President's Letter

Deborah C. Henry, CANS 2014 President and Associate Editor

The 42nd Annual Meeting of the California Association of Neurological Surgeons takes place January 16-19, 2015 at the Balboa Bay Resort in Newport Beach. Located on the Newport Channel and home to numerous lidos and yachts, it is the perfect place to reflect on sailing and ships, what it means to commodore a vessel and hence what it takes to lead a ship. The origin of the word leadership is relatively new, dating back to 1821. The idea that word leadership encompasses the traits necessary to be an effective leader is even newer, from only the late 19th century. With its 400 members, the California Association of Neurological Surgeons is our nation's largest and one of the most active state neurosurgical organizations and thus a tremendous responsibility to lead.

Our board is composed of many experienced individuals from all walks of neurosurgical life: academic, employed, group practice and solo practice. Yet at times we remain stymied by the number of other leadership positions we assume, from department chairs to chief of staffs, to CSNS leaders, to spouse, caretaker, mom and dad. Without directions and deadlines, we all become mired in the cacophony of life.

Last night, I watched a history channel special on the two World Wars and was intrigued with the presentation of General Douglas Macarthur. Granted my history knowledge is rather weak, and though I know of Macarthur's endeavors in the Pacific during WWII, I did not know of his campaigns in Europe during the first war. What caught my attention was how he led-walking side-by-side with his soldiers and propelling them to become better than what they would have been individually. The true making of a good and perhaps great leader is say to take an organization of 400 men and women and develop a team of exceptional visionaries with a mission. Macarthur's mission was relatively straightforward: to win a war with minimal loss of life. Ours is in some ways more difficult: to steer our ship through uncharted waters of new health care delivery and provide responsible care for all individuals at a reasonable cost. To do this will require great leaders both now from your silver-haired board and in the future from the youth of our organization. Let us work together to inspire and develop great leaders for our future.

Deborah Henry, M.D.
President, CANS
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INSIDE THIS ISSUE:

Letter to the Editor:

(Upon the recommendation of Associate Editor Jack Bonner, the following editorial that appeared in the May edition of Vital Signs, the monthly publication of the Fresno Madera Medical Society is reproduced with permission of the author. It has been edited for length. The complete article can be obtained from Dr. Lynch at lynch@npimmg.com—Ed.)

2014: THE DESTRUCTION OF PRIVATE PRACTICE MEDICINE
By
Michael W. Lynch, MD, FACP, DTM&H

On November 1st 2014, I will celebrate my 30th year in private practice in Fresno. In addition to Internal Medicine (IM), I have had the opportunity to develop a subspecialty interest in Travel Medicine. It has been an adventure of privilege and exhilaration to build the practice and to be primarily responsible for the care of my patients. After completing college, four years of graduate studies, internship and residency, I was hungry to create something that belonged to me. I have no reservations about the choices I have made. I enjoy my practice and patients on a daily basis.

I am writing this piece because of the importance of discussing with you, my colleagues, the ongoing revolution and the attack on private practice by the US Government, the State of California and the health insurance companies. The Affordable Care Act (ACA) is truly a Trojan horse. The pretense was to provide healthcare coverage to 32 plus million people who were denied health insurance in the US. In actuality it is a takeover of every element of healthcare and a relegation of physicians to a position where we have ultimate responsibility but with minimal authority. This is the definition of a dysfunctional system.

The ACA promised to put primary care physicians "in the driver's seat " but in truth the gear is stuck in reverse. Do I feel empowered? Do I have opportunity on the horizon? Not based upon what I see. Patients are prevented from keeping their insurance and keeping and/or choosing their doctors. I have longstanding friends and patients who now cannot find insurance coverage that will allow them to continue to see me as their physician. They are given no choices other than Covered California.

Do you know what a health insurance company is? They are gamblers with the goal of creating wealth by stacking the odds in their favor. They do this by betting that there will be more money coming in than money going out. The alignment of proper incentives for each member of the healthcare system including patients, doctors, and drug companies has little to do with their formulas for financial success. The idea of supporting and perpetuating quality has little to do with their decision making. If they can forge alliances with the government and create a system to generate wealth, they are going to do that - and they have.

So where are we going with health insurance in our state? With the implementation of Covered California there are only three options available in our Fresno area:

1. Anthem Blue Cross, PPO and HMO.
2. Blue Shield PPO.
3. Kaiser.

Continued on next page

Blue Cross and Blue Shield hold the monopoly in the Valley. Under their new plans they have reduced reimbursement to physicians by 30% and 10%, respectively. The Blues are promising physicians that the increase in patient volume will make up for the reduction in reimbursement. A physician can only see so many patients in a day and can only monitor so many mid level practitioners. Sufficient patient time is a must if physicians are going to respect patients' individual needs as they use their skills to diagnosis and treat disease.

There is a lawsuit currently in the Superior Court of the State of California, County of Los Angeles, sponsored by Edward Gaines, insurance broker and State Senator out of Rocklin. The law suit challenges whether Peter Lee, Executive Director of Covered California, has the right to prevent other insurance products from competing in the current market place.

I am recommending the following:

1. Physician-representative organizations including the AMA, CMA, FMMS and subspecialty organizations must get the word out educating the public as well as our legislative representatives.
2. Educate physicians to the facts so they can make rational choices. Who determines what you are worth? Can you possibly survive financially? Should the government be able to control your insurance contracts, your business and every other aspect of your medical practice?
3. Promote a free market. What exists now is totally void of competition. The Blues have a total monopoly in the Valley. They fix your prices, but you the physician are legally unable of doing the same.
4. Support Edward Gaines, State Senator out of Rocklin and insurance broker in his lawsuit against the State of California. Call him at 916-651-4001.
6. Feel free to talk to Barbara Cordova, my Office Supervisor at Spruce Multispecialty Group, (559) 439-5757. She has been on the top of these issues and has given me supporting information.

We must be involved in the process and we cannot continue to just sit back and observe. We are in the current situation because we have taken a back seat to the process. Whether you work at Kaiser, a private office setting, the VA, or a university-affiliated system we all are physicians, and the integrity of our profession is under attack. It is not just about us, it is about future generations of patients and doctors. We have no choice other than getting involved now.

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CANS MISSION STATEMENT

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

New Hoops to jump through in Work Comp

Randall W. Smith, MD, Editor

The California Division of Workers' Compensation is proposing a revision to the Medical Treatment Utilization Schedule (MTUS) that goes into some detail as to what is approved as treatment for an injured worker. The new proposal continues to embrace the American College of Occupational and Environmental Medicine (ACOEM) guidelines with the Official Disability Guidelines (ODG) of The Work Loss Data Institute as acceptable if the ACOEM guidelines do not apply.

A physician requesting authorization for a diagnostic study or a treatment should choose the recommendation that is supported with the highest level of evidence. If the current versions of ACOEM or ODG are more than five years old (which the ACOEM Guidelines specified in the proposal are having last been published in 2004), or if no applicable recommendation is found, or if the treating physician believes there is another recommendation supported by a higher level of evidence, then the doc can cite other nationally recognized guidelines (e.g. AANS , NASS or others). If the requesting doc feels that no guidelines appropriately cover the patient's situation or if he/she feels that higher levels of evidence supporting the recommendation exist, the doc may search for current studies, five years old or less that are scientifically based, peer-reviewed, and published in journals that are nationally recognized by the medical community to find recommendations applicable to the injured worker's specific medical condition. In citing these articles, the doc needs to follow a detailed strength of evidence methodology (Evidense Based Medicine) listed in the proposed revision.

It would seem that the busy neurosurgeon should make every effort to find justification for a proposed study or treatment in the ACOEM or ODG guidelines which, although theoretically capable of being trumped by AANS or NASS guidelines, are generally felt to be presumed correct. If the treating docs request based upon the above guidelines is denied by Utilization Review, then a Medline search for applicable articles can be carried out, and the studies supporting the docs's recommendation then ranked by level of evidence rules and the issue further pursued via the UR appeal process. If that doesn't work, the the Independent Medical Review Process can be initiated by the patient's attorney.

As an example, both the ACOEM and ODG guidelines are pretty iffy about allowing a L5-S1 fusion for a degenerated disc without instability causing axial low back pain only while the NASS guidelines do feel it is OK as long as there are end plate modic changes, a one year history of good but failed conservative treatment, no psych issues or more than minor degeneration at the other lumbar levels and no smoking.

Presuming the revised MTUS is adopted as proposed, getting an OK to do a discectomy for radiculopathy or a fusion for spondylolithesis should be a relative slam dunk while pushing for a 2-level fusion for dark discs causing only axial back pain will be a real battle. ❖

Transitions in Neurosurgery

Jack Bonner, MD, Associate Editor

Individuals enrolled in Covered California are discovering that few physicians will provide care for them due to the low reimbursement rates that Obamacare provides. A case publicized in the San Joaquin Valley is that of a woman who allegedly required surgical repair for a cut tendon in her hand. This woman, who enrolled in Covered California, reportedly telephoned over 40 physicians that were listed in her provider network -- only to find that none accepted her Covered California medical insurance. The reason: according to Anthem Blue Cross, doctors feel they are not properly reimbursed by Covered California for the care they provide. This sad situation also occurred for another local Fresno area woman who became pregnant in November but, with Covered California, was unable to obtain an obstetrician until March, some five months into her pregnancy. (KMJ580 News, ABC 30 Action News). These are but two examples, yet they are indicative of a wider problem. As physicians, we all desire to provide care to those who need it, but if reimbursement will not cover expenses, physicians will be unable to provide the requisite care to those enrolled in Covered California. Until adequate reimbursement is provided, I doubt that significant improvement in patient access to care will occur. Consequently, the Obama Administration's stated objective in implementing the Affordable Care Act – namely, increasing medical care access -- has resulted, paradoxically, in the loss of care to many.

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A recent IRS ruling has prohibited employers from moving health costs to the government by directing employees to Obamacare health exchanges while providing employees with help with premiums. The Obama Administration has indicated that this practice violates the law and that employers could be fined $100 per day ($365,000 per year) for each employee who gets insurance in the individual exchanges. This IRS ruling clarifies, according to the Obama Administration, that employers may not shift the cost to taxpayers of providing health insurance for employees. ❖

DO YOU KNOW A NEUROSURGEON NEW TO CALIFORNIA?

TELL THEM ABOUT CANS AND DIRECT THEM TO THE CANS WEBSITE: WWW.CANS1.ORG! THERE IS A MEMBERSHIP APPLICATION ON THE SITE!

Brain Waves

Deborah Henry, MD, Associate Editor

Just last month, a pediatrician, the clinic director, and the director's father were shot and killed at the Cure International Hospital in Kabul, Afghanistan by the security guard hired to protect them. Last year, an urologist was shot and killed in his office by a presumed patient at Newport Beach. In 2003 another urologist was shot by a patient at his office at Kaiser Permanente in Baldwin Park (California) and survived. The year before my residency, a neurosurgeon was shot and killed at his home by a begrudged chronic pain patient. In November, an ob-gyn doctor was killed at his home by a man he had delivered 30 years earlier. Finally, on this Memorial Day weekend, a cardiologist from Ohio was shot and killed by militants in Pakistan where he had traveled to help treat patients at Tahir Heart Institute. The list goes on and on of doctors, both soldiers and civilians, young and old, killed in their line of duty.

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Memorial Day, the day to honor our fallen veterans, officially started as Decoration Day on May 5, 1866 in Waterloo, New York, a tiny town located on Hwy 20 only 45 miles from where I did my residency in Syracuse. This small town closed its businesses while residents decorated gravesites with flowers and flags. Two years later, General John A. Logan of the Grand Army of the Republic declared May 30th to be the annual Day of Decoration as it did not represent any particular battle day, and it was thought that flowers would be readily available throughout the nation in order to decorate the gravestones of those lost in the Civil War. After the soldiers lost in World War I, the day turned to honor all fallen Americans of war. The day was officially named Memorial Day in 1967 and in the Uniform Monday Holiday Act of 1968, the day was moved to the last Monday of May.

I have had the honor to work with many armed forces neurosurgeons throughout my time doing locum tenens. I wish now that I had taken the time to learn about their experiences in Afghanistan and Iraq. In December 2000, the Congress passed the National Moment of Remembrance Act. This act encourages Americans to pause at 3PM on Memorial Day for a minute of silence in order to remember and honor those who have died in the service of our nation. From now on, I will utilize that time to also remember our fellow physicians and health care providers who have also fallen while in the service of others. ❖

CANS NEEDS SOME HELP!

Ken Blumenfeld, MD CANS Treasurer, is also the Chairman of the CMA Council on Legislation (COL). Ken was a longtime member of the council representing CANS but as Chair, can no longer represent CANS. Ken is looking for an interested CANS member to join him on the Council. The CMA COL formulates policy recommendations to the Board of Trustees regarding sponsored legislation or positions on anticipated major legislation affecting physicians. The council generally meets twice a year in person, with telephone conference calls, as needed, to address amended legislation. All council members must be CMA members.

Contact Ken at **kennethblumenfeld@mac.com** if you are interested in serving.

Tidbits from the Editor

Opting Out of Blue Cross Exchange Network

The California Medical Association has issued the following alert regarding Anthem Blue Cross and their impending contract revisions:

Physicians who do not want to participate in Anthem Blue Cross's individual/exchange network have until June 30, 2014, to opt out.

Anthem Blue Cross recently notified over 11,000 practices that are currently participating in its individual/exchange network of a contract addendum that will become effective July 1, 2014. The amendment only applies to physicians who are currently participating in the Anthem Blue Cross individual/exchange network.

According to the notice, which was mailed on March 31, the addendum contains new regulatory requirements. While many provisions are requirements of Covered California, the California Medical Association (CMA) has concerns with certain provisions that appear to be beyond the scope of regulatory requirements.

One provision of significant concern is language in section 12 that removes a participating physician's ability to opt out of the individual/exchange product without affecting the underlying Prudent Buyer contract, as is allowed currently. Effective July 1, the only option for physicians who wish to opt out of the individual/exchange product is to terminate the underlying Prudent Buyer PPO agreement.

Physicians do have the right to opt out of the Anthem exchange product without affecting the underlying Prudent Buyer PPO contract if Anthem receives notice before the effective date of the addendum, July 1, 2014. The notice must be received by Anthem by June 30.
If you do not wish to participate in the individual/exchange product, you can opt out by providing 90 days written notice, which should be sent via certified mail with return receipt, to: Anthem Blue Cross Prudent Buyer Plan Contract Processing, Attn: Individual/Exchange Contract Processing, Mail Station 8A, P.O. Box 4330, Woodland Hills, CA, 91365-4330

Please cc CMA on any opt-out notices submitted to Anthem at California Medical Association, Center for Economic Services, 1201 J Street, STE 200, Sacramento, CA 95814. For more information on the Anthem exchange addendum, go to http://www.cmanet.org/news.

Doc as politicians

Some interesting folks are running for public office—they are doctors. Drs. Richard Pan and Vito Imbasciani are running for California state Senate seats. Dr. Imbasciani, a urologist with 28 years' service as an officer of the U.S. Army Medical Corps and currently with the Southern California Permanente Medical Group, is running for California State Senate, District 26 (Hollywood to Torrance). Dr. Pan, a pediatrician and former UC Davis educator, was elected to the state Assembly in 2010 and now is vying for the state's 6th District Senate seat (Sacramento).

Dr. Vanila Singh, a Stanford anesthesiologist, is vying for the 17th Congressional District (Silicon Valley; 50% Asian) seat in the US House of Representatives. Republican Singh is running against incumbent Democrat Mike Honda and another Democratic challenger Ro Khanna.

Of more neurosurgical interest, Monica Wehby, a pediatric neurosurgeon from Portland, is shooting for one of Oregon's United States Senate seats. She just defeated all comers in the GOP primary and will tackle Oregon's first term Democratic Senator Jeff Merkley's attempt at re-election. Polls show her to be a very viable candidate in the overwhelmingly Democratic Pacific Northwest state. Monica is a moderate Republican whose primary mantra is: Keep your doctor—change your Senator. She could use some bucks (http://www.monicafororegon.com/donate/).

PA Rules up for Modification

The Medical Board of California is proposing to modify the Physician's Assistant regulations as follows (deleted words indicated by ~~strikeout~~; added words underlined):

(1) Perform surgical procedures without the personal presence of the supervising physician which are customarily performed under local anesthesia. Prior to delegating any such surgical procedures, the supervising physician shall review documentation which indicates that the physician assistant is trained to perform the surgical procedures. All other surgical procedures requiring other forms of anesthesia may be performed by a physician assistant only in the personal presence of ~~an approved~~ supervising physician.

(2) A physician assistant may also act as first or second assistant in surgery under the supervision of an ~~approved~~ supervising physician. The physician assistant may so act without the personal presence of the supervising physician if the supervising physician is immediately available to the physician assistant. "Immediately available" means **the physician is physically accessible and** able to return to the patient. without **any** delay, upon the request of the physician assistant ~~or~~ to address any situation requiring the supervising physician's services.

One can interpret these changes as clarifying that the physician has to be an official supervising physician(s) and not some "approved" category and that "immediately available" means same building or maybe as much as just across the street but probably does not mean away at a more distant location or on the way to the golf course. Hopefully the MBC might clarify the term a bit further if this modified regulation is adopted. ❖

Thought for the Month

"Hard work never killed anybody, but why take a chance?"
(Edgar Bergen)

Meetings of Interest for the next 12 months:

Nsurg. Soc. of Amer: Ann. Mt., June 8-11, 2014, St.Andrews-by-the Sea, New Brunswk, Canada
Rocky Mountain Neurosurgical Society: Ann. Meeting, June 14-18, 2014, Victoria, B.C., Canada
New England Neurosurgical Society: Annual Meeting, June 26-28, 2014, Brewster, MA
Western Neurosurgical Society: Annual Meeting, August 16-19, 2014, Sun Valley, ID
CSNS Meeting, October 17-18, 2014, Boston, MA
Congress of Neurological Surgeons: Annual Meeting, October 18 - 22, 2014, Boston, MA
North American Spine Society: Annual Meeting, November 12-15, 2014, San Francisco, CA
AANS/CNS Joint Pediatric NS Section: Ann. Meeting, December 2-5, 2014, Amelia Island, FL
Cervical Spine Research Society: Ann. Meet., Dec 4-6, 2014, Hyatt Regency Grand Cypress, Orlando, FL
North American Neuromodulation Society: Ann. meeting, December 11-14, 2014, Las Vegas, NV
CANS Annual Meeting, January 16 – 18, 2015, Balboa Bay Resort, Newport Beach, CA
AANS/CNS Joint Cerebrovascular Section: Annual Meeting, 2015, TBA
Southern Neurosurgical Society: Annual Meeting, 2015, TBA
AANS/CNS Joint Spine Section: Annual Meeting, March 4-7, 2015, Phoenix, AZ
CSNS Meeting, May 1-2, 2015, Washington, DC
AANS/CNS Joint Pain Section Bi-Annual Meeting, May 1, 2015, Washington, DC
AANS: Annual Meeting, May 2-6, 2015, Washington, DC

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. Deborah Henry 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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