CANS newsletter

CANS Board Meeting April 18, 2015

Randall W. Smith, MD, Editor

The CANS Board Of Directors meeting on April 18th ran rather smoothly under the direction of **CANS President Phil Kissel**. Attendance was good and by: Officers Kissel, Mummaneni, Blumenfeld, Rhoten, Rosario, Henry and Kaczmar; Directors Panchal, Holly, Ratliff, Asgarzadie; Consultants Abou-Samra, Bonner, Colohan, Lippe, Shuer, Vanefsky, Wade, Prolo, Smith and CANS Executive Secretary Emily Schile.

The much discussed meeting of the Long Range Planning Committee is tentatively set for September or October in conjunction with the autumn meeting of the BOD and will be held in Sacramento at the CANS office building conference room. At least a full day will be devoted to LRP and a facilitator will be engaged.

Dr. Kissel outlined his desire to have both state and national legislators play a prominant role in the 2016 CANS Annual Meeting to be held very near San Luis Obispo at the Cliffs Resort overlooking the Pismo Beach/Shell Beach area. The dates for the meeting were adjusted to January 22-24, 2016, a weekend later than usual.

The 2015 Annual Meeting evaluations by the 60 attendees were strongly positive and the 23 exhibitors were instrumental in making the meeting the most profitible one in recent memory.

CANS membership continues to slip downward as each year a number of active members fail to pay dues even after repeated reminders while new member applications are few. Active members now total only 155 almost matched by 144 resident members (California residents are automatically considered members paying no dues but with no vote) and 61 senior members. The Membership Committee has put forth no suggestions to address this problem. The Board approved **Alexa Smith, MD**, a pediatric neurosurgeon working locum tenens at Kaiser for active membership.

The Board reaffirmed its desire to distribute the newsletter to all California neurosurgeons in the hopes that those who are not CANS members might be encouraged to join because of the newsletter's value. The policy of charging $50 to apply for membership which once awarded, is all that needs to be paid for the year in which membership is bestowed followed by only $175 for the first full year as a member and then only having to pay the full active member annual dues of $350 in the second full year of membership was noted.

It was determined that an Errors and Ommissions insurance policy be obtained in addition to the Directors and Officers insurance CANS already has. E&O insurance covers issues not addressed by a D&O policy.

INSIDE THIS ISSUE:

The team of delegates CANS will send to the CSNS meeting May 1-2 in D.C. was appointed by Dr. Kissell with Board concurrence. CANS delegates will be Drs. Abou-Samra, Blumenfeld, Bonner, Henry, Panchal, Ratliff, Vanefsky and Wade. The Board voted to take positions on the 7 resolutions (listed in detail in last month's newsletter which is on the CANS Web site at cans1.org) as follows:
Resolution 1—support; 2—support; 3—neutral; 4—support; 5—oppose; 6—oppose; 7—neutral.

Ruth Haskins, MD, Ob-Gyn from Folsom and Speciality Resesentative to the CMA Board of Trustees, a position for which she fought and won when the CMA planned to eliminate the Specialty Representative slot on the BOT, addressed the CANS Board during lunch. She is running for CMA President and presented her views on the future direction she sees for the CMA particularly as it pertains to specialty organizations. We appreciate her time and efforts in sharing with the BOD despite our limited influence with regards to the election process (CANS has three votes in the 400+ member CMA House of Delegates who elect the CMA President).

The final hour or so of the meeting was spent discussing extensive revisions to our by-laws prepared by the By-Laws committe. Committee chair and CANS President-Elect Praveen Mummaneni and committee members Deborah Henry, Ted Kaczmar and Phil Lippe explained the reasoning behind their suggested changes and got a lot of input from the Board. The final amendments will be chosen by the committee and circulated to active members with appropriate explanations 75 days prior to the 2016 annual meeting. Any suggested changes to the amendments by an active member must be returned to the secretary 45 days prior to the annual meeting. The secretary and the Bylaws Committee will have 2 weeks to incorporate or reject any suggestions. At least thirty (30) days prior to the annual meeting, the final proposed amendments will be mailed to active members of CANS for approval or disapproval. It takes a 2/3 majority of active members voting to approve the amendments. ❖

Position wanted:

Alexa Reeves Smith, MD, is interested in joining a practice in southern California (Ventura on south including the inland empire). Dr. Smith is a graduate of the Med School at the University of Washington and the neurosurgery program at UC Irvine. She recently completed a fellowship in pediatric neurosurgery at UCSD but also would be interested in an adult practice. Michael Levy MD, her mentor at UCSD, happy to provide a reference (mlevy@rchsd.org) as well as CANS consultant Marc Vanefsky, MD (marc.a.vanefsky@kp.org).

Guest Editorial

Physicians Aid-in-Dying

In recent weeks California Senate Bill 128 " End of Life Options Act" authored and introduced by Senators Monning and Wolk in January 2015 passed the Senate Health Committee with a vote of 6-2, with one notable abstention by a Senator Richard Pan who is also a physician, and the Senate Judiciary Committee by a vote of 4-2. Next the bill will be heard in the Senate Appropriations Committee prior to consideration by the full Senate.

Prior bills and ballot measures supporting physician aid in death have failed. But this time the environment is a little different. Driven by heavy media coverage of Brittany Maynard, a 29 year old California resident with glioblastoma who moved to Oregon for the sole purpose of taking advantage of a "Death with Dignity" law; physician assisted death is again front and center for public comment. Five states, Oregon-Washington-Montana-Vermont-New Mexico, currently allow physicians to aid dying patients. Of these states three have laws and two court precedence. With that said, at least 25 states have introduced similar legislation this year.

So when Brittany Maynard's video testimony was presented posthumously at the first Senate committee hearing the atmosphere was very emotional and charged. Maynard's recording included statements that could only have been intended for such an occasion: "I moved to Oregon with my family from California because it is one of only five states that do authorize the patient a right to do a choice with death with dignity. The decision about how I end my dying process should be up to me and my family, under a doctor's care. How dare the government make decisions or limit options for terminally ill people like me."

With the stage set and public interest growing there appears to be increasing acceptance if not support for the concept of physicians-aid-in-dying. Although formally a legislative process, a ballot like campaign has evolved with the group in favor of the bill retaining three Sacramento lobbying firms and the opposition establishing a coalition called Californians Against Assisted Suicide, which includes medical groups, religious organizations and advocates for people with disabilities. A strong fight can be anticipated.

So where is the California Medical Association? Traditionally CMA policy has been strongly opposed to physicians aiding in death. However their position is changing. At a recent CMA board of trustees meeting reports were heard from the Council on Ethical Affairs, Council of Legislation, and in house legal staff. Testimony from the trustees, CMA survey results, and extensive comments from the House of Delegates web board were also considered. In the end existing CMA policy on "physician-aid-in-dying" was sunsetted and a position of "oppose unless amended" taken on SB 128. This position is couched on the premise that the bill has technical issues that if amended by the authors would allow CMA to move to a neutral position

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The changes CMA wants made are:

1) Immunity for all acts or omissions associated with the physician's aid in dying.
2) Distinguishing the capacity for decision making as opposed to competency.
3) Independent mental illness and/or capacity assessment.
4) Medically correct cause of death on death certificate.
5) Diversion of lethal controlled substances.
6) Elimination of potential influence or coercion by third parties.
7) Protections for physicians so that they cannot be forced to participate in PAD.
8) Removal of the term "medication".

It is our understanding that Senators Wolk and Monning have already agreed in principle to take all of CMA's amendments so we think it unlikely that CMA will take an oppose position unless something unforeseen happens.

Moustapha Abou-Samra, MD; CMA Council on Ethics 2009-2014; past CANS President
Ken Blumenfeld, MD; Chair of CMA Council on Legislation; CANS 2nd Vice-President

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

Variety is the very spice of life,
That gives it all its flavor
From *The Task,* William Cowper*, 1785*

Diversity is the buzz-word of the dawning of the 21st century. And it is about time. In 1952, women made up 5% of medical school graduates; in 2011, it was 48%. They now make up 6.5% of the practicing neurological surgeons and over 12% of the residents and fellows.

However when looking at race, diversity is hardly the word. The percentage of African American men *applicants* in 2011 was only 2.5% compared with 9% for Asian and 11% for Hispanic males. Two times as many African American women apply and are accepted into medical school than their male counterparts. The number of black male graduates declined from 2.6% in 2002 to 2.4% in 2011. African Americans account for 13% of the US population yet less than half as much (6%) are enrolled in medical school and less than 3% of the practicing physicians are black men. However this disparity starts long before medical school. Like medical school applicants, only 3% of black males earn undergraduate degrees and 2/3 of the black students that earn degrees are female.

Female African American neurosurgeons make up less than five percent of the approximately 285 practicing female neurosurgeons. The number of practicing male African American neurosurgeons is quite elusive and this number is likely far less than 1% of the 4000 actively practicing male neurosurgeons, not the 260 needed to be representative of the population.

Our increasingly colorful population means that the white population will be in a minority by 2050. The National Institute of Neurological Disorders and Stroke (NINDS) have, as of April 21st, at least five grants or awards based on promoting diversity. Role models, mentors, less expensive education, loan forgiveness, and a pathway to medicine, and jobs are all needed in order to increase diversity.

With women in neurosurgery, we have come a long way from my medical school days when the common sentiment I heard while interviewing for residency was "women did not belong in neurosurgery", that "we had to see how our token female resident did before we would accept another", that "we will never take another women resident", and that we are afraid that" if you marry, you will quit the program". We still have far to go. Women physicians earn

70% of their male colleagues. When accounting for multiple variables, women are still earning at least 12% less than their male colleagues (Gender differences in compensation in academic medicine: the results from four neurological specialties within the University of California Healthcare System; Michael T. Henderson et al, July 2014, *Scientometrics*).

But there is one thing about achieving diversity that I will miss. At neurosurgical meetings, I never had to wait in line at the bathroom. C'est la vie. I will celebrate the day when the women's lines are as long as the men's. ❖

Transitions in Neurosurgery

John Bonner, MD, Associate Editor

The AANS (American Association of Neurological Surgeons) is having their annual meeting this May in Washington, DC. This is a meeting that I only occasionally attend, but I am going to the meeting this year as the status of medicine is so uncertain, mainly with Obamacare issues. The future of physician income and patient care are particularly uncertain with the onset of the Affordable Care Act.

The Supreme Court recently heard oral argument in a challenge to the Affordable Care Act. Specifically, several states argue that the ACA only provides for tax credits to offset the cost of health insurance for those who purchase their insurance in states that have set up state-run exchanges (as opposed to those who purchase insurance directly through the federal Healthcare.gov website). Currently, only 13 states (including California) have set up state run exchanges; the vast majority of states do not have their own exchanges. Consequently, as the *Wall Street Journal* has reported (March 6, 2015, p. A3) , "[s]upporters and opponents of the law [ACA], say a Supreme Court decision invalidating the tax credits – along with the penalties for going without insurance – would cause widespread problems for insurers and more than six million people who already have the credits for 2015."

If the Supreme Court were to invalidate the tax credits, the ruling would ordinarily come into effect 25 days after the opinion (expected in June, 2015). (*Ibid*.) Obviously, states would be hard pressed to set up an exchange in 25 days. (*Ibid*.) However, Supreme Court Justice Samuel Alito has offered a solution to this potential problem. Justice Alito has questioned whether "it wouldn't be possible to stay the mandate until the end of this tax year." (*Ibid*.) Indeed, a ruling invalidating the tax credits would affect the lives of many people, and the Wall Street Journal notes that the Justices may find that "an extraordinary situation calls for an extraordinary remedy." (*Ibid*.)

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The *Helena Independent Record* (March 17, 2015, p. A5) reported that more than 16 million American adults were estimated to have acquired health insurance since the Affordable Care Act was implemented some five years ago (although precise numbers for each state are not yet available). According to the Obama Administration, the percentage of the 199 million American adults aged 18-64 without health insurance has fallen from 20% to 13%, so about 26.3 million adults in that age group still have no health insurance. (*Ibid*.) Nonetheless, a large number may be attracted to buy policies on the marketplace because of the subsidies currently allowed to offset the cost. A large number of applicants may also be just renewing or replacing prior policies.
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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

Some Relief From those Work Comp UR Denials

One of the joys of caring for Work Comp patients is the all too frequent denial of ongoing benefits that have been operational for some time and inexplicably become "unnecessary". The situation of a post-op patient's having their pain meds or PT suddenly denied by Utilization Review while the patient is in the midst of recovery comes to mind.

California State Senator Richard Pan, D-Sacramento (an MD) has authored Senate Bill 563 which is sponsored by the California Medical Association and which would establish that utilization review is prohibited for:

1. Treatments proposed solely to maintain an injured worker's current health care regimen due to a preexisting industrial injury.
2. Treatment requests already approved on the grounds of medical necessity.
3. Unaltered treatment requests when there has been no change in the injured worker's condition necessitating a corresponding change in care.

CMA made the bill a priority after conducting a survey of its members last year and finding frustration with the medical-review process established through Senate Bill 863, according to a fact sheet from the association. The survey included responses from 231 practices in 35 specialties. Two-thirds reported having trouble getting care authorized for the treatment of injured workers since the implementation of SB 863, while half said that the utilization-review system inappropriately denied medically necessary treatments and tests. Although the Division of Workers' Compensation has ruled that claims administrators can't deny care they previously approved without a corresponding change in the claimant's condition, CMA wants to drive the point home with a statute.

There is also a section of the bill that would require utilization-review companies to disclose the methods they use to compensate physician reviewers. The reason for this section is that some workers' compensation industry stakeholders have expressed concern that UR companies are giving reviewers incentives to deny claims and save payers money.

SB 563 has drawn fire from the California Chamber of Commerce, which has labeled the bill a "job killer." One might feel that if among the jobs killed were those of out-of-state UR docs, so much the better.

Oh! The Feds—How we Love Thee

The Medicare Physician Quality Reporting System (PQRS) is a reporting program that has used a combination of incentive payments and payment reductions to promote reporting of quality information by eligible professionals. PQRS is mandated by federal legislation. The program, which started in 2009, provided an incentive payment up through 2014 to practices with eligible professionals (EPs) who satisfactorily reported data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B fee-for-service (FFS) beneficiaries. The last year to receive an incentive payment was 2014.

Beginning in 2015, using data from 2013, the program will reduce payments to eligible professionals who do not satisfactorily report data on quality measures for covered professional services. The payment penalty for 2015 is 1.5 percent and increases to 2 percent in 2016 and beyond.

PQRS is closely tied to another congressionally enacted program known as the value-based modifier (VM). Successful reporting of PQRS will provide quality data for determining tiering calculations for VM payment incentives or penalties. Those who do not report PQRS or are not successful reporters are subject to both the PQRS and the VM payment reductions.

If you don't have a headache yet, the AMA in an article by Robert Steinbrook,MD, in JAMA's April 17th edition points out that the recent SGR-fix legislation requires that in " . . . 2019, a new incentive payment program, termed the Merit-Based Incentive Payment System, or MIPS, will replace and consolidate 3 existing incentive payment programs: the Physician Quality Reporting System, the value-based payment modifier, and the meaningful use of electronic health records. Payments to individual clinicians would be subject to adjustment depending on whether they participated in MIPS or approved alternative payment mechanisms. Alternative payment mechanisms include accountable care organizations (ACOs), medical homes, bundled-payment arrangements, and other models being evaluated by the CMS Innovation Center. Such models involve a risk of financial loss and a quality measurement component.

Under MIPS, the payment rates in 2019 will be maintained through 2025 but with positive and negative adjustments based on the composite performance score of each eligible physician or other health professional on a 0- to 100-point scale. MIPS will assess performance in 4 categories: quality, resource use, meaningful use of electronic health records, and clinical practice improvement activities. The new incentive payments will be complicated and many of the details remain to be worked out. The adjustments, however, are designed to be offsetting in aggregate so that there would be no effect on overall payments beyond an additional $500 million that would be made available each year from 2019 to 2024 to reward exceptional performance".

Considering this mish-mash, little wonder the older doc is retiring early and the younger docs in private practice are heading for employment by an organization that will deal with this stuff for them.

Neurosurgeons Fail to Make List

Medscape, in their physician compensation report for 2015 (Medscape Physician Compensation Report 2015.) notes that the 10 highest paid specialties are:

- Orthopedics — $421,000
- Cardiology — $376,000
- Gastroenterology — $370,000
- Anesthesiology — $358,000
- Plastic surgery — $354,000
- Radiology — $351,000
- Urology — $344,000
- Dermatology — $339,000
- General surgery — $317,000
- Emergency medicine — $302,000

The survey includes responses from 19,657 physicians across 26 specialties. Apparently not enough neurosurgeons responded to the survey so the 26 specialties omit we poor surgeons of the nervous system.

Becker's Spine Review, however, just published the following 12 statistics on neurosurgeon average salary based on payscale.com data.

1. The salary for neurosurgeons ranges from $99,503 to $718,747.
2. Median reported salary is $355,034.
3. The top 10 percent of neurosurgeons reported salary around $720,000.
4. The bottom 10 percent of neurosurgeons reported salary around $100,000.
5. Bonuses for neurosurgeons were reported at $248.89 to $99,378.
6. Profit sharing for neurosurgeons reached $1,007 to $397,317.
7. Commission for neurosurgeons was at $4,900 to $110,000.
8. Hourly rates for neurosurgeons were $17.62 to $316.02 per hour.
9. Hourly overtime pay reached $438.50.
10. Compensation for entry level neurosurgeons was around $300,000 on average.
11. Neurosurgeons with five to 10 years of experience reported around $400,000.
12. Average compensation for neurosurgeons with 10 to 20 years of experience was over $450,000. ❖

Wise observation for the Month:

If the enemy is in range, so are you-
-Infantry Journal

Meetings of Interest for the next 12 months:

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
AANS/CNS Joint Neurotrauma and Critical Care Section Meeting, June 28, 2015, Santa Fe, NM
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. Meet., December 10–13, 2015, Las Vegas, NV
CANS Annual Meeting, January 22-24, 2016, The Cliffs Resort, Pismo Beach, CA
AANS/CNS Joint Cerebrovascular Section: Annual Meeting, 2016 TBA
Southern Neurosurgical Society: Annual Meeting, 2016, TBA
AANS/CNS Joint Spine Section: Annual Meeting, March 16-19, 2016, Orlando, FL
Neurosurgical Society of America: Annual Meeting, June 19-26, 2016, Dublin, Ireland

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. Phillip Kissel 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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Executive Secretary Emily Schile
emily@cans1.org

This newsletter is published monthly from the Executive Office:

California Association of Neurological Surgeons
5380 Elvas Avenue
Suite 215
Sacramento, CA 95819
Tel 916 457-2267
Fax 916 457-8202
www.cans1.org