CANS NEWSLETTER

California Association of Neurological Surgeons Volume 38 Number 4 April 2011

Council of State Neurosurgical Societies meets in Denver

Randall W. Smith, M.D., Editor

The CSNS held its spring meeting on April 8-9 in the mile high city. In attendance were 116 delegates and guests. CANS President Mark Vanefsky lead the fully manned CANS delegation which included **Drs. Abou-Samra, Blumenfeld, Caton, Kusske, Linskey, Smith and Wade**. Some selected highlights of the meeting:

1. **Nick Bambakidis** presented the Medico-legal Committee's study on the legal implications of neurophysiologic monitoring or lack thereof. They could not identify any current standards as to when the monitoring should be employed. There appeared to be wide use of the monitoring in cases of major scoliosis correction surgery and apparently the AANS/CNS Joint Section on Spine recommends its use in instrumented spine fusion cases, presumably to reduce the likelihood of root injury when placing pedicle screws. He reviewed 54 litigated cases of quadriplegia following cervical spine surgery and noted that only three made allegations of failure to monitor as below par. There is some concern that in monitored cases that result in neurologic deterioration not detected by the monitoring, supplying the voluminous recordings to the plaintiff's counsel just gives them ammunition to note a squiggle "that should not have been ignored". (Vince Traynelis reported at the AANS meeting that in many hundreds of unmonitored cervical decompression cases, only three patients were mildly worsened (none from anterior) and all recovered back to or better than baseline.)
2. **Lisa Beebe** from NERVES reported that 375 neurosurgeons are now members with a 62% private practice, 32% academic split. Their most recent survey indicated that the average private practice neurosurgeon turns out 12,221 RVUs a year compared to 10,132 for academics. Median compensation among all members was 730K/year. The median compensation for covering level I & II trauma centers was $1700-2000/day. She indicated that NERVE's database is the largest one for neurosurgeons but institutions with whom you might be negotiating a contract may choose to use the MGMA database which contains fewer neurosurgeons and a lower median compensation number. She continues to encourage more neurosurgical practices to join nerves since the larger the membership, the more powerful the survey data.
3. **John Davis** reported on a neurosurgeon's worth to a hospital and felt the most commonly quoted figure was 2.9-2.9 million dollars per year of hospital revenue. He also noted that that figure increases if all surgeries are done on an inpatient basis and if one counts all DME/PT/OT/drugs associated with the neurosurgeon's patients.
4. **John Wilson** of the Coding and Reimbursement Committee reported that the ACD+F code will be valued 17% less for the first level and 27% less for each additional level but the graft and plate codes have not been devalued. He also noted there will be a drop of some 20-30% in compensation for PLIF plus postero-lateral fusion since 75% of the time they are done together.
5. The **Neurosurgical Political Action Committee** raised 490K in the last election cycle (2 years) with the same 11% of neurosurgeons carrying the rest. If you are in the 89%, don't bother to gripe since you are more the problem than the solution.
6. The CSNS girl Friday, **Melany Thomas**, who has been keeping us all on track for 23 years at around 100

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annual meetings and Board meetings, was given the Lyal Leibrock Lifetime Achievement Award for her dedication to the Council and in support of America's neurosurgeons. Melany is retiring and takes with her a very fine gold bracelet as official recognition by the CSNS as well as a substantial cash gift generated by dozens of well wishing contributors.

Finally, at the Saturday morning plenary session, the following actions were taken (*italics*) on the 11 resolutions submitted:

RESOLUTION I [*Adopted*]
Title: Centralization of Information Technology for the AANS, CNS, Joint Sections and CSNS
BE IT RESOLVED, that the CSNS work with the AANS and CNS to establish infrastructure support for the CSNS website

RESOLUTION II [*Adopted and combined with Resolutions III and XI*]
Title: Support of Resident Socioeconomic Education
BE IT RESOLVED, that the CSNS develop and market an online educational product as well as curriculum for a socioeconomic practical course for residents addressing socioeconomic issues in medicine in each of the residency training core competencies; and
BE IT FURTHER RESOLVED, that the CSNS request that the American Association of Neurological Surgeons (AANS) and Congress of Neurological Surgeons (CNS) support resident socioeconomic education through waiver of course fees for select residents in practice management workshops, coding and billing seminars, and other formal programs in socioeconomic education that are currently presented by the AANS or CNS; and
BE IT FURTHER RESOLVED, that the CSNS work with the SNS, CNS and the AANS to incorporate a socioeconomic curriculum in future courses.

RESOLUTION III [*See Resolution II*]
Title: Establishment of a Formal Socioeconomic Curriculum
BE IT RESOLVED, that the CSNS stimulate our parent organizations, AANS, and CNS to protect the graduating resident physician and empower them through the institution of a formal socioeconomic curriculum during residency; and
BE IT FURTHER RESOLVED, that the CSNS and the Washington committee support an emailed cross-sectional survey to recent graduates and current residents, in order to study their socioeconomic educational needs prior to the implementation of a formal socioeconomic curriculum into residency programs.

RESOLUTION IV [*Adopted*]
Title: Payor Policy Response for Cervical Artificial Discs
BE IT RESOLVED, that the CSNS work with the AANS and CNS to establish an infrastructure through the joint sections to proactively review payor policies regarding neurosurgical procedures.

ESOLUTION V [*Adopted*]
Title: Urgent Organized Neurosurgery Response to the Leapfrog Group
BE IT RESOLVED, that the CSNS petition the AANS and CNS to take immediate and effective action, potentially working with the ABNS and the Society of Neurological Surgeons, in response to the Leapfrog Group's position vis a vis neurosurgeons as recognized neurocritical care intensivists potentially including pursuing legal action against the Leapfrog Group; and
BE IT FURTHER RESOLVED, CSNS requests the AANS and CNS to petition the ABMS to produce a statement that can be distributed to all hospitals and insurance carriers.

RESOLUTION VI [*Adopted*]
Title: Neurosurgical Sports Injuries
BE IT RESOLVED, that the CSNS work with the Joint Section of Neurotrauma and Neurocritical Care to develop a tool kit with protocols and indexed references for those neurosurgeons interested in caring for athletes; and
BE IT FURTHER RESOLVED, that this Sports-Related Neurotrauma Toolkit will be housed on the CSNS website.

RESOLUTION VII [*Adopted*]
Title: The Neurosurgical Safety Coalition
BE IT RESOLVED, the CSNS survey the practice patterns and perceived value and efficacy of electrophysiological monitoring for specific spine surgical procedures and analyze the medico-legal implications. This information will be presented to the CSNS by the Spring of 2012.

RESOLUTION VIII [*Adopted*]
Title: Increasing Neurosurgical Content on National Board of Medical Examiners Subject Exams
BE IT RESOLVED, that the CSNS build an epidemiologic case for increases neurosurgical content on NBME examinations; and
BE IT FURTHER RESOLVED, that the CSNS work with the AANS and CNS to petition the NBME and FSMB for increased representation on the USMLE Examination Committee to ensure that common neurosurgical problems are appropriately represented on the NBME.

RESOLUTION IX [*Adopted*]
Title: Physician grading in surgical field; exploring the scope and recognizing the pitfalls.
BE IT RESOLVED, the CSNS study the scope of insurer-based quality rating programs impacting neurosurgeons; and
BE IT FURTHER RESOLVED, that the CSNS study the parameters tracked so the accuracy of the data and methodological flaws affecting measurement tools can be evaluated and summarized in the report.

RESOLUTION X [*Adopted*]
Title: Congressional Contact Information Database for Neurosurgical Patients
BE IT RESOLVED, the CSNS will house on their website, an online link to contact information for federal government representatives.

RESOLUTION XI [*See Resolution II*]
Title: Development of Core Curriculum
BE IT RESOLVED, that the CSNS develop an educational webinar series addressing socioeconomic issues in medicine in each of the residency training core competencies; and
BE IT FURTHER RESOLVED, that this webinar material be marketed as a CSNS product to residency programs of all medical specialties throughout the United States. ❖

Truth for the month:

Dogs will come when you call them. And they'll be happy.
Cats will have someone take a message and get back to you.

Letter to the Editor

Scott Lederhaus, M.D., Pomona

Since the CANS meeting last January, I have been bothered by the presentation from Alliance Medical who discussed the Physician Ownership Distributors (PODs). I was hoping there would be a point-counter-point to that presentation, but there wasn't. Based on the confusion it would seem that anyone involved in a POD is walking a tight rope and could fall under the Stark legislation as being illegal. The problem is due to the widely varying opinions as to what is legal. Attorneys can argue either side, but the bottom line is that the docs may be left in the middle holding the bag when all hell breaks loose and the feds decide to come down on those docs involved in the PODs. Since this is potentially a huge issue with neurosurgeons it would be exceedingly valuable to be knowledgeable about the laws pertaining to the Stark Legislation as it relates to Medicare Fraud and Abuse. A representative from Alliance or other PODs could be involved in a panel discussion with someone from Medicare Fraud and Abuse and an advocate of ethics in spine surgery.

The POD issue will involve competitors in spine surgery. Let's say that a group of neurosurgeons (Surgeons A) play by the book and only use reputable big name spine implant companies, no royalties, no financial connection to any supplier of implants, etc. Let's also say that another group (Surgeons B) decides to be involved in a POD. What happens next is more than just use of a POD. Since Surgeons B are making a lot of money on implants they can now go to the various insurance groups, IPAs, HMOs, etc., and bargain for the contracts. Surgeons B now are generating enough income off the implants that they can offer to do the spine work for 50% of Medicare. Surgeons A can't compete so they decide Surgeons B can take the contract. As a result Surgeons B group now have all the local contracts, including the capitated contracts. A capitated IPA would never deny Surgeons B to do cases since the capitated IPA group figures that Surgeons B are only performing indicated procedures and the capitated IPA calculates the reimbursement to be 40% of Medicare due to excessive and extensive surgeries done by Surgeons B. What a great deal for the capitated IPA? Surgeons B now are busy enough that they hire additional surgeons, pay them a salary and then stand to profit off their surgeons as employees particularly since they are only allowed to use the implants from their PODs.

Now, Surgeon's B group could then collectively negotiate for higher reimbursements from the insurers since the local competition has fled the area. You could also see how Surgeon B group could simply come into a new, different community and immediately start underbidding the docs who have been in the community for a long time using the same model and thus eliminating competition in another geographic area. This is nothing short of predatory pricing with the advantage of a POD.

These are real scenarios and as a result we need to know what is legal with respect to PODs. We either need to join them or fight them and those who abuse the system with taking illegal advantage of honest docs. This will continue to be an escalating problem. If PODs are deemed illegal it could mean docs may lose their license and potentially go to jail. If they are fully legal I want to buy into all the PODs I can afford. CANS should fully evaluate this issue. ❖

Transitions in Neurosurgery

John T. Bonner, M.D., F.A.C.S., Associate Editor

Certain members of the California Legislature are attempting to create havoc for physicians:

Legislation to weaken the Corporate Bar of Medicine: The law currently in place assures that only physicians may practice medicine. Fortunately, AB 824 (Chesbro), which would weaken the Corporate Bar of Medicine, was pulled from the Health Committee on April 26, 2011 due to lack of support. Unfortunately, expect it to reappear next year. Nonetheless, AB 1360 (Swanson), an alternate bill to affect the Corporate Bar, is scheduled to be heard in the Health Committee the week of May 1, 2011. Despite attempts to erode the CMA's disapproval of the bill, organized medicine remains opposed to it. Please contact your legislative friends to oppose AB 1360.

Legislation to Weaken MICRA: The law currently in place caps on damage awards for pain and suffering from physicians deemed negligent. Right now, there is no active attempt by the trial lawyers to weaken MICRA – but there is plenty of evidence that such an attempt is in the wings. Any erosion of MICRA would increase the cost of physician malpractice coverage, and ultimately, raise health care costs. We must remain vigilant to any efforts to weaken MICRA.

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As we and the public are aware, narcotic abuse has become a more prominent issue, born from fear of undertreatment of pain issues and legal charges outside of medical legal malpractice coverage. But this has progressed to the point where some physicians unfortunately have become narcotic prescription abusers, allowing some patients to become addicted, narcotic dependent. Physicians have become sources for drug seeking and narcotic addicted patients to prey on. Vicodin and Oxycontin have been over-prescribed, leading to addiction, and patient conversion to less expensive Heroin, often leading to death by overdose. Many recent magazine and newspaper articles have featured this. For example, an article in the local Fresno paper dated March 20, 2011 found that prescription drug abuse was present and increasing among valley youth, more often those from more affluent homes where Vicodin and especially Oxycontin can be obtained from patient's (parents) medicine cabinets. The paper reported that there is a 20% increase in minors using such narcotic prescriptions. More concerning are injuries, especially athletic injuries, which unnecessarily lead to such addiction and abuse. Even cough syrups for bronchitis have been known to lead to such abuse. One teenage athlete locally acknowledged that by age 19 or 20 he had five different doctors writing 12 or 15 prescriptions a month to different pharmacies, leading eventually to a Heroin overdose from which he narrowly escaped death.

We physicians, often unwittingly, but unfortunately not always so, can be a source of such narcotic habits, and we are often very surprised who the physicians are. I recently reviewed a record of a patient who was much improved two and one-half months after his lumbar microdiskectomy, radicular pain gone, low back pain improved, and I was surprised to see that a well known member of CANS, who shall not be identified, gave this patient a prescription for 150 Percocet. This inappropriate prescription was even more injurious since the patient was a substance and alcohol abuser with cirrhosis and the Percocet which contains oxycodone and acetaminophen, the latter which would aggravate the hepatic dysfunction.

We find that we need also to modify our own professional practice. Low back pain with no radicular pain, no inflammatory processes and normal or only minor lumbosacral degenerative changes on x-ray is a major alleged disability narcotic abuse problem. Narcotic and other substance abuse, including so called medical marijuana is an issue that medicine as a profession must appropriately and objectively deal with.

On April 19, 2011, the White House released the Obama Administration's plan (described by the Administration as comprehensive) to address the national prescription drug abuse epidemic. This report is, I believe, somewhat superficial and lacking in depth concerning the various aspects of the problem, but is an important attempt to deal with it. Some of the more notable items in the Report are:

*One-third of people age 12 and over who used illicit drugs in 2009 began by using prescription drugs non-medically (yes, narcotics that we physicians prescribed).
*Over 70% of those who abuse prescription pain relievers obtained them from friends and relatives (only 5% from a drug dealer or via the Internet).
*Prescription drugs are the second most abused category of drugs after marijuana.

Unfortunately, we all know that certain physicians over-prescribe narcotics, more so than appropriate pain care requires, which makes some physicians legalized 'illicit sources' of narcotics for addicts. We must become more educated regarding the prescribing of analgesics, especially narcotics, in order to be appropriate providers of care to our patients. I would suggest that we all obtain "Epidemic: Responding to America's Prescription Drug Abuse Crisis." I do congratulate the Administration for drawing attention to this issue. ❖

Brain Waves

Deborah Henry, M.D., Associate Editor

I am in a hotel in Amarillo, Texas as I write this, taking trauma call for 26 counties in the Texas panhandle. I don't want to jinx myself, but so far, today is relatively quiet. I have had three consults this afternoon. The first was an unfortunate middle age male found in his driveway with a right hemiparesis. By the time he arrived at the hospital, he was a GCS of 3 and his CT revealed an 8x5cm left hemisphere hemorrhage with intraventricular extension. The medical resident called me, afraid to do nothing (this is a subject all to itself - the fear of doing nothing). So I waited a bit and then did the brain death exam.

The second consult was a five-day old who was a difficult birth and was vacuum extracted resulting in a cephalohematoma. His pediatrician decided to order a skull series to rule out possible fracture. The report stated no fracture, but the radiologist could not evaluate the sutures and recommended a CT scan. The CT scan showed no craniosynostosis, but revealed a 4mm hemorrhage next to the occipital horn with a recommendation for a follow-up CT scan. This prompted a neurosurgery consult (sound familiar?). Of course throughout all this, the kid is fine neurologically. His fontanelle is soft, head circumference normal; he is feeding well and has no vomiting. I did not recommend a follow up scan (though he still may get one). I think his brain has had enough radiation for 5 days of life.

The third consult was another middle-age male, this one with alcoholic cirrhosis, elevated PT and INR and platelets of 65k. He had a hemorrhagic stroke 2 weeks ago with a stable hemiparesis. At the original hospital, he underwent several CT scans and an MRI scan - all consistent with a stable hemorrhage. Two weeks out on the weekend, he was transferred to a hospital that I was covering. He underwent another CT scan which still showed some hemorrhage and you know the rest of the story - I was consulted - you've been there too.

There is a much-needed push to get more neurosurgical education into the medical school curriculum. I remember the number of back pain lectures I received (you don't need your fingers to count). I think I had more talks on Menke's kinky hair disease and Fanconi's anemia that I did on any disease of the brain. It would be nice for future doctors to see and learn a little more about strokes (hemorrhagic or otherwise) that are the third leading cause of death in our country.

As far as those intracerebral hemorrhages go, one ER doctor said it best to me: "You neurosurgeons are all alike. Either it's too small or too large to take out". That pretty much sums up the majority of cases. (And of course I jinxed myself. It was plenty busy the rest of the night!) ❖

Protect the Ban on the Corporate Practice of Medicine

AB 1360 (Swanson) will significantly expand the ability of Health Care Districts to employ and charge for services rendered by a physician and surgeon. This bill will erode the patient protections that the bar on the corporate practice of medicine preserves. **It will be heard in the Assembly Health Committee on Tuesday, May 3rd** .

CMA is urging physicians to call their Assembly Members using the Legislator Connect Hotline at 877-362-8455. Talking Points and CMA's proposed amendments can be found on attached Key Contact Alert. ❖

Tidbits from the Editors

FDA clears first-of-a-kind electrical device for cancerous brain tumors

Novocure announced it has "received US approval for a first-of-a-kind" treatment for cancerous brain tumors. The company said the Food and Drug Administration has approved Novocure's portable device, which uses "electric fields to disrupt the division of cancer cells that allows tumors to grow." The approval was based on a "237-patient" study, which showed that people using the device lived about as long as, and had significantly fewer side effects, than "those taking chemotherapy." One might question the reasoning here since chemotherapy is so abysmal in effect, it might be fair to say that Novocure's device is just as good. ❖

Concussion return-to-play guidelines

The most recent issue of the AANS Neurosurgeon includes an article on safely returning an athlete to play by Deborah Benzil. The article includes Bob Cantu's guidelines which are quite clear and can be printed out for personal use. The article can be accessed by using the following address, then clicking on "Contents":
http://www.aansneurosurgeon.org/ ❖

Special Symposium rate for CANS members

CANS Board member **Praveen Mummaneni**, who is Co-Director of the UCSF Spine Center, is putting on a Spine Symposium June 3-4 at the Marriott Union Square hotel in San Francisco. He has extended a reduced registration rate of $225 for CANS members. You can view the detailed program and download a registration form at: https://www.cme.ucsf.edu/cme/CourseDetail.aspx?coursenumber=MOR11003. Discounted rates can't be managed on-line so it will need to be by phone or registration form. Members can just write "Member CANS" on the form next to their name and mark the early bird rate box. By phone they can just identify themselves as CANS members. ❖

Doctors as economic engine

In line with John Davis' report about the worth of a neurosurgeon to a hospital (see above CSNS meeting report, #3), the AMA has released a national study that noted each office-based physician (presumably a private practice doc who maintains an office which would include neurosurgeons) supports 6.2 jobs, with more than 2.3 million folks working in physician's offices in 2010. Each doc leads to $1.3 million in wages and benefits and $2.2 million in overall financial activity. Each doc generates or pays $100,000 in state and local tax revenues and the overall impact of the nation's docs is to support 4 million jobs and contribute $1.4 trillion in economic activity. Our reward? We'll get back to you. ❖

Selected docs do most of narcotic prescriptions

Fitting in with Dr. Bonner's op-ed in this issue, the California Worker's Compensation Institute has published some interesting statistics about narcotic use in the work comp population. They noted that a select 3% of docs wrote 55% of the narcotic prescriptions used by all comp patients. Further, over 20% of comp patients with non-surgical back sprains and strains were given Fentanyl, usually as patches. It is hard to judge these figures when so many patients are referred to "pain" docs whose goal is to try to alleviate pain rather than the old "stiff upper lip" approach prevalent in the last century. Further, a three day Fentanyl patch can work pretty well and obviate the need for dozens of pills. As one who has had a bout of severe non-surgical back pain, this writer would not rush to judgment on this issue. ❖

2012 CANS
Annual Meeting

January 13-15, 2012
(Martin Luther King weekend)
Hotel group rate - $219.00
(Reservations 714 520-5050)

Meetings of Interest for the next 12 months:

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
Western Neurosurgical Society: Annual Meeting, September 10-13, 2011, Kauai, HI
CANS: Board of Directors Meeting, September 24, 2011, Oakland, CA
CSNS Meeting, September 30-October 1, 2011, Washington, DC
Congress of Neurological Surgeons: Annual Meeting, October 1-6, 2011, Washington, DC
North American Spine Society: Annual Meeting, November 1-5, 2011, Chicago, IL
Cervical Spine Research Society: Annual Meeting, December 7-10, 2011, Scottsdale, AZ
CANS: Annual Meeting, January 13-15, 2012, Anaheim (Disney Grand Californian Hotel), CA
Southern Neurosurgical Society: Annual Meeting, March 28-31, 2012, Amelia Island, FL
CSNS Meeting, April 13-14, 2012, Miami, FL
AANS: Annual Meeting, April 14-18, 2012, Miami, FL
Neurosurgical Society of America: Annual Meeting, June 10-13, 2012, Park City, Utah

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* ***two-month 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: To place a newsletter ad, 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. Marc Vanefsky 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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