CANS newsletter

Cheatham hits the spotlight again

Randall W. Smith, MD, Editor

It seems that CANS member **Melvin Cheatham** can't seem to avoid the spotlight. On May 11th, Mel was one of the recipients of the Ellis Island Medal of Honor for 2013. The highly prestigious Ellis Island Medal of Honor awards are given each year by The National Ethnic Coalition of Organizations (NECO) to men and women who have distinguished themselves through living their lives in service to others. Six former Presidents of the United States, Nobel Prize winners, and leaders in government, business, industry and the arts have been recipients of this high award that focuses upon the ethnic diversity and immigrant experience that collectively have made our nation so great. The United States Senate and the House of Representatives have both officially recognized the Ellis Island Medals of Honor, and each year the names of recipients of this high award are read into the Congressional Record.

Dr. Cheatham is a member of the Boards of Directors of the Billy Graham Evangelistic Association and of Samaritan's Purse, an international humanitarian assistance organization in which he serves as a Special Assistant to the President with special reference to North Korea, a country he has visited twenty-five times bringing help to people in need of medical, dental and other humanitarian assistance.

As our readers probably know, Mel is retired from his Ventura practice and devotes himself full time to volunteer work. He and his wife Sylvia have done medical mission work in countries including Kenya, Uganda, Somalia, Rwanda, The Congo, Sudan, South Korea, Bosnia, Kosovo, Former Soviet Union, and North Korea. He is currently developing a Neurosurgical Education Series by satellite transmission for doctors in developing countries. Because of Dr. Cheatham's worldwide volunteer work, Whitworth University bestowed upon him an honorary Doctor of Humane Letters degree.

Dr. Cheatham, former President of CANS and the Western Neurosurgical Society, is the author of four books each focusing upon "giving one's life away, through service to others. In the foreword for Dr. Cheatham's book entitled, "Make A Difference," Dr. Billy Graham wrote, "Over a half-century ago, John F. Kennedy penned a bestseller entitled Profiles in Courage. Mel Cheatham's … book might well be called Profiles in Courage: Part Two." ❖

INSIDE THIS ISSUE:

Transitions in Neurosurgery

John Bonner, MD, Associate Editor

It is hard for a physician to have confidence in what the future will hold with so much current uncertainty in the practice of medicine. Recent scandals -- such as the Justice Department investigation of reporters without any obvious good reason, and IRS targeting groups related to the Tea Party – has brought concern as to how well the government will be able to implement the Affordable Care Act (although many of us would be happy with a delay in the implementation of the new health care plan, or its repeal).

Nonetheless, some aspects of Obamacare are already being implemented, such as the expansion of electronic medical records. In 2008, about 17% of physicians used electronic records, but now 50% have demonstrated meaningful use and reached the incentive payment. In 2008, 9% of hospitals had electronic records, but HHS found that 80% now have electronic records in place. HHS Secretary Kathleen Sebelius stated "We have reached a tipping point in adaptation of electronic health records," noting that, "they are critical to modernizing our health care system." Yet, I have noticed that electronic or computerized records lack specific detail and/or are overly redundant. Also, it appears that the development of electronic records has decreased physician communication with one another regarding patient care. One wonders whether other facets of Obamacare will have similarly negative, perhaps unintended, yet very real, consequences in the delivery of patient care.

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This time of year is the season for graduation of new physicians. While it is a time of celebration, one wonders what the future will hold for new physicians. It appears that fewer are likely to enter private practice of medicine, and that many desire more controlled (and perhaps less harried) lives, which differs from what many of us experienced. This is also a time when many of us have the opportunity to reflect on our education with classmates at reunions. My wife Romona and I will be attending my 50th medical school reunion this June. I must admit that I enjoyed my medical education, the further training I received, and life in private practice. I am concerned that our new physicians will not have the opportunity to know or experience the practice of medicine as so many of us have. Indeed, with all the changes slated for medicine, one wonders whether new physicians will be able to develop a proper physician-patient relationship and be able to exercise independent judgment in the delivery of care. Furthermore, many students go into deep debt in obtaining a medical education. One wonders whether they will be able to afford pleasant life experiences with the new system of declining reimbursement. ❖

Brain Waves

Deborah Henry, MD, Associate Editor

May and June. This is the time when graduations abound as high school, college, and medical students move on to the next phase of their lives. In the following month, residents will leave their protected environment to fly solo. Commencement addresses resound and strive to inspire. These speeches are structured teaching moments in our lives, but in truth the real teaching moments occur in more subtle fashion.

I knew it as Death and Donuts, the weekly morbidity and mortality rounds that made even the bravest resident quake in his or her boots. These teaching moments have evolved over the year to the now Quality Assurance or other euphemisms and may not quite carry the venom they did in my early career days. As teaching moments, they left a lot to be desired. I perhaps learned more from what was not said than what was said. A memorable time was when a fellow resident presented an infant's surgical death. This young child underwent repair of an elective craniosynostosis. The resident anesthesiologist (and attending) had not placed an arterial line. During the course of the operation, the child lost a tremendous amount of blood and ultimately died of a cardiac arrest. Indeed, the primary teaching moment here was the need to carefully monitor the precarious blood volume in any surgical case especially involving an infant. However, the teaching event for me was much different. The attending physician was visibly absent from the M and M rounds and left the resident of the case to present this alone. This cowardly act made me realize the importance of taking responsibility for what one does.

Many years later when I was an attending, a piece of the craniotome saw broke off while the resident was opening the skull. We searched for the piece, but did not find it and assumed that the craniotome blade was already broken, as it did not function well from the beginning. The next day when the patient went for an MRI, an astute technician saw the tiny piece on a scout film and alerted us. As future MRIs were important in following this patient, he was told of the problem, and a second surgery was performed to remove the piece that had actually slipped intradurally. The Quality Assurance teaching moment was never to assume that a broken part was not left in the wound but verify this with an X-ray. The teaching moment for me was not only for me to take responsibility but to teach the fellow residents to do so as well.

In three weeks, my son will graduate from sixth grade and move onto middle school. With his hormones budding on the horizon, teaching moments will need to be even more by example than words. This weekend we were at a friend's soccer game and when it was over, I noticed how awful the field look with debris littered everywhere. I gathered my son and his friend, and I declared time for community service. We picked up the litter and collected the bottles for recycling. When we were done, we surveyed our efforts and were proud of the spotless field.

A mom turned to me and said "There's your good deed for the day." "Hopefully not the only one," I said subtly. Don't let those teaching moments pass you by. ❖

Tidbits from the Editors

EHR's increase costs to the Feds, not just the docs

We recently lamented in this newsletter that Electronic Health Records have lead to numerous digital pages to record a relatively simple follow-up visit that used to take a couple of typed or hand written paragraphs in the patient's paper record. We also expressed some concern that the templates used in the EHR tend to create a visit entry that is prone to indicating activities that did not occur (such as repeating the FH, PMH, ROS, Social history, etc.) which potentially could be viewed as fraud.

The Feds have noted a general increase is the number of higher codes submitted over the past few years with the 99205 complex new patient code accounting for 13% of bills in 2010 vs. 9% in 2002, the established patient complex visit code 99214 going from 22% in 2002 to 36% in 2010 and the ER complex visit code 99285 going from 30% to 48%.

An article in the May 20th edition of the AMA's American Medical News points out that there should be no rush to consider such upcoding fraudulent. The article points out that with the templates, when docs fill in what they did do, they now have confidence to bill at a higher level whereas with the hand written or typed paper record there was the fear that the Medicare police would attack, audit and fine so the tendency was for the doc to downcode a click to play it safe. With such legitimate increase in use of more complex codes, the office docs may help to pay for the EHR system they bought (and which the $44,000 Fed subsidy doesn't completely cover-- the average cost per physician to adopt, implement and upgrade a certified EHR is $54,000, plus $10,000 in annual maintenance costs) as well as stand as another unintended consequence of Federal brilliance.

Those pushing for AANS-CNS merge continue the endeavor

We note that the One Neurosurgery Committee (now called the One Neurosurgery Advocacy Committee) has decided to encourage the 1800+ neurosurgeons who responded affirmatively to their survey about amalgamating the AANS/CNS to send email or letters to the Presidents and Presidents-Elect of the AANS and CNS encouraging not only combining the two organizations but also pushing for one annual meeting and no membership requirement to attend such meetings. The Committee notes that the results of the survey were sent to the Presidents of the AANS and CNS and that no response from either has so far occurred.

There are 5,152 voting members in the AANS and 4,620 voting members in the CNS and one supposes that the voice of the not so silent minority of 1800 won't be interpreted as a cause for change. The email/letter maneuver is unlikely to lead to some change but will exhaust the final option of One Neurosurgery before they take the ultimate step of proposing amendments to the by-laws of each organization which will force a vote of all members the results of which will be binding. Whether by-laws amendments forcing combining the two groups would pass legal muster is unclear, an amendment removing the meeting attendance requirement is certainly legit and may be the most change the One Neurosurgery folks can achieve.

In the meantime, those wishing to send the email/letter to the AANS/CNS officers can easily do so by visiting the One Neurosurgery Advocacy Committee website at http://oneneurosurgery.com/take_action.html. Stay tuned.

California comes in third in malpractice payouts for 2012

A total of $3.6 billion was paid out for medical malpractice lawsuits in 2012, and 48% of those payouts occurred in five states, according to Diederich Healthcare's 2013 Medical Malpractice Payout Analysis based upon 2012 data from the U.S. Department of Health and Human Services' National Practitioner Data Bank. The states with the highest medical malpractice payouts were: New York -- $763,088,250; Pennsylvania -- $316,167,500; California -- $222,926,200; New Jersey -- $206,668,250; Florida -- $203,671,100.

Settlements were responsible for the bulk of the payouts (93%), whereas judgments were responsible for only 5% of the payouts. States with the lowest per capita malpractice payouts were Texas, North Dakota, Wisconsin, Mississippi and Indiana. Malpractice allegations were primarily related to diagnosis (33%), followed by surgery (24%), treatment (18%) and obstetrics (11%). A similar proportion of payouts were awarded to both inpatient (45%) and outpatient (41%) malpractice allegations, and 9% of payouts were attributable to both inpatient and outpatient treatment.

Despite an increase in the number of payouts awarded from 1998 and 2001, the monetary value of malpractice awards has been dropping steadily since 2003; 2012 payouts were 3.4% lower than in 2011. Sort of good news for California docs although it's kind of like the good news that there were fewer car bombs in Iraq last month.

The Opioid Police lose a round

The California Senate failed to pass SB 809, a bill that would have provided the CURES program with funding from an increase in licensing fees on pharmacists, physicians and other prescribers and a tax on drug makers to allow the attorney general to hire teams of investigators to crack down on drug-seeking patients and doctors who recklessly prescribe to them. The pharmaceutical industry lobbied heavily against the bill which led to the defeat. Those that support the bill plan another go round this time dropping the pharma tax. Guess who will now have to pay more to make up the loss of the pharma money?

Since the bill would also require every doc to report every opioid prescribed (plus Ritalin, Methadone, Ketamine, Anabolic steroids, Valium, Ambien and Clonazepam) to the CURES database, one wonders about the legality of a system that contains medical information about every patient who legally gets the meds, said system being freely accessible to any doc or pharmacist or DOJ staff (and hackable by whomever) who may or may not have a need to know about that patient's meds. HIPAA, where are you when we need you?

At press time, we earned that the Senate passed an amended bill in which the pharma tax was dropped as was the requirement that all docs consult the CURES database before prescribing the drugs noted above. The amended bill still taxes the docs to fund the CURES program at the same level as in the original bill. It is unclear if docs will have to report all opioid prescriptions to the CURES database.

Neurosurgeons' worth to hospitals falling

We reported last month that Jackson & Coker, a physician staffing firm providing permanent physician placement plus locum tenens, had published a report that a neurosurgeon generates an

annual $2.63 million for a hospital at which they work. Now comes a report from physician recruiting firm Merritt Hawkins that the times they are a changin'. Merritt Hawkins lists neurosurgeons as only providing about $1.7 million per doc (down from $2.8 million in 2010) while orthopods provide $2.6 million (up from $2 million in 2010). The ortho rise is felt to be due to more old geezers getting new joints. With the developing alignment of primary care docs with hospitals, the MH data lists family practitioners as generating just over $2 million. We don't know enough about the methods the two firms used to explain the difference in income generated by neurosurgeons but one suspects the truth lies somewhere between the two figures. It does appear we neuro docs are losing some clout.

Deadline for avoiding 2014 E-Prescribing penalty is June 30

In 2014, a Medicare payment penalty of 2 percent will be applied to individual eligible professionals or group practices participating in the Electronic Prescribing Group Practice Reporting Option (GPRO) if they are not successful electronic prescribers. CMS will automatically exclude from the penalty those professionals and group practices who meet the criteria listed in the CMS Electronic Prescribing (eRx) Incentive Program: 2014 Payment Adjustment Fact Sheet. Individual eligible professionals and groups participating in eRx GPRO who were not successful electronic prescribers in 2012 can avoid the 2014 payment adjustment by meeting the specified reporting requirements between January 1 and June 30, 2013.

Clinicians also can apply for hardship exemptions, which include: (1) practicing in a rural area without sufficient high-speed Internet access; and (2) being barred by local, state, or federal law from e-prescribing. The deadline for hardship exemption applications, accomplished by including a G-code on a Medicare claim, is also June 30. Significant hardships associated with a G-code may be submitted via the CMS Communication Support Page or on at least one claim during the 6-month 2014 eRx reporting period (January 1 – June 30, 2013). If submitting a significant hardship G-code via claims, it is not necessary to request the same hardship through the Communication Support Page. Please note that the hardship exemptions for achieving Meaningful Use or demonstrating intent to participate by registering in the Medicare or Medicaid Electronic Health Record (EHR) Program by June 30, 2013, will be automatically processed by CMS. Therefore, entering a hardship exemption request through the Communication Support Page will not be necessary.

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Truism of the Month:

To be old and wise, you first have to be young and stupid.

Jump Start for Exhibitors

Emily Schile, Executive Secretary

Please consider joining us next year in Monterey at the Monterey Hotel & Plaza! The dates are January 17th – 19th, 2014. It's a great time of year to be near the beach! The Monterey Plaza looks out onto Monterey bay on one side and historic Cannery Row on the other! Please contact me at Emily@cans1.org for more information❖

Meetings of Interest for the next 12 months:

Rocky Mountain Neurosurgical Society: Annual Meeting, June 15-19, 2013, Sun Valley, ID
New England Neurosurgical Society: Annual Meeting, June 27-29, 2013, Brewster, MA
Western Neurosurgical Society: Annual Meeting, September 15-18, 2013, Half Moon Bay, CA
North American Spine Society: Annual Meeting, October 9-12, 2013, New Orleans, LA
CSNS Meeting, October 18-19, 2013, San Francisco, CA
Congress of Neurological Surgeons: Annual Meeting, October 19-23, 2013, San Francisco, CA
AANS/CNS Joint Pediatric NS Section: Ann. Meeting, December 3-6, 2013, Toronto, Canada
North American Neuromodulation Society: Annual meeting, December 5-8, 2013, Las Vegas, NV
Cervical Spine Research Society: Annual Meeting, December 5-7, 2013, Los Angeles, CA
CANS Annual Meeting, Monterey Bay Resort, January 17-19, 2014, Monterey, CA
Southern Neurosurgical Society: Annual Meeting, 2014, TBA
Neurosurgical Society of America: Annual Meeting, 2014, TBA
CSNS Meeting, April 4-5, 2014, San Francisco, CA
AANS/CNS Joint Pain Section Bi-Annual Meeting, 2014, TBA
AANS: Annual Meeting, April 5-9, 2014, San Francisco, CA

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 the CANS office by E-mail (emily@cans1.org) or fax (916-457-8202)—Ed. ❖

The assistance of Emily Schile and Dr. Ted Kaczmar in the preparation of this newsletter is acknowledged and appreciated.

- To place a newsletter ad, contact the executive office for complete price list and details.
- Comments can be sent to the editor, Randall W. Smith, M.D., at rws-avopro@sbcglobal.net or to the CANS office emily@cans1.org.
- Past newsletter issues are available on the CANS website at www.cans1.org.
- If you do not wish to receive this newsletter in the future, please E-mail, phone or fax Emily Schile (emily@cans1.org, 916-457-2267 t, 916-457-8202 f) with the word "unsubscribe" in the subject line.

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