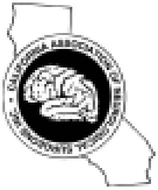

CANS NEWSLETTER

May 2007

CALIFORNIA ASSOCIATION OF NEUROLOGICAL SURGEONS, INC. Volume 34 Number 5

Renewing Your Fluoroscopy Permit

Randall W. Smith, M.D., Editor

When renewing your fluoroscopy permit as you must every two years, 10 hours of approved CME is required. The definition of approved CME is any CME accepted by the Medical Board of California (MBC) for maintain ing your California medical license that **includes instruction in subjects related to the application of X-ray to the human body**. Certainly the Category I CME we get when attending the AANS and CNS, their sponsored courses and seminars and Joint Sections, is accepted by the MBC and very many of those offerings include instruction on the appropriate use of fluoroscopy, X-ray and CT scans in patient treatment. In reviewing the AANS program from the April 2007 meeting in Washington, D.C. (and not citing the Sat-Sun special courses and the breakfast seminars), one can easily find among the 20+ CME hours provided, five hours of morning lectures and afternoon Joint Section presentations wherein the use of fluoroscopy, X-ray and CT scans was discussed and would legitimately constitute instruction in a subject related to the application of X-ray to the body. On your renewal form you need to indicate how many hours you claim at which meeting but your actual CME certificate need not be submitted, only maintained by you should you get audited. A good way to maintain your CME files is to use the AANS Web site CME tracking feature which nearly automatically posts AANS sponsored and jointly sponsored CME and they will add your CNS and other category I CME upon request. The fluoroscopy renewal forms can be obtained via the Web at **www.ca.gov** - health - health care services - find a form - forms index - food, drug and radiation safety - radiologic health - DHS 8238 SRA (renewal form). ❖

CANS Board Meeting Actions

At the May 5th meeting of the Board of Directors, the following actions were taken (this is a selected list, does not include all issues discussed at the 5 hour meeting and items are mostly listed in chronological not importance order):

a. Reiterated CANS' position with Blue Shield that *Spinal Arthroplasty Using Artificial Discs* is acceptable treatment in certain circumstances and should be reimbursed. Voted to draft an approval letter for *Percutaneous Radiofrequency Neurotomy of Cervical Facet Joints for Treatment of Chronic Cervical Pain* noting that even though most physicians do not routinely perform this procedure, it can be effective if done with proper indications; however, duration of success is variable.

b. Noted CANS' nomination of Drs. Mark Linskey, Robert Friedlander and Marc Vanefsky to the positions of President, Vice-President and Director-at-Large, respectively, of the Congress of Neurological Surgeons (CNS). Also noted was Dr. Linskey's appointment to the AANS/CNS Washington Committee replacing Dr. John Kusske.

c. Heard from Dr. William Caton about some preliminary results of the CANS survey of California ED neurosurgical stipends. One of the difficulties with such a survey is trying to compare stipends when the coverage requirements vary (covering pediatric neurosurgery?, working behind a provided PA who can act as the first neuro responder?, guaranteed RVU rate for patient care?, trauma vs. all neurosurgical emergencies?, spine included?, etc.). One early trend noted is generally higher stipends in northern vs. southern parts of the State. The final report is expected at the September Board meeting and will be published in this newsletter.

d. Voted to approve the new member applications of Drs. Henry Aryan, Michael Dogali, Clarence Hyshaw, Paul Jackson, Andrew Parsa, Mahmoud

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Rashidi and Peter Sun, and accept the resignation of membership by Dr. Karen Fagin.

e. Noted 80 active members have yet to pay their 2007 dues and that the 2007 annual meeting in Sacramento as expected lost about $4000 and that exhibitors at the meeting were disappointed with the amount of time spent by meeting attendees at the exhibits. Further noted was about $5000 being held in reserve ear-marked for MICRA support when the latter is next challenged which does not appear to be this year. CANS has about 80K in the bank as of 4/24/2007.

f. Noted Dr. Wade's plan for the 2008 meeting at Disneyland over the Martin Luther King holiday weekend with Saturday AM socio-political subjects; Saturday PM reports by the California academic neurosurgical programs and a Sunday Work Comp QME CME offering.

g. Voted to hold the 2009 annual meeting at the Quail Lodge in Carmel Valley near Monterey.

h. Noted an offer by CAP/MPT to treat CANS members as a group for its medical liability product if 10 or more members join thus resulting in a discount. Some questions were raised about the offer and CAP will be invited to a future Board meeting to present the program in more detail.

i. Voted to oppose AB374, the assisted suicide bill and not to take a position on SB767, a drug overdose treatment bill. ❖

Guest Editorial: Personal Observations About The "SPORT" Study

Philipp M. Lippe, M.D., F.A.C.S.

The superiority of operative versus non-operative management for lumbar disc disease related to disc hernia tion has long been a matter of debate, conjecture and controversy. Little wonder then that The Spine Patient Outcomes Research Trial ("SPORT") Study attracted widespread attention from the profession, the public and the media.

The "SPORT" study involved a randomized clinical trial spanning several years and including 13 multidisciplinary spine clinics in 11 states. Subjects consisted of individuals suffering from persistent lumbar radiculopathy related to disk herniation. Patients were divided into two cohorts: an intent-to-treat cohort and an observational cohort. Each cohort consisted of two groups: one treated operatively and the other treated non-operatively. The intent of the study was to compare results of operative versus non-operative treatment

The study design, analysis and results were published in JAMA. Two articles were published: "A Randomized Trial" and "An Observational Cohort." These can be found in the November issue of JAMA volume 296 pages 2441- 2450 and pages 2451 - 2459. It is strongly recommended that these articles be read in their entirety.

The first article focuses on the intent-to-treat cohort. Individuals were divided into two groups, those assigned to an operative treatment protocol and those assigned to a non-operative treatment protocol. A very large, and greater than anticipated, cross over of patients occurred in both groups (greater than 40%).

An analysis of the results of the intent-to-treat cohort disclosed that both the operative and non-operative treatment groups improved substantially. While improvements were consistently in favor of surgery, these results were not statistically significant. The authors caution "because of the high numbers of patients who crossed over in both directions, conclusions about the superiority or equivalence of the treatments are not warranted based on the intent-to-treat analysis alone."

There is a brief mention that in the as-treated group, the results of operative management were superior to non-operative care.

The second article focused on the observational cohort. This consisted of patients who selected either operative intervention or non-operative care. The results in this observational cohort were similar to the as-treated results from the randomized cohort. Patients in both groups experienced substantial improvement over time irrespective of treatment selected. But improvement was significantly greater for those patients who underwent surgery. In view of the study design the authors caution that the results "must be interpreted cautiously".

One of the principal investigators of the "SPORT" study, and an author of the JAMA papers, spoke to a group of the neurosurgeons in March 2007 at the meeting of the AANS/CNS Joint Section on Spine and Peripheral Nerves in Phoenix. He reviewed the details of the study and cautioned about the interpretation of the results. The large percentage of cross over patients in both groups of the randomized cohort made it difficult to validate the results of the intent-to-treat group. The as-treated group of the randomized cohort were similar in outcome to the

observational cohort. Both groups had a significantly better result with operative treatment.

Unfortunately both papers published in JAMA failed to clearly distinguish the results of the intent-to-treat group from the as-treated group. The first paper provides detailed data analysis of the intent-to-treat group in the randomized cohort. No such similar data were provided for the as-treated group. This leaves a potential inference that both the operative as well as the non-operative group did equally well, whereas in fact in both the as-treated group and the observational cohort the results of operative treatment were superior to a non-operative management.

Certainly such inferences, deliberate or not, have given rise to implications and conclusions that non-operative management of lumbar radiculopathy and disk herniation is as good as operative management. These erroneous conclusions could possibly have been avoided had the articles published the data of the as-treated group and the observational cohort in the same manner as the data for the intent-to-treat group.

When asked why this was not done, and the author replied that "the AMA did not permit it". No explanation for this decision was given. The reasons for what accounts to censorship is conjectural. However many neurosurgeons at the meeting speculated that the reasons that JAMA suppressed the data favoring surgical outcome was because of an allegiance to the insurance industry, which might conceivably benefit from denying operative care to patients.

One can only speculate. However, if indeed the AMA and JAMA censored the release of this data for financially motivated political reasons, one can only express displeasure, dismay and disappointment. Perhaps even outrage. Our patients deserve better from our medical profession. Our profession deserves better from our AMA.

Excerpt from AANS Code of Ethics (12) Communication

Investigators shall ensure that all reports and projects are materially complete and comprehensible to colleagues with the appropriate technical expertise. They should distinguish clearly between hypotheses and conclusions, between assumptions and findings, and between theory and fact. The discussion section should address any material limitations in the study, and conform to scholarly norms particularly with respect to the matters noted in paragraphs 1, 2, and 3 above. ❖

Other News

Randall W. Smith, M.D.

CA Health Plan, the Legislature and the CMA

The democratic leaders in the state Assembly and Senate have proposed a hybrid iteration of their separate plans and have had it looked at by the same analyst that prepared the cost analysis of the Massachusetts health plan and Arnold's California plan. The punch line is that the legislators' plan would only cover about 70% of the uninsured (and does not include an increase in MediCal reimbursement rates as the Governor's plan does). These cost analyses make a lot of presumptions, one of which is what the premiums would be for those individuals who get subsidized insurance from the pool of money created by the tax on employers who choose to contribute to the pool rather than provide the insurance. Apparently the premiums necessary to make the pool idea work in Massachusetts came in higher than estimated (surprise!), potentially forcing a limit being placed on who will get the coverage or what will be covered. It would probably be a safe bet that whatever premium estimate was used for the California analysis will be too low forcing some re-thought. The real catch here is the reimbursement rate to be paid to docs for providing their services to the pool insurance crowd. One wishful thought was something like Medicare plus a little. Why do I think that to ameliorate higher than expected premiums and to maximize the number of covered persons, provider reimbursement rates will be on the table and end up closer to current MediCal rates rather than Medicare? Maybe I'm just a pessimist. Or maybe a realist. ❖

New Billing Form Delayed. On March 19, 2007, CMS released Transmittal 1208, CR5568, which instructed Medicare contractors to continue to accept the Form CMS-1500 (12-90) version due to reports of an incorrectly printed version of the Form CMS-1500 (08-05) that was being sold by some print vendors. Although a tentative date was set for using the new form on June 1, 2007, CMS now states that providers will now be required to **begin submitting the Form CMS-1500 (08-05) on July 2, 2007**.❖

Technical Advisory Group

John A. Kusske, M.D.
Member EMTALA TAG and Chairman, On-Call Subcommittee

Pursuant to Federal regulation in 2003, the Department of Health and Human Services (HHS) was mandated to establish a Technical Advisory Group (TAG) to review issues related to the Emergency Medical Treatment and Labor Act (EMTALA) and its implementation. General responsibilities of the EMTALA TAG included (1) the TAG shall review EMTALA regulations; (2) the TAG may provide advice and recommendations to the Secretary concerning these regulations and their application to hospitals and physicians; (3) the TAG shall solicit comments and recommendations from hospitals, physicians, and the public regarding implementation of such regulations; and (4) the TAG may disseminate information concerning the application of these regulations to hospitals, physicians, and the public.

The EMTALA TAG consists of 19 members, including the Administrator of CMS and the Inspector General of HHS or their designees. Members appointed by the Secretary include: Four representatives of hospitals, including at least one public hospital representative having experience with the application of EMTALA and at least two representatives from hospitals that have not been cited for EMTALA violations, seven physicians drawn from the fields of emergency medicine, cardiology or cardio-thoracic surgery, orthopedic surgery, neurosurgery, pediatrics or a pediatric subspecialty, obstetrics-gynecology, and psychiatry. Meetings have been held at least twice per year. The EMTALA TAG will terminate September 30, 2007 as mandated by the MMA, 30 months after its first meeting, unless there is a legislative mandate to extend the duration of the TAG Charter. A TAG subcommittee was also chartered, the On-Call Subcommittee chaired by Dr. John A. Kusske, also representing the prescribed position for a neurosurgeon on the TAG, to identify on-call issues and develop recommendations.

The EMTALA TAG first meeting was held on March 30-31, 2005 and the last on May 4-5, 2007. At these meeting myriad groups testified before the TAG and provided background information for the TAG in its deliberations.

One of the first groups to testify was the American Hospital Association who testified that the refusal by specialty physicians to take emergency call limits patient access to specialty care. The Association asked CMS to address this issue, perhaps by revising the Medicare Conditions of Participation for physicians to require emergency call participation. The Federation of American Hospitals (investor owned hospitals such as Tenet and others), suggested that CMS revise the Medicare Conditions of Participation to allow hospitals to prohibit appointment/reappointment of medical staff members who refuse to participate in emergency call.

Testimony was provided by Alex B. Valadka, M.D., representing the AANS/CNS. He identified numerous areas of concern, such as the vagueness of the phrase "best meets the needs of hospital patients" in relation to physician staffing requirements in the interpretive guidelines, and the demands by hospitals on neurosurgeons to commit to an excessive on-call schedule. He suggested the interpretive guidelines be modified to allow hospitals to define acceptable response times in a range of minutes and to permit exceptions when the ability to respond within the defined limits is beyond the physician's control. Dr. Valadka also asked the TAG to consider revisions to the current guidelines on "selective" call, backup call plans, and elective surgery by on-call physicians.

Following other extensive testimony, the TAG recommended that CMS not require physicians to take emergency call as Condition of Participation in Medicare. Dr. Kusske was charged with preparing a rationale to accompany the recommendation. His subcommittee did not believe that mandating physicians to participate in ED call was a solution to this multifaceted issue. It noted that forcing physicians to carry this burden, by taking away the ability to participate in Medicare will only exacerbate the problem, further reducing physicians available to Emergency Departments. More ominously, such a requirement would undoubtedly lead to significant access to care problems for the Nation's seniors and disabled, as physicians would likely reconsider their Medicare participation as the result of such a mandate. CMS concurred with the recommendation.

There was also a discussion regarding Physician Response Times in Minutes following calls from the Emergency Department. The On-Call Subcommittee recommended that a range of minutes for physician emergency on-call response is acceptable and that the range should be determined on a local basis. There was also a recommendation that the initial response to the Emergency Department by telephone or other electronic means be considered appropriate for meeting the criterion for a response in a range of minutes.

The following statements represent the consensus of the TAG, which recommends that CMS incorporate these concepts into the Guidelines for availability of on-call physicians:

- When a physician takes call for patients with whom he/she has a preexisting medical relationship that is *not* considered "selective call."
- When a physician is not on the call roster, he/she is not obligated to provide call coverage (e.g., when he/she

is in the hospital seeing patients).

- If the EMTALA-related call list is adequate and meets the requirements of the statute, physicians may see patients in the hospital as they see fit.
- A physician on-call must see patients without regard for any patient's ability to pay.
- If a physician volunteers to see patients in the emergency department while not participating on the call list, the physician must agree to see patient regardless of any patient's ability to pay.

The TAG has also recommended that CMS incorporate the following concepts into the Guidelines:

- The presence of a specialty physician on the call roster is not, by itself, sufficient to be considered a specialized capability. At the time of transfer, the receiving hospital should also have available the necessary equipment, space, staff, etc., to accommodate the patient transfer.
- The presence of a physician who has privileges at the receiving hospital but is not on the call roster or who is not on call at the time of the transfer should not be considered a specialized capability.
- The TAG further recommended that all hospitals, including specialty hospitals, should maintain a call list.

At this juncture there are a number of issues still outstanding with the EMTALA TAG which need further discussion. Of most importance to neurosurgeons are:

- Better methods for developing regional, shared or community call consistent with EMTALA. A review is occurring to ensure that EMTALA does not pose barriers to regional call sharing arrangements. Various examples of successful call sharing plans are being collected for presentation to the TAG.
- Duties of Hospitals with Specialized Capabilities to Accept Patient Transfers have been discussed at length by the TAG. This issue is one of the most contentious and deals with referral from an Emergency Department to a recipient hospital that provides "a higher level of care."
- The expansion of the role of telemedicine to meet the needs of ED response.
- The development of guidelines for determining the adequacy of on-call lists posted by hospitals.

Further reviews of the EMTALA TAG activities should be forthcoming soon and will be made available to CANS members.❖

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

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

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