CANS newsletter

MD and DO Training Moving Closer to Each Other

Randall W. Smith, MD, Editor

The American Osteopathic Association (AOA) and the American Association of Colleges of Osteopathic Medicine (AACOM) now are members of the Accreditation Council for Graduate Medical Education (ACGME). Eventually, the partnership will lead to a system in which graduates of allopathic and osteopathic schools will complete their residency or fellowship in ACGME-accredited programs and demonstrate achievement of common competencies. Currently, the ACGME and AOA maintain separate accreditation systems for all allopathic and osteopathic programs.

About 22 percent of medical students attend an osteopathic medical school, pointing to a fast-growing health care segment. This past fall, new enrollment at DO schools increased 5.2 percent over new enrollment in 2013, with nearly 6,800 students beginning their medical education at one of 30 DO-granting medical schools, according to the American Association of Colleges of Osteopathic Medicine. Total enrollment at osteopathic schools is more than 24,000, an increase of 6.7 percent over the fall 2013 total.

The accreditation system merger is now underway. As of Jan. 1, 2015 the accreditation systems for allopathic and osteopathic graduate medical education (GME) programs are partners, driving forward the implementation of a single accreditation system for all GME programs in the country. The move is another significant milestone on the path to creating an ideal medical education continuum.

Beginning July 1, AOA-accredited programs will launch a five-year transition to ACGME accreditation. ACGME standards will be added to Osteopathic standards to define osteopathic programs, and MDs and DOs will be eligible for all residencies, meaning graduates will be able to transfer from one accredited program to another without being required to repeat education. Each AOA program, like all allopathic programs, will have to apply for ACGME accreditation. Once that accreditation is achieved, the AOA program's graduates will be eligible to take the ABNS board exam if they have completed all or most of their training following their program's ACGME approval.

(Please read the guest editorial by Javed Siddiqi, MD included in this newsletter.—Ed.) ❖

INSIDE THIS ISSUE:

Guest Editorial

Osteopathic Neurosurgery Residency Programs in California

Graduate medical education (GME) in the USA is currently organized within two parallel processes under the aegis of the Accreditation Council for Graduate Medical Education (ACGME, which accredits approximately 10,000 Residency Programs) and the American Osteopathic Association (AOA, which accredits approximately 1,000 Residency Programs). With the impending Single Accreditation System, the ACGME and AOA are going to unify their programs and ALL GME within the USA will be under one umbrella--the transformation of AOA residencies to ACGME status will start on 7/1/15, and finish by 6/30/2020. Traditionally, 60% of Osteopathic Medical School graduates have gone on to residency training within ACGME-accredited residency programs; however, hitherto no MD's were allowed to participate in the AOA-accredited residency programs. The Single Accreditation System will end the parallel accreditation systems and create one graduate medical education system, into which both MD's and DO's will have access, based solely on merit. While the training of medical schools in allopathic (MD) medical schools and osteopathic medical schools (DO) will continue unchanged, multiple downstream consequences for board certification and professional society participation may be anticipated from the Single Accreditation System. For example, while accepting foreign neurosurgeons, the AANS and CNS have not permitted AOA trained neurosurgeons (or even AOA neurosurgery residents) to apply for membership, thus indirectly excluding them from the benefits of mainstream neurosurgery in the USA (and forcing them to establish parallel professional organizations to represent their interests).

While there are two osteopathic medical schools in California--the College of Osteopathic Medicine of the Pacific (COMP), and Tuoro University College of Osteopathic Medicine (Tuoro California), the formal training of DO neurosurgeons in California started in 2000 when I founded the first AOA-accredited Neurosurgery Residency Program at Arrowhead Regional Medical Center (ARMC). Since its founding, the ARMC Neurosurgery Program has grown to be the largest of ten neurosurgery training programs in California (and the only one with an osteopathic focus). One hundred percent of Graduates from ARMC Neurosurgery Residency have continued to fellowship training in California and across the USA, at named institutions such as Johns Hopkins, Mayo Clinic, University of Miami, UC Davis, Oregon Health Sciences University, etc. In January 2015, a second AOA-accredited Neurosurgery Residency Program was approved at Palm Springs, California, at Desert Regional Medical Center (a Tenet facility)--I was involved as the founder of the new Desert neurosurgery program as well, and in anticipation of an accreditation approval in 2015, I resigned my position as Program Director of the ARMC Neurosurgery Program. As a new, distinct, and free-standing neurosurgery residency program, DRMC will be accepting PGY1 residents for July 2015 start in a seven year training program. I am personally very excited about the prospect of developing the DRMC neurosurgery program into another outstanding training program in California, and the eleventh neurosurgery residency program to participate in CANS activities in the future. As the only neurosurgeon to have founded two (AOA or ACGME) neurosurgery residency programs, I feel especially privileged to undertake the heavy responsibility associated with this historic honor.

Javed Siddiqi, MD; Riverside
[Dr. Siddiqi is the only MD ever to receive the AOA Presidential Citation (2014) and the Presidential Citation from the American College of Osteopathic Surgeons (2005).—Ed.]

In Memoriam

CANS has just learned that long time member **Winston Ekren** passed last September 5th. Like so many CANS members he consistently maintained membership and was one of what we might call the silent service—solid supporting members who listen but are rarely heard from. He joined CANS in 1975 soon after it was born and steadfastly remained a member until his death, the last 15 years as a senior member even though he was retired. Dr. Ekren was born in Kensal, North Dakota on February 19, 1926. He attended the University of North Dakota, served in the U.S. Navy during World War II and returned to complete his Doctor of Medicine at the University of Illinois in 1952. Dr. Ekren began his medical career as a general practitioner in Moab, Utah. After seven years, he decided to specialize in neurosurgery and returned to school at the University of Virginia for his neurosurgical training. He began private practice as a neurosurgeon in Santa Rosa, California in 1966 and retired in 1999. He was able to enjoy his retirement years with skiing, kite flying, golf and classical music. He is survived by his wife Louann, his brother Einar, five children and 7 grandkids. ❖

Guest Editorial

Eliminating the Global Fee

CMS is planning to change the rules. And they didn't bother to check with us. I am sure this comes as no surprise to anyone. What may be surprising is what they want to change.

CMS plans to eliminate the 10 and 90 days global payment system that we've used for years. Most neurosurgical procedures have 90 days follow-up included in the global fee.

Their reason is: there are a lot of variations in the way surgeons manage their patients post-operatively; some see them frequently, some hardly at all. So in CMS' view the surgeons that don't see their patients frequently are overpaid. I am sure that it did not cross the bureaucratic minds at CMS that those surgeons who see their patients frequently after surgery are in fact underpaid.

So in its infinite wisdom CMS plans to phase out the global fee system- eliminating in the 10-day global period in 2017 and the 90-day global period in 2018.

What's wrong with this? And why should we oppose it?

- CMS will in all likelihood divide the global fee into two components, a fee that covers the procedure/surgery and a fee(s), much like E/M codes, that will cover any "medically necessary" post-operative and follow up care. It is clear, since the intention is to cut cost, that they will undervalue the surgery component.
- Speaking of "medically necessary", we can be sure that CMS will increase their post-payments audits; the audit police will show up at the doors of more surgeons.

- Current practice expense and professional liability insurance values are tied to higher global work values. When reconfigured, this higher value may still be considered even though surgeons will be reimbursed for their follow-care at a lower rate.
- The transition from one system to the other is not clearly outlined and will be burdensome; 4200 of the 9900 CPT codes will need to be re-valued. In fact, I understand that the bureaucrats have no idea how to go about implementing the change, which will result in an additional 63 million claims for Medicare alone.
- This change is intended only for Medicare patients. What will happen to third-party payers? Some have said they have no intention of adopting this policy, so surgeons may have to use two separate fee schedules.
- Physicians' office staff will be unduly burdened because they will have to bill their patients and CMS for each encounter using E/M methodology as opposed to one bill for the entire global surgery period.
- Patients will be unhappy because they will be receiving many more bills and because they know that every time they see their surgeon they are charged and will have to pay their hated copay. Life is "simpler" now since they get one bill only for the 90-day period of care, after which, most of them don't need their surgeons any longer.
- This will undoubtedly have some medico-legal implications. Let's face it: patients will not have free access to their surgeons and may hesitate to make an appointment, for which they have to pay. A small problem, ignored because of the hesitance to call the surgeon, may escalate leading to a complication that opens the door to a malpractice claim. We know that most claims are generated because of poor communication. The proposed system discourages ongoing communication between patients and their surgeons.
- And finally, this goes against the present trend: bundling. When it comes to every other aspect of compensation for medical services CMS is planning to bundle payments, which is another story for another day.

So why are they planning to change the global fee for surgeons? Obviously to cut down on our compensation without admitting it!

Moustapha Abou-Samra, MD; Ventura
CANS Consultant
(with the help of Katie Orrico, JD; AANS-CNS Washington Office) ❖

CANS MISSION STATEMENT

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

Brain Waves

Deborah Henry, MD, Associate Editor

"You don't need another hole in your head," exclaimed my dad as I attempted to persuade him to let me get my ears pierced at the age of 16. Of course I didn't want any holes in my head. Where did this phrase come from anyway?

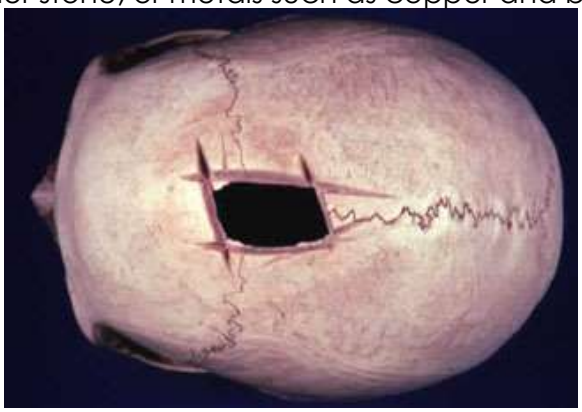
Perhaps it comes from 6500BC when trephination was first practiced. In France, one third of the skulls from an archeological site representing the Neolithic period showed signs of holes in the skull. Trepanning existed in Pre-Columbia Mesoamerica and into central Mexico. Drilling holes in the head occurred also in China as far back as 5000BC. People may have needed a hole in their head to release demons, relieve migraines, stop seizures, and cure mental disorders.

Hippocrates Treatise "On Wounds in the Head" recommended the use of trepanning when treating head injuries. The only head injury that was not advocated for trephination was a depressed skull fracture. Trephination was thought to help heal individuals by allowing their blood to pour out of the skull and not become stagnant.

By the time the Renaissance rolled around, trephining was used fairly frequently for head injuries especially depressed skull fractures and penetrating head wounds. Until the 1800s, trephination was done in the comfort of one's own home. In the 19th century, drilling holes in the head became hospital based, but with little success for any cure and with a high death rate, it became quickly unpopular.

The word trepan comes from the Old French meaning to "bore" and bore comes from the early German word "buron" which perhaps gives us the term burr holes. Trepanation is the older form of the word. Trephination referred initially to the type of saw used, but today, the terms are interchangeable.

Trephination historically took on many different shapes-often quadrilateral, sometimes circular, and sometimes a scrapping of bone until the dura was reached. The bone removed may have been worn around the neck as an amulet. The first blades were made of obsidian or other stone, or metals such as copper and bronze.



Straight-cutting example of trephination

From the Cyber museum of Neurosurgery
http://www.neurosurgery.org/cybermuseum

Trephination continues today in Africa primarily as a treatment for headaches. Self-trepanation began its public journey around 1960 with an individual boring a hole in his head with a dental drill in order to increase brain blood volume and perhaps encourage enlightenment. And yes, there is a web site dedicated to drilling holes in your own head.

I think I will stick with those two holes in my earlobes. ❖

Transitions in Neurosurgery

John Bonner, MD, Associate Editor

As we know, there has been much interest about the danger of being involved in athletics, especially for children. Of course, none of us want injuries to occur, but an opinion editorial by two neurosurgeons points out the dangers of being, perhaps, too risk adverse when it comes to childhood contact sports.

Recently, an article was published by Joseph Maroon, M.D. (team neurosurgeon for the Pittsburgh Steelers) and Julian Bailes, M.D. (neurosurgical consultant to the NFL Players' Association), which offers a different perspective on contact athletics for children. In the article ("Weighing the childhood risks of contact sports", *Washington Times,* January 29, 2015), Drs. Maroon and Bailes opined that "staying on the sidelines carries far more health danger than getting into the game." Maroon and Bailes stated that they believe, based on available medical data, that "the benefits of organized contact sports on childhood and adolescent development far outweigh the risks." Organized sports, according to Maroon and Bailes, provide "invaluable contributions to character development and future success of children by teaching [children] teamwork, discipline, self-control and triumph over adversity." Additionally, Maroon and Bailes note that such sports are a "bulwark against the very real health risks associated with childhood obesity such as diabetes, hypertension and cardiac disease."

Perhaps more to the point, Maroon and Bailes describe the concern about concussions in children playing sports as "near hysteria." The article provides statistics to back up these doctors' argument (finding, for example, that the medical literature on Chronic Traumatic Encephalopathy shows that, in the past 10 years, 63 football players, out of some 44 million players, were diagnosed with CTE – and almost all of these 63 were professional players). Maroon and Bailes noted that, even among former professional football players, research indicates that they are living as long as their peers, with lower rates of cancer and heart disease. Nonetheless, Maroon and Bailes applaud some of the changes brought about in children's contact athletics by concerned parents (e.g., advances in helmet technology and Immediate Post Athletic Concussion Testing). Maroon and Bailes conclude that they believe in "medical technology advancements, thoughtful rule changes and safety protocols to protect players of all ages", that "increased levels of public and private investment in concussion prevention and management research should be a national priority", and that we, as a nation, should "refocus attention away from fear and toward a more balanced approach, preserving the physical and character development benefits of sports."

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With decreased patient reimbursement and increased patient enrollment in government-provided health care, there is a concern among some physicians of declining income as well as the declining ability to meet expenses. Some hospitals may also have similar concerns. For example, the Daughters of Charity are trying to sell six not-for-profit Catholic hospitals to Prime Healthcare Systems due to the Catholic hospitals' financial problems. I'm sure that other hospitals may also be facing similar financial problems. (Beth Kutscher, "Daughters of Charity sue SEIU for interfering with sale to Prime", *Modern Healthcare.com*, February 25, 2015.) ❖

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!

Tidbits from the Editor

Meaningful Use Criteria Eased

Physicians will have to attest to meeting Stage 2 meaningful use criteria for their electronic health records for 90 days in 2015, officials at the Centers for Medicare and Medicaid Services announced Jan. 29.

Before this announcement, physicians would have had to attest that they met requirements for the entire year or be subject to a Medicare payment reduction. Low attestation numbers for 2015 suggested that many doctors would not be able to meet the full year requirement. Recently, a group of 37 medical societies led by the American Medical Association sent a letter to Health and Human Services...saying the certification program is headed in the wrong direction, and that today's electronic records systems are cumbersome, decrease efficiency and, most importantly, can present safety problems for patients. AMA President-elect Steven Stack, MD, said, "Physicians passionately despise their electronic health records." He added, "We use technology quickly when it works. … Electronic health records don't work right now."

The change, along with a few other program modifications, will be detailed in a proposed rule. "The new rule, expected this spring, would be intended to be responsive to provider concerns about software implementation, information exchange readiness, and other related concerns in 2015," Dr. Patrick Conway, CMS Chief Medical Officer, said.

Open Payments Database

We are informed that the CMS recently updated the information in its Open Payments database. You can check your data by going to: **https://openpaymentsdata.cms.gov/**

CANS at work for its members

On February 11, 2015, John Ratliff, MD and Philipp M. Lippe, MD attended the California Carrier Advisory Committee (CAC) meeting held at the Double Tree Hilton Hotel, SFO, as the representatives for CANS (both are volunteers and receive no compensation from CANS).

Attendance at such meetings is one of the functions of CANS on behalf of its members. The CAC advises Noridian, the Medicare administrator for California. A major focus of these meetings is to review and comment on draft Local Coverage Determinations (LCD) which subsequently are then published for a 90 day comment period before they are finalized. Once adopted, a LCD will rule on issues in California (unlike National Coverage Determinations which apply to Medicare everywhere and cannot be created by Noridian but a Noridian LCD could be adopted as a NCD by Medicare administration in DC).

Most draft LCD's do not pertain to the practice of neurosurgery but some under consideration are for facet rhizotomy and intrathecal infusion pumps for chronic pain about which Dr. Lippe is knowledeable and he will represent CANS in any discussion about those LCD's. CANS has learned that Noridian is working on an LCD for spinal fusion in the Medicare population. That draft LCD was not presented or discussed at the 2/11/2015 CAC meeting but can be anticipated to surface in the future. The next California CAC Meeting will be held in the LA area on June 24, 2015 from 10:00 am – 2:00 pm PT.

For those interested in what Noridian is up to, navigate to the Noridian web site for extensive information including webinars and slide sets. The link is https://med.**noridian**medicare.com then go to Education and Outreach Tab; then explore.

Court of Appeals nixes hospital system buy of doc group

We realize that Idaho is not California, but the across the board willy-nilly purchase of medical practices by hospital systems may have finally crossed the line. A three-judge panel of the Ninth U.S. Circuit Court of Appeals backed a ruling by an Idaho federal judge who had nixed the St. Luke's Health System's 2012 acquisition of Saltzer Medical Group. Both entities are located in the great Boise, Idaho, area and St. Luke's is the only nonprofit health system based in Idaho. Saltzer Medical Group is the largest physician-owned multi-specialty group in the state of Idaho.

The Idaho federal judge ruled the acquisition as anticompetitive and ordered the health system to divest of Saltzer. The appeals court concurred and said that the acquisition could lead to higher prices in the local market. The Federal Trade Commission has been pushing to block healthcare mergers the FTC believes are anticompetitive and FTC Chairwoman Edith Ramirez noted, "The acquisition would have delivered no benefit to consumers that could not be achieved in ways other than the anticompetitive merger."

The Ninth Circuit panel Judge Andrew Hurwitz wrote that mergers to improve service to patients are "a laudable goal, but the Clayton Act does not excuse mergers that lessen competition or create monopolies simply because the merged entity can improve its operation." He said that it was not enough to show that healthcare mergers would allow health systems to better serve patients if the merger creates substantial risk of higher prices.

Concierge Company nailed in malpractice suit

The practice of neurosurgery does not lend itself to the concierge concept but it is of interest that companies that help primary care docs sell the concierge way of practicing may be a bit

less likely to be the entrepreneurial darling they had imagined. Those companies have maintained that they are brokers between the doctor and the patient and, as such, are not responsible for the practice outcomes of their affiliate physicians. A recent $8.5 million med mal decision in Florida would beg to differ.

MDVIP, a concierge medicine practice company, was found liable along with one of its contracted docs for mishandling the diagnosis in a case that led to an amputation. This was the first malpractice verdict against MDVIP and is believed to be the first against any concierge management firm. MDVIP is affiliated with almost 800 physicians in 41 states. The fifteen-year-old company is the nation's largest concierge medicine practice and has enjoyed rapid growth built around offers of exceptional care, quick access to doctors, same-day appointments and more personalized care in exchange for a $1,500 annual membership fee.

Whether or not this verdict in runaway awards, no-MICRA Florida will chill the concierge movement remains to be seen. The 6,000 doctors throughout the U.S. who have moved to concierge style practice in the past 15 years, many with the assistance of concierge companies like MDVIP, should be on alert.

Final WC Conversion Factor for 2015

Last month we reported that the proposed conversion factor (CF) for Work Comp surgery in 2015 would be $48.265/RVU pending some further fine tuning. That fine tuning, which modifies the WC rate because of the annual Medicare CF update which has to be factored in, has been carried out and the final surgery CF to be paid as of March 1st will be $51.6570/RVU. ❖

A special thank you to
Baxter Healthcare!

Observation for the Month:
My kids text me "plz" which is shorter than please. I text back "no" which is shorter than "yes".

Meetings of Interest for the next 12 months:

Southern Neurosurgical Society: Annual Meeting, March 25-28, 2015, Naples, FL
AANS/CNS Joint Spine Section: Annual Meeting, March 4-7, 2015, Phoenix, AZ
Neurosurgical Society of America: Annual Meeting, April 12-15, 2015, Newport Beach, CA
CANS BOD Meeting: Sheraton, LAX, April 18th, 2015, Los Angeles, CA
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
Rocky Mountain Neurosurgical Society: Annual Meet., June 20-24, 2015, Colorado Springs, CO
New England Neurosurgical Society: Annual Meeting, June 25-27, 2015, Chatham, MA
Western Neurosurgical Society: Annual Meeting, September 10-13, 2015, Kauai, HI
California Neurology Society: Annual Meeting, 2015, TBA
CSNS Meeting, September 25-26, 2015, New Orleans, LA
Congress of Neurological Surgeons: Annual Meeting, September 26-30, 2015, New Orleans, LA
North American Spine Society: Annual Meeting, October 26-29, 2015, Boston, MA
AANS/CNS Joint Pediatric NS Section: Ann. Meeting, December 8-11, 2015, Seattle, WA
Cervical Spine Research Society: Annual Meeting, December 3-5, 2015, San Diego, CA
North American Neuromodulation Society: Ann. meeting, December 10–13, 2015, Las Vegas, NV
CANS Annual Meeting, January 15–17, 2016, The Cliffs Resort, Pismo Beach, CA
AANS/CNS Joint Cerebrovascular Section: Annual Meeting, 2016 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, Dr. Deborah Henry and Dr. Phil Lippe 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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