CANS newsletter

Work Comp switch to RBRVS-Part 3

Randall W. Smith, MD, Editor

The Department of Workers' Compensation (DWC) has published its Official Medical Fee Schedule for 2014 and it includes and incorporates the conversion to the RBRVS system in California WC that was mandated by SB863 which passed last year. The goal of the RBRVS conversion is to use the RVU values from Medicare and adjust the Conversion Factors (CF) in such a way as to ultimately have one CF for all treatment including surgery. The full adoption of the RBRVS system will take place by 2017 with a blended system commencing in 2014 (75% current OMFS; 25% RBRVS) and then 50/50 in 2015, 25/75 in 2016 and the full Monty in 2017. The complete shift to RBRVS in 2017 will result in a 40% payment increase for E&M codes, a 65% increase for physical therapy, a 2.6% increase for Psychiatry and a 20% decrease for surgical codes.

The 2014 Surgery Conversion Factor will be $52.478 per RVU as compared to the present surgery scale that comes out as about $55 per RVU with the final surgery CF in 2017 of $40.845 (120% of the current Medicare CF of $34.042). This 4 year transition to a full RBRVS is purportedly designed to lessen the impact on us surgeons or maybe to slide it by us so we won't notice until our practice managers discover that the work hours associated with handling a WC case are quite large compared to what we get paid. The 64-dollar question is will orthopods and neurosurgeons do WC work for $40+/RVU? This writer suspects there are enough orthopods plus a few neurosurgeons whose practices would nearly implode without WC cases to the point that these docs will stick with the system even at a $40/RVU level since to them $40/RVU is better than what they get paid for sitting in the office reading journals. At least that is what the legislature and the DWC are betting on.

The California Society for Industrial Medicine and Surgery has pointed out that **every state that has implemented an RBRVS system for Work Comp with a single conversion factor as planned in California has failed.** They cite the Texas experience which went to an overall RBRVS of 125% of Medicare but had to subsequently increase that to 160% to keep doctors in the Work Comp system. We shall see if California docs are easy compared to Longhorns. ❖

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'

Transitions in Neurosurgery

John Bonner, MD, Associate Editor

The Fall season is upon us, and with it comes the return of football, a change in the weather, and the beginning of a new school year. I always enjoyed my educational experiences. From grade school to residency, I have fond memories of my time learning new things. Though I am a little long in the tooth, I can even remember well my neurosurgical education, especially my idols of Sean Mullen and Joseph Evans. I also remember other demanding and colorful instructors such as George Block at Chicago, Guy Odom at Duke, and Art Ward at Washington. Things were different then, and times certainly have changed – mainly for the better.

I can remember being responsible for working up patients from the time they were admitted to their discharge from the hospital, having to do the initial blood draw to performing a full craniotomy. I also remember the now-antiquated imaging that we considered a God-send back then. Many of us may recall reliance on plain x-rays of skull and spine and extremities. When necessary, a variety of studies were used such as direct stick carotid angiography, retrograde brachial artery injections and ventriculography. Spinal studies mainly consisted of myelography utilizing Pantopaque or air myelography for sagittal area studies. Improved studies are now available through CT and MRI and beyond. CT and MRI have provided much better information and details of the disease or disorder, and patients find these studies more comfortable and convenient.

Lastly, I remember being on-call every day and every night for four years (with the luxury of being on call every other night for the fifth year). I understand this is no longer the practice in neurosurgical education. Indeed, while I am glad to hear that some change has occurred in the preparation of new neurosurgeons, I am concerned of that there is a lot of variety now in neurosurgical education, with varied results. I understand the need for more specialization and, perhaps, decreased demands in term of hours required to be on-call. Yet, I believe that my experience prepared me well for the practice of neurosurgery. ❖

Brain Waves

Deborah Henry, MD, Associate Editor

My new love is word origins or etymology (from *etumos* for true or real). I am passionate about analyzing them. Let's see: analyze-from the Greek *ana* for up and *lysis* to break. So bear with me as I share what I have learned over the past few years. One of my favorites is acetabulum. The *acet* is the same as in acetic acid or good old-fashioned vinegar and the *bulum* refers to a cup. In the ancient days, meals were served with vinegar and the vinegar was supplied in a small cup.

Muscle, from the Latin *musculus*, means little mouse. In Greek, *mys* (think myo) is both muscle and mouse. That biceps brachii muscle of yours looks like a little mouse crawling under your skin.

Do you remember the nine regions of the abdomen? The left and right hypochondria sit just below the rib cage (*hypo* for below and *khondros*- the cartilage of the sternum). And yes, this is the origin of the term hypochondriac. Just think of that butterfly feeling you used to get as a resident when asked a question in Morbidity and Mortality Conference. The ancient Greeks thought this area was the source of the vapors that caused illness.

For our bones, fibula means to fasten and later the clasp of a broach. One can imagine that in the years of the early anatomists, a broach clasp may have been made from the fibula of a small animal or bird. The humerus (a misspelling from the Latin *umerus* which is shoulder) has a medial epicondyle called the trochlea (hook) that attaches to the ulna and a capitulum (head) that articulates with the radius head. The carpal bones include the scaphoid (ship-like), the lunate (lunar), capitate (head), and hamate with its hamulus (hook). Malleolus is mallet or hammer-I think the tibial (pipe flute) malleolus makes a better hammer than the fibular end. Coracoid (as in the coracoid process jutting out from the scapula) means beak-like. The thyroid is shield-like and the cricoid is ring-like.

The thalamus means inner chamber or bedroom and of course the hippocampus is seahorse and amgydala is almond. The limbic system comes from *limbicus* meaning border or margin. Pineal means like a pine cone and pituitary is phlegm. After all, this is where snot came from if you lived a long time ago.

One morning I awoke thinking of brain waves especially alpha and beta waves. So in those wee moments before getting out of bed, I kept saying alpha and beta in my head until I dropped the "a" off the beta and got alphabet—never occurred to me before that alphabet was the first two Greek letters thrown together. I love words. ❖

Tidbits from the Editors

Sunshine Act data collection begins

As most docs probably know, the Sunshine Act reporting by corporations has begun. The data submitted by the corporations will be posted in a searchable public database starting in September of next year. The Congress of Neurological Surgeons (CNS) put out an email to its members that covers an important issue and is reproduced here in part.

On Thursday, August 1, data collection began for the Transparency Reports section of the Physician Payments Sunshine Act. If you have not already done so, we encourage you to visit the National Plan and Provider Enumeration System (NPPES) website to ensure the accuracy of your National Provider Identifier (NPI) data **https://nppes.cms.hhs.gov/NPPES/Welcome.do** The National Provider Identifier (NPI) is a unique identifier provided by the National Plan and Provider Enumeration System (NPPES) for all health care providers, which is used to collect identifying information on health care providers.

The new Physician Payments Sunshine Act requires public reporting of certain transfers of value from pharmaceutical, biologics and medical device manufacturers to physicians. Companies are required to report certain transfers of value to physicians. In generating these reports, companies will be required to use the NPPES, which CMS maintains on its website, to identify physicians by their

distinct NPIs.

This new rule presents several complexities that could potentially lead to confusion when companies are required to report transactions publicly beginning in 2014. These include the fact that multiple physicians share the same name, a single physician may be licensed in multiple states, a physician may be retired or on a sabbatical, or a physician may be associated with more than one, or no, NPI. More importantly, if your NPI has not been updated to correspond with your current specialties, there is a potential that a reported professional interaction could be perceived as unethical or in violation of applicable Food and Drug Administration's (FDA) regulations.

To help ensure accurate reporting of your professional interactions, it is important to update your NPI or obtain an NPI through the NPPES website, and to begin tracking your own payments from companies and clarifying reportable data with company representatives.

Under the Sunshine Act, manufacturers of drugs, medical devices, and biologics must submit annual reports to the CMS outlining certain payments and items of value given to physicians and teaching hospitals. In addition, manufacturers and group purchasing organizations (GPOs) must report certain ownership interests held by physicians and their immediate family members. Reportable transactions include direct and indirect payments and transfers of value, as well as payments and transfers of value that are made to a third-party at the request of or on behalf of a physician. From time to time, companies may provide funds to the CNS in support of faculty travel, food and beverages or other expenses for the CNS Annual Meeting and other educational courses, and in such cases, the NPI number may be required for reporting these exchanges of value to the CMS. In these cases, the CNS will ask you to verify your NPI number and notify you that the value is reportable under the Sunshine Act.

The CNS is proud to partner with the Partners for Healthy Dialogues Campaign to help promote the value of interactions between physicians and industry, from better patient care to advancing medical innovation. To learn more about the Sunshine Act and how it will impact you, visit the Partners for Healthy Dialogues website at **http://www.healthydialogues.org/health-care-professionals**.

Doc recruiting on the rise

The Medicus Firm, a physician recruiter with offices in Dallas and Atlanta, released a study in June showing that more than half of practicing physicians get at least three employment solicitations a week with twenty-three percent getting six to 10 notices. Those numbers are based on responses of more than 2,500 physicians in 19 specialties. Interestingly, the company only lists two solicitations for neurosurgeons, one in California.

According to a survey by Merritt Hawkins & Associates, another physician recruiting firm, sixty-three percent of job searches between April 2011 and March 2012 were on behalf of hospitals, up from 11% in 2004. The Medicus Firm also found that recruiters target doctors long before they enter practice. The firm's survey found that nearly 28% of residents get three to five solicitations a week, and 9% received 21 to 50 weekly. The number of solicitations began to increase in the late 1990s and early 2000s, partly because email added another way to reach physicians, said Jim Stone, president of the Medicus Firm. More than 80% of the nation's roughly 5,000 hospitals are recruiting at any given time, Stone said.

Merritt Hawkins also reported that based upon their 2012 data neurosurgeons were still commanding 670K plus such goodies as signing bonuses, relocation allowances, medical insurance and malpractice coverage.

Utilization Review treatment denials—what next?

For those of you out there who are treating Work Comp patients or acting as a surgical consultant on one, the issue will arise if your treatment recommendation was submitted to Utilization Review (UR) and denied. The issue then is what you need or should do as a next step. First of all, you don't have to do anything. You have given your best opinion and if it is ignored or overruled by someone who has never seen the patient, that is not your problem unless of course such treatment is necessary in an emergency or urgent situation in which the lack of your further care will likely result in irreparable damage to the patient. Though such emergent/urgent cases is very infrequent in WC, when it occurs, you should file an immediate appeal with the insurer's adjuster pointing out the emergent nature of the case and the dire consequences you predict absent your recommended treatment. You can also cover your patient by informing him/her to go to the ED where you work for an evaluation wherein, if you are called, you can assume care of the patient and proceed with what treatment you deem necessary and let the chips fall where they may after the patient is safeguarded.

In the non-emergent case, you don't have to but probably should file an appeal of the UR denial (even if the patient has an attorney) and the avenue to do so will be outlined in the UR denial document. Your appeal should be entitled a Supplemental Report and you may well get paid for creating the document. The UR denial letter should be read over carefully for errors the UR doc made or what you perceive as issues about the case that the UR doc obviously didn't know or chose not to address. Make sure the UR doc is of a specialty pertinent to your recommendation (if you are recommending an epidural it can be denied by a physiatrist or a pain doc but if your recommendation was for surgery the reviewer needs to be a surgeon). Your appeal usually goes to a different UR doc.

If your appeal is denied, and the patient has no attorney, then you have pretty much done what is expected of a reasonable neurosurgeon. You can go one step further and file for an Independent Medical Review (IMR) which requires you to complete a request for IMR (http://www.dir.ca.gov/dwc/forms.html) --and also submit the UR denials and any comments you might wish to make about what was wrong with the UR denials--to the Administrative Director (AD) of the DWC. If the AD approves the IMR, then it is up to the insurance company to submit all the medical records to the IMR (and pay for the review at $560 a pop) and you should hear the outcome in about 6 weeks. If the IMR denies your treatment, the game is over. There is no realistic appeal from an IMR opinion.

If the patient has an attorney, they should file for the IMR. You may be called upon to provide comments you might wish to make about what was wrong with the UR denials but the attorney should handle the rest.

The best way to avoid all of the above fun and games is to not handle WC cases. The next best approach is to be very familiar with the guidelines that UR folk use to judge your recommendations which are usually the ODG guidelines. The rules governing treatment in the first 6 months after injury are the ACOEM guidelines but we neurosurgeons are much more likely to see the injured worker after 6 months and then the ODG guidelines come into play. An online subscription to the ODG guidelines costs $350/year.

Little wonder that Texas docs refused to engage in the above for 120% of Medicare (se RBRVS article above). ❖

OBSERVATION OF THE MONTH:

Why do so many jokes begin with "A guy walked into a pub . . . "? Well, how many good jokes have your ever heard that begin "A guy walked into a salad bar . . ."?

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, June, 2014, Hawaii
New England Neurosurgical Society: Annual Meeting, June 26 – 28, 2014, Brewster, MA

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.

CANS Board of Directors

President	Theodore Kaczmar, Jr, MD	Salinas
President-Elect	Kimberly A. Page, MD	Redding
1st Vice-Pres	Deborah C. Henry, MD	Newport Beach
2nd Vice-Pres	Phillip Kissel, MD	San Luis Obispo
Secretary	Praveen V. Mummaneni, MD	San Francisco
Treasurer	Kenneth Blumenfeld, MD	San Jose
Immed Past Pres	Austin R. T. Colohan, MD	Loma Linda
Past President	Marc A. Vanefsky, MD	Anaheim
Directors		
Northern CA	Michel Kliot, MD	San Francisco
	John K. Ratliff, MD	Stanford
	Marshal Rosario, MD	Campbell
Southern CA	Langston Holly, MD	Los Angeles
	Frank Hsu, MD	UCI
	Bob Carter, MD	San Diego
	Patrick R.L. Rhoten, MD	Beverly Hills
Consultants	Moustapha Abou-Samra, MD	Ventura
	John T. Bonner, MD	Fresno
	William L. Caton III, MD	Pasadena
	John A. Kusske, MD	Irvine
	Philipp M. Lippe, MD	San Jose
	Donald J. Prolo, MD	San Jose
	J. Ronald Rich, MD	Santa Monica
	Lawrence M. Shuer, MD	Stanford
	Randall W. Smith, MD	Escondido
	Patrick J. Wade, MD	Glendale
	Kenneth Ott, MD	San Diego

Executive Secretary Emily Schile
emily@cans1.org

Editorial Committee

Editor
Randy Smith, M.D.

Associate Editors
John Bonner, M.D.
Deborah Henry, M.D.

This newsletter is published monthly from the Executive Office:

California Association of Neurological Surgeons
5380 Elvas Avenue
Suite 216
Sacramento, CA 95819
Tel 916 457-2267
Fax 916 457-8202
www.cans1.org