CANS newsletter

Work Comp review process great--says the reviewer

Randall W. Smith, MD, Editor

We have written about the new Work Comp rule in California that mandates that any utilization review (UR) denial of doc recommended care (before or after an appeal by the doc) has to be submitted to independent medical review (IMR) if the treating doc or the worker's attorney wishes to challenge the UR decision. The IMR is conducted by Maximus Federal Services which is supplied with a request form and the detailed UR denial at a minimum but hopefully also with copies of the treating docs records. The IMR process has been in effect since January and Tom Naughton, vice president of Maximus who recently spoke at a Anaheim conference, said the organization received about 600 IMR requests between July 1 and July 13 after getting 400 requests in June. He noted that review of a large sample of decisions in July found Maximus affirmed the UR denials about 60% of the time.

Mr. Naughton said one of the most important things that IMR will do is to educate California's workers' compensation community about patterns involving certain procedures or diagnostic tests. His thesis is that WC insurance companies will learn which IMR requests consistently overturn the UR denial and not bother to submit the treatment requests to UR in the first place, thus saving time and money. (The Workers' Compensation Insurance Rating Bureau has estimated that about 11% of all money spent on medical benefits goes to the UR process.)

This writer feels Mr. Naughton may be a bit Pollyannish in his opinion. We must recall that all requests for treatment go to the worker's case adjuster at the insurance company and that adjuster is not a doc. Since these adjusters hold the key to the insurer's money, they tend to err on the side of sending the request to UR (which is done by a doc) to cover their backsides. To think that those adjusters will integrate which UR denials are consistently overturned by Maximus into their minds and simply authorize a $30,000 surgery or a $1000 MRI is a stretch. One might hope that the all to common submission of a $50 prescription for Vicodin and Soma to UR and potentially IMR, which will cost about $500, will indeed be curtailed but we shouldn't be very optimistic. ❖

INSIDE THIS ISSUE:

CANS MISSION STATEMENT

'An organization of Neurosurgeons to promote the professional education and scientific achievement of surgeons and quality care for Californians'

Letter to the Editor

Dr. Bonner's paragraph in his "*Transitions*" column of the Newsletter brought back very fond memories of my own experience as a neurosurgical resident at the University of Chicago in the sixties. I fondly recall exposure to the "greats" of the neuroscience field and their impact on me as a young student of the brain. Dr. Buchanan's wonderful teaching abilities, and especially for me, the opportunity to assist Dr. Ruth Rhines in teaching the freshman medical students' course in Neuroanatomy. Dr. Rhines, in "payment" for my efforts, gave me a complete serially sectioned box of slides stained with the Kluver stain (which illustrated both myelin and cell bodies), and I hold it as a remembrance of those heady days.

I also look upon the dedicated training by Dr. Joseph Evans and Sean Mullan as forming the central core of my long and enjoyable career as a neurological surgeon. We should frequently look back on such experiences and consider ourselves fortunate to have had such great teachers and mentors.

Robert A. Fink, M. D.
El Sobrante, California ❖

Transitions in Neurosurgery

John Bonner, MD, Associate Editor

As many probably are aware, President Obama intends to postpone partially the full implementation of the Affordable Care Act. Specifically, President Obama has signaled a reprieve for the mandate of health insurance coverage for workers for those businesses that employ over 50 persons. This requirement, which carries a $2000 per worker penalty if the business does not provide health insurance coverage, is now slated to be in force by January 1, 2015, instead of January 1, 2014. (Some pundits speculate that the fine will be cheaper than the health coverage!) Nonetheless, I would not be surprised to see further delay in implementation of this portion of Obamacare. Even a sponsor of the Affordable Care Act, Montana Senator Max Baucus, has admitted that implementation of Obamacare is a "train wreck." Indeed, the ACA certainly seems unworkable.

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In 2009, the California Legislature eliminated the state-run Medicaid program in an effort to save money. The reason provided for eliminating the program was that health care was not being provided exclusively by medical doctors. The Ninth Circuit Court of Appeals, however, recently ruled that only Congress can change the terms of Medicaid coverage. Such Medicaid coverage includes care provided by dentists, podiatrists, optometrists and chiropractors, in addition to services provided by physicians and osteopaths. Many of us would consider some of these services to be unnecessary and this, in turn, results in decreased income for physicians who do provide necessary services. ❖

Brain Waves

Deborah Henry, MD, Associate Editor

Prepare for the worst; hope for the best. That was often my motto when treating patients. I felt it was better to know one's enemy and therefore confront it rather than sit in the darkness of ignorance. As a resident, I was often the bearer of bad news when the patient with the glioblastoma was rushed to the emergency room at three in the morning with recurrent disease and no knowledge of his or her limited mortality. During my chief year, there was the woman with the glioblastoma whose family wanted all information withheld. Post-operatively she developed a stroke and spent the rest of her remaining days in a coma. Henceforth, I would walk that fine line with my patients, balancing precious little hope with a firm dose of reality. Sometimes that was not the best clinical practice.

Early in my career, I operated on a middle-aged woman with a ring-enhancing lesion. As I suspected, the diagnosis was a glioblastoma multiforme. After surgery, diagnosis in hand, I went to talk with the family. Colored by my past experiences, I strongly felt she should know her enemy and the choices before her. Only with this knowledge could she make a reasonable decision for her future. Imagine my young self's surprise when she said she did not want to know. I think I told her anyway. She went home and passed away within 48 hours, cause unknown. Medical reasoning would say she had a pulmonary embolism. But I felt she had died from my disclosure of her brain cancer.

A friend of mine who is premed has an aunt with pancreatic cancer. He went with her for her pancreatectomy. He has taken her to her chemotherapy and her follow up MRIs. She is happily going about with having had treatment for her malady. She has an incisional hernia that she finds amusing as she is told not to worry about it. She does not know that she has cancer. She is of the generation where the decisions are best made by the doctors, or at least by her caring family members. Telling her would not make her live any longer, nor would it make her better, but only take away the bountiful hope that she has having just a malady.

A few months ago, Susan Partovi, MD, medical director for Homeless Health Care in Los Angeles, wrote an opinion piece to the LA Times on the importance of "Prescribing Silence." Unlike my early experiences of uniformed patients, hers in medical school was one similar to my friend's. When her patient was asked if he wanted to know the details of his illness, for instance if he were dying or had cancer, he said "no." Her patient happily lived out his remaining days in the bliss of ignorance. At the family's request, she had prescribed silence. Sometimes I wonder if my one patient would have lived longer if I had done the same.

One of the most quoted bible verses is I Corinthians 13:13: *And now these three remain: faith, hope, and love. But the greatest of these is love.* But sometimes in medicine, it is hope. ❖

Tidbits from the Editors

Residency training drops under ACGME rules

A study published online July 10 in *JAMA Surgery*, compared case logs of 52 interns working under the new work hour restrictions instituted by the ACGME in 2011 to the annual case logs of 197 interns from the four years prior to the new restrictions and found that the interns under the new restrictions worked an average of 66 operations, compared to the previous interns average of 89 operations; participation in operations assisting experienced surgeons and major cases also went down. Lengthening the training programs to compensate is a solution delightful to residents and should interest the feds who pay for much of each year of residency. A Johns Hopkins spokesperson stated the obvious with the comment that "the study highlights a 'predictable consequence' of the hour restriction." Of course the babysitters at the ACGME could care less since they don't seem to have to worry about mundane topics like adequacy of training.

Here come the MICRA killers

As reported by the LA Times in their 7/25 edition, Consumer Watchdog has launched a ballot initiative to "raise limits on medical malpractice 'pain and suffering' jury awards." In addition to increasing the cap to about $1 million to match inflation, "the proposal also would require mandatory drug and alcohol testing for doctors and mandatory use by doctors of an electronic database that tracks prescriptions dispensed in California, otherwise known as CURES, about which we have written in our February issue. As might be expected, a coalition of healthcare providers including the California Medical Association, California Dental Association, California Hospitals Association and Planned Parenthood "has denounced the proposed initiative," claiming it would "would drive up medical costs." C. Duane Dauner, chief executive of the California Hospital Association is quoted as stating: "At a time when hospitals and healthcare providers are attempting to lower costs and prepare for an influx of new patients, any attempt to increase lawsuit payouts will harm patient access and increase costs."

One may presume the signature gathering for the imitative will be at least in part be underwritten by the plaintiff's bar and we could have a major MICRA battle if the initiative qualifies for a vote. What is a bit difficult to understand is the drug and alcohol testing for docs and how that meshes with the CURES and change to MICRA concepts. We may have some docs in California who are pretty free with Percocet prescriptions but they almost certainly do that sober. Of course, anything that muddies the MICRA challenge will help defeat it. It will be interesting to see how Californians respond to an initiative that embraces reporting them to the state every time they get a Rx for Vicodin and that all their docs have to be treated like DUI suspects.

POD's under federal scrutiny

The federal Department of Justice is on a hunt for physician owned distributorships (POD) that may run afoul of one law or another. Although PODs can be legal, the Department of Health and Human Services' Office of Inspector General issued a special fraud alert on PODs in March and the *Wall*

Street Journal, in a front page article in their 7/26 edition, detailed a case of a neurosurgeon in Ventura who was part of a POD and who did over 300 spine operations in his first year after residency. The neurosurgeon in question also had more than two dozen med mal lawsuits come out of those 300+ cases which has garnered the attention of the Medical Board of California. The lesson here for a California neurosurgeon is to be very diligent about who you hire to join your practice when the hire has no grown-up track record and being involved in a POD may be a risky way to make an extra buck.

Work Comp switch to RBRVS—Part 2

Contrary to what we published about the Work Comp conversion to RBRVS in last month's newsletter, the Rand corporation, which always speaks from on high, apparently had a senior moment when it published its original estimates of how the RBRVS will affect doc payouts which we used for our article and which the Division of Worker's Compensation embraced as what is going to happen with RBRVS adoption. Seems the Rand gurus counted inflation factors improperly so that its estimates of whose ox gets gored were wrong. After correction, it turns out that we surgeons will get cut 20% instead of the 13% Rand initially estimated. At this rate, we are one revision away from just quitting the whole mess.

Mama don't let your babies grow up to be doctors

Jackson Healthcare, a Georgia-based staffing company, ran a survey which was completed by 3,456 docs between March 7 and April 1, 2013, wherein they found that 59% of physicians would be unlikely to encourage a young person to become a doctor. The surveyed docs dissatisfaction with medical practice is reflected in the career satisfaction numbers in the survey. Only 20% of physicians said that they were very satisfied in their work, while 39% were somewhat satisfied and 42% were somewhat or very dissatisfied. The satisfied ones tended to be those employed by a hospital or working at a physician-owned practice where they had no ownership stake. The dissatisfied doctors tended to own their practices, worked longer hours and had few physician extenders. Since there does not appear to be a dearth of applications for admission to medical schools, maybe a new cadre of applicant is emerging and potentially replacing the sons and daughters of physicians, presuming of course that the dissatisfied docs actually tell their kids to go into engineering. ❖

FLYING TRUISM OF THE MONTH:

When one engine fails on a twin-engine airplane, you always have enough power left to get you to the scene of the crash.

Application for Exhibitors/Board Members

Emily Schile, Executive Secretary

EXHIBITORS: Exhibitor registration information & form is **NOW AVAILABLE** on our website: www.cans1.org!

BOARD MEMBERS: Our next Board meeting is scheduled for October 5th, 2013. If you have an issue or topic, please submit to me via email at Emily@cans1.org before Sept. 23rd. Also, the minutes from the last Board Meeting are available on the BOD secure page on our website.

ATTENTION CANS MEMBERS: Do you know a neurosurgeon new to California? What about an existing CA neurosurgeon who isn't yet a member? Please direct them to our website: www.cans1.org for more information! The more the merrier! ❖

Meetings of Interest for the next 12 months:

Western Neurosurgical Society: Annual Meeting, September 15-18, 2013, Half Moon Bay, CA
CANS Fall BOD: Board Meeting, October 5th, 2013, Oakland, 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, February 19-22, 2014, San Juan, Puerto Rico
Nsurg. Soc. of Amer: Ann. Mt, June 8-11, 2014, St. Andrews-by-the Sea, New Brunswick, Canada
CSNS Meeting, April 4-5, 2014, San Francisco, CA
AANS/CNS Joint Pain Section Bi-Annual Meeting, April 4, 2014, San Francisco, CA
AANS: Annual Meeting, April 5-9, 2014, San Francisco, CA
Rocky Mountain Neurosurgical Society: Annual Meeting, 2014, TBA
New England Neurosurgical Society: Annual Meeting, 2014, TBA

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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