goals. I learned this lesson very early in my career when I encouraged a patient to lose weight in order to help her back pain. I had little confidence that she would do it-perhaps little confidence that my opinion would be taken seriously. She returned to see me several months later, 50 pounds lighter and free of back pain. I empowered her and likewise her success empowered me to help others.

John Wooden's Pyramid of Success was based on his belief that "success is peace of mind which is a direct result of self satisfaction in knowing you made the effort to do the best of which you are capable." What brilliant advice on which to base your mission in life. We will miss you John Wooden.

For more on John Wooden's Pyramid of Success see www.coachwooden.com. ❖

Meetings of Interest for the next 12 months:**CANS: Board Meeting, October 2, Los Angeles, CA**

North American Spine Society: Annual Meeting, October 5-9, Orlando, FL

Western Neurosurgical Society: Annual Meeting, October 8-11, Santa Fe, NM

CSNS Meeting, October 15-16, San Francisco, CA

Congress of Neurological Surgeons: Annual Meeting, October 16-21, San Francisco, CA

Cervical Spine Research Society: Annual Meeting, December 2-4, Charlotte, NC

CANS: Annual Meeting, January 14-16, 2011, San Francisco, CA

Southern Neurosurgical Society: Annual Meeting, February 23-27, 2011, Orlando, FL

Neurosurgical Society of America: Annual Meeting, March 27-30, 2011, Island of Hawaii, HI

CSNS Meeting, April 8-9, 2011, Denver, CO

AANS: Annual Meeting, April 9-13, 2011, Denver, CO

New England Neurosurgical Society: Annual Meeting, June 11-12, 2011, Chatham, MA

Rocky Mountain NS Society: Annual Meeting, June 18-22, 2011, Taos, New Mexico

Neurosurgical Position

Any CANS member who is looking for a new associate/partner/PA/NP or who is looking for a position (all California neurosurgery residents are CANS members and get this newsletter) is free to submit a 150 word summary of a position available or of one's qualifications for a one time posting in this newsletter. Submit your text to me by E-mail (rws-avopro@sbcglobal.net) or fax (858 683-2022). ❖

Comments can be sent to the editor, Randall W. Smith, M.D., at rws-avopro@sbcglobal.net or to the CANS office at janinetash@sbcglobal.net. Past newsletter issues are available on the CANS website at www.cans1.org.

ATTN Vendors: CANS is now accepting newsletter ads.

Please contact the executive office for complete price list and details.

The newsletter is a mix of fact, rumor and opinion. The facts are hopefully clearly stated. The rest is open to interpretation. The opinion is mine. R.S. The assistance of Janine Tash and Dr. Ken Ott in the preparation of this newsletter is acknowledged and appreciated. If you do not wish to receive this newsletter in the future, please E-mail or fax Janine Tash janinetash@sbcglobal.net, (916-457-8202) with the word "unsubscribe" in the subject line.

California Association of Neurological Surgeons, Inc.

5380 Elvas Avenue, Suite 216, Sacramento, CA 95819

Tel: 916 457-2267; Fax: 916 457-8202 www.cans1.org**Editorial Committee:**Editor: **Randall W. Smith, M.D.**Associate Editor: **John T. Bonner, M.D.**Associate Editor: **Deborah C. Henry, M.D.**President: **Kenneth Ott, M.D.**Editorial Assistant: **Janine M. Tash**