CANS newsletter

ICD-10 Implementation Loosened

Randall W. Smith, MD, Editor

The CMS announced that it will be implementing a one-year grace period for transitioning to ICD-10. The **elements of the deal are as follows**:

- For a one year period starting October 1, Medicare claims will not be denied solely on the specificity of the ICD-10 diagnosis codes provided, as long as the physician submitted an ICD-10 code from an appropriate family of codes. In addition, Medicare claims will not be audited based on the specificity of the diagnosis codes as long as they are from the appropriate family of codes. This policy will be followed by Medicare Administrative Contractors and Recovery Audit Contractors.
- To avoid potential problems with mid-year coding changes in CMS quality programs — Physician Quality Reporting System (PQRS), Value-Based Payment Modifier (VBM), or Electronic Health Record/Meaningful Use (MU) — for the 2015 reporting year, physicians using the appropriate family of diagnosis codes will not be penalized if CMS experiences difficulties in accurately calculating quality scores. CMS will continue to monitor implementation and adjust the duration if needed.
- CMS will establish an ICD-10 Ombudsman to help receive and triage physician and provider problems that need to be resolved during the transition.
- CMS will authorize advanced payments if Medicare contractors are unable to process claims within established time limits due to problems with ICD-10 implementation.

The California Department of Workers' Compensation has also adopted the same leniency as the Feds on the bills they receive from this October 1 until 10/1/2016.

An outfit called Coding Leader is offering a 90 minute Webinar on August 19th specifically aimed at neurosurgeons (http://codingleader.com/products/neurosurgery-icd-10). The Webinar costs $200 and for another $50 you get a CD of the Webinar as well. We can't vouch for the quality of this offering but it seems a small price for instructions for you and your office staff.

This is what CMS says about Family of Codes: "Family of codes" is the same as the ICD-10 three-character category. Codes within a category are clinically related and provide differences in capturing specific information on the type of condition. For instance, category H25 (Age-related cataract) contains a number of specific codes that capture information on the type of cataract as well as information on the eye involved. Examples include: H25.031 (Anterior subcapsular polar age-related cataract, right eye), which has six characters; H25.22 (Age-related cataract, morgagnian type, left eye), which has five characters; and H25.9 (Unspecified age-related cataract), which has four characters. One must report a valid code and not a category number. In many instances, the code will require more than 3 characters in order to be valid.

If you are a bit unclear as to what "Family of Codes" as used by CMS really constitutes, it might be good to be accurate from the git-go. Here are some conversions kindly provided by CANS President-Elect Praveen Mummaneni:

ICD-9 721.0 Cervical spondylosis without myelopathy
ICD-10 M47.812 Spondylosis without myelopathy or radiculopathy, cervical region

INSIDE THIS ISSUE:

721.1Cervical spondylosis with myelopathy
M47.12 Other spondylosis with myelopathy, cervical region

721.3 Lumbosacral spondylosis without myelopathy
M47.817 Spondylosis without myelopathy or radiculopathy, lumbosacral region

721.41 Thoracic spondylosis with myelopathy
M47.14 Other spondylosis with myelopathy, thoracic region

721.42 Lumbar spondylosis with myelopathy
M47.16 Other spondylosis with myelopathy, lumbar region

336.9 Unspecified disease of spinal cord
G95.9 Disease of spinal cord, unspecified

721.8 Other allied disorders of spine
M48.9 Spondylopathy, unspecified
722.0 Displacement of cervical intervertebral disc without myelopathy
M50.20 Other cervical disc displacement, unspecified cervical region

722.10 Lumbar intervertebral disc without myelopathy
M51.26 Other intervertebral disc displacement, lumbar region
M51.27 Other intervertebral disc displacement, lumbosacral region

722.4 Degeneration of cervical intervertebral disc
M50.30 Other cervical disc degeneration, unspecified cervical region

722.52 Lumbar or lumbosacral intervertebral disc
M51.36 Other intervertebral disc degeneration, lumbar region
M51.37 Other intervertebral disc degeneration, lumbosacral region

722.71 Intervertebral disc disorder with myelopathy, Cervical region
M50.00 Cervical disc disorder with myelopathy, unspecified cervical region

723.0 Spinal stenosis of cervical region
M48.02 Spinal stenosis, cervical region

723.1 Cervicalgia
M54.2 Cervicalgia

724.02 Lumbar region, without neurogenic claudication
M48.06 Spinal stenosis, lumbar region

724.03 Lumbar region, with neurogenic claudication
M48.06 Spinal stenosis, lumbar region
G95.29 Other cord compression

724.2 Lumbago
M54.5 Low back pain

724.3 Sciatia
M54.30 Sciatica, unspecified side

724.4 Thoracic or lumbosacral neuritis or radiculitis, unspecified M54.14 Radiculopathy, thoracic region
M54.15 Radiculopathy, thoracolumbar region
M54.16 Radiculopathy, lumbar region
M54.17 Radiculopathy, lumbosacral region

724.5 Backache, unspecified
M54.89 Other dorsalgia
M54.9 Dorsalgia, unspecified

724.8 Other symptoms referable to back
M54.08 Panniculitis affecting regions of neck and back, sacral and sacrococcygeal region

733.13 Pathologic fracture of vertebrae
M48.50XA Collapsed vertebra, not elsewhere classified, site unspecified, initial encounter for fracture
M80.08XA Age-related osteoporosis with current pathological fracture, vertebra(e), initial encounter for fracture
M84.48XA Pathological fracture, other site, initial encounter for fracture
M84.68XA Pathological fracture in other disease, other site, initial encounter for fracture

737.10 Kyphosis (acquired) (postural)
M40.00 Postural kyphosis, site unspecified
M40.209 Unspecified kyphosis, site unspecified

737.30 Scoliosis [and kyphoscoliosis], idiopathic
M41.20 Other idiopathic scoliosis, site unspecified

738.4 Acquired spondylolisthesis
M43.00 Spondylolysis, site unspecified
M43.10 Spondylolisthesis, site unspecified

756.12 Spondylolisthesis
Q76.2 Congenital spondylolisthesis

805.01 Cervical, closed, first cervical vertebra
S12.000A Unspecified displaced fracture of first cervical vertebra, initial encounter for closed fracture
S12.001A Unspecified nondisplaced fracture of first cervical vertebra, initial encounter for closed fracture

996.49 Other mechanical complication of other internal orthopedic device, implant, and graft
T84.498A Other mechanical complication of other internal orthopedic devices, implants and grafts, initial encounter

239.2 Neoplasms of unspecified nature; Bone, soft tissue, and skin
D49.2 Neoplasm of unspecified behavior of bone, soft tissue, and skin ❖

CANS to Examine itself in Sacramento

A **Long Range Planning meeting** of the CANS Board of Directors has been scheduled for Saturday evening August 29th and Sunday August 30th at the Embassy Suites hotel in downtown Sacramento. The last LRP meeting was held in 2006. As might be anticipated, topics to be addressed will at least include ongoing operations of the Association and their relevance to the modern practice of neurosurgery in California. If there ever was a time for a CANS member to put his/her 2 cents-worth into the pot—this is it. You are encouraged to email your comments on what CANS is doing right, what it is doing wrong and what it isn't doing to our executive secretary Emily Schile at emily@cans1.org. Rest assured that any comment will be reviewed and discussed at that meeting.❖

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

Making assumptions is one of the deadliest mistakes that we can make as doctors. But assumptions don't just play a part in mistaken diagnoses. I first learned the pitfall of assumptions when early in practice, I walked into the examining room and said to the middle-aged gentleman, " And so this is your daughter?" Already, you know what happened. It was his wife. Immediately, I changed my routine when entering an exam room filled with more than one individual. I first ask, "Who is the patient?" and then have the patient introduce everyone in the room. It is a practice that I wished every physician would adopt.

Countless times I have been at the wrong end of an assumption. It happens a lot when you are in a male-dominated field and your last name just happens to be Henry. If paid for the mistakes, I could fund my retirement plan with the number of times people assumed I was male simply because my last name is Henry. Just last week, I got an email addressing me as Henry as if it were my first name. It's a problem, I am sure, for a lot of us with a last name of the opposite sex or with two "first" names.

When I was a resident and people asked about my profession, I would say that I was a neurosurgeon. Many times those asking would only hear the "neur" part and fill the rest in as "rse" or nurse. Sometimes I tired of this assumption. Once, in residency, I was in the elevator with two young teenagers. They asked what I did, and I said "brain surgeon." It was a much different response than when I said neurosurgeon. They giggled with awe.

I have been at the wrong-end as a patient and a mom many times. Once when my son was about 5, my nanny called to say he was ill. She took him to Kaiser and I met them there. A nurse practitioner opened the door and said to us "Mom and Grandma". My son's nanny, who is 8 months older than me, and I looked at each other and wondered who was the older looking one. We each probably thought it was the other.

Perhaps the worse time someone made an assumption about me was not in medicine but in the line to see Santa Claus. My son, around age seven, made the yearly trek to see Santa Claus. After my son had his picture taken, Santa turned to me and said, "It's nice that Grandma brought him." I must have given him a look to kill. He replied, "You're not Grandma?" I shook my head no. Yes, it's tough when even Santa Claus gets it wrong. ❖

Transitions in Neurosurgery

John Bonner, MD, Associate Editor

It is well known that, under the Affordable Care Act, individuals face a monetary penalty if they do not acquire health insurance. However, less well known is the penalty that small businesses face when they try to help their employees with health costs. According to the Fresno Business Journal, an IRS regulation that went into effect as of July 1, 2015 exacts penalties from those small businesses that choose to help their employees pay for health insurance by providing tax free individual premium assistance or tax free assistance with medical care costs. Such small businesses who try to aid their employees' health care concerns could face monetary penalties of up to $100 per worker per day (up to $36,500 per year). This regulation could cost small businesses over 18 times more than the Obamacare penalty for larger businesses that do not provide health insurance for employees. Consequently, this IRS regulation could mean cost increases for hundreds of thousands of workers employed by small businesses. (Fresno Business Journal, Friday, July 17, 2015.)

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The overall costs of Obamacare are still uncertain. While it is estimated that health care premiums in 2016 will rise approximately 4% in California (Fresno Bee, July 28, 2015), nationwide the costs may rise more significantly. Individual state regulators will begin approving premiums in each state. Insurers must receive regulatory approval for any increase more than 10%, and, in many states, analysts are finding that premiums must be raised over 10%. According to the Wall Street Journal, nearly every state has multiple plans facing more than a 10% increase in health care premiums. Many plans could face up to 30, 40 or even 50% increases in health premiums – an increase that has occurred faster than anticipated and is more costlier to Americans (well over what the Affordable Care Act was advertised to provide). It is understood that consumers will object to such high cost increases, and insurance companies will respond by artificially lowering premiums (and charge taxpayers for their losses). This method will make it difficult to assess costs, and expenses will be hard to control. (Wall Street Journal, July 17, 2015.)

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California health exchanges will be studied this summer. Data to be collected includes insurance company information on prescriptions, doctor visits and hospital stays for every Obamacare patient in California. The focus of the study is to measure the quality of care patients receive and to hold health care insurers and medical care providers (we, the physicians) accountable under the Affordable Care Act. California has signed a five-year, $9.3 million contract with Truven Health Analytics, Inc. of Michigan to conduct the study. Not everyone is happy with this plan and expected results.

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The United States is not the only country lacking adequate physicians. The July 1, 2015 Wall Street Journal notes that many European countries are lacking physicians, especially Germany. According to the WSJ, Germans are not accustomed to foreign physicians, yet nearly 30% of hospital doctors in Germany are foreign. Apparently, many German physicians leave for the US, UK and Switzerland for better pay and less-rigid hospital hierarchies. Germany also faces shortages in other kinds of highly trained workers, such an engineers and information technology specialists. In the US, roughly one-quarter of doctors are foreign nationals, or have trained abroad. Varied physician training is now common in many countries. ❖

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

Surgeon Report Card on Medicare Fusions

On July 13, *ProPublica*, an investigative news organization that has analyzed other aspects of medical practice, posted its Surgeon Scorecard with complication rates for almost 17,000 surgeons at 3575 hospitals. The data are based on Medicare billing records from 2009 to 2013 and they analyzed 8 common procedures including three types of spinal fusion — neck fusion, PLIF and posterior lumbar fusion. They stated that overall complication rates, based on hospital readmissions within 30 days of the surgery and death during the initial stay, ranged from 2% to 4% during the 5-year study period. The database excludes trauma and other high-risk cases more prone to complications as well as procedures performed on patients admitted from a hospital emergency department or some other healthcare facility.

ProPublica noted that not every 30-day readmission counts as a reportable complication. ProPublica confined itself to readmissions that could be "reasonably attributed to complications from surgery," and not some other aspect of care. Such complications include infections, blood clots, uncontrolled bleeding, and misaligned orthopedic devices. The North American Spine Society leadership worked with *ProPublica* to identify appropriate elective procedures, define "complications" and offer ongoing risk-adjustment guidance for the scorecard project. "It is our hope that the data released will help patients ask questions and make informed choices when surgery is required and help physicians and hospitals to identify and offer the highest quality care to patients," said Charles Mick, MD, former NASS president. David Teuscher, MD,

president of the American Academy of Orthopedic Surgeons (AAOS), told *Medscape Medical News* that *ProPublica's* methodology "looks to be appropriate and fair.", but he did wonder if the adjustments to complication rates are granular enough to account for all patient differences. The American College of Surgeons posted a somewhat guarded appraisal of the study, pointing out that an operation is a team experience and questioning how much data is helpful to a patient's decision. The AANS/CNS Washington Committee spokesperson Katie Orricco stated the committee will discuss this topic and will determine an appropriate response. She raised many concerns about the data which she feels are incomplete and misleading to consumers.

ProPublica claims they adjusted the rates to reflect factors such as the age and health of each patient and the overall performance of the surgeon's hospital. The database does not include complication rates for physicians who performed an operation fewer than 20 times.

This writer searched the *ProPublica* database (https://www.propublica.org/--click on Surgeons Scorecard) regarding a number of busy, well thought of San Diego neurosurgeons and none of them had any ranking in the *ProPublica* database since none of them had performed 20 of the fusions on Medicare patients over the 5 years of the database. Plumbing the database for Praveen Mummaneni, CANS President-Elect and co-director of the UCSF Spine Program and Bill Taylor, head of the UCSD Spine Program, also failed to find either of them ranked for the same reason. It would appear that many if not most neurosurgeons are not mining the Medicare crowd for spine fusion cases.

CURES –More Info

All individuals practicing in California who possess both a state regulatory board license authorized to prescribe, dispense, furnish or order controlled substances and a Drug Enforcement Administration Controlled Substance Registration Certificate (DEA Certificate) **must register** to use the Controlled Substance Utilization Review and Evaluation System (CURES) by January 1, 2016. **There is no state mandate to use CURES before prescribing** (although a bill mandating a CURES check before prescribing controlled substances has been introduced in the CA legislature in light of such a mandate having failed in the 2014 general election).

CURES applicants must complete their registration process by submitting an online registration at https://pmp.doj.ca.gov/pmpreg/RegistrationType_input.action# (on-line registration). Additionally, they must submit a notarized application form (available to print immediately after submitting the online registration), along with the validating documents listed at the top of each application form. Having the following documents available will be helpful to completing the registration application: U.S. Government-issued ID, Drug Enforcement Administration (DEA) Registration, State Professional License (i.e., Physician, Pharmacist, Veterinarian, Physician Assistant, Registered Nurse, etc.) The application must be submitted to the Bureau of Criminal Identification & Investigative Services/PDMP, P.O. Box 160447, Sacramento, CA 95816, or electronically in the form of PDF attachments to pmp@doj.ca.gov .

True Private Practice may not be dead after all

A new AMA report looked at both short- and long-term changes in physician practice arrangements using data from the most recent AMA Physician Practice Benchmark Survey. The 2014 survey found that growth in hospital ownership has been slow while most physicians still provide care for patients in small practices.

The number of physicians in small practices with 10 or fewer physicians remained the majority at 60.7 percent. The share of physicians who worked directly for a hospital or in practices that had at least some hospital ownership, meanwhile, increased modestly from 29 percent in 2012 to 32.8 percent in 2014. The share of physicians in solo practice fell from 18.4% in 2012 to 17.1% in 2014 and is down from more than 40% in 1983.

The report noted:

- Younger physicians were more likely than older physicians to be employed. About 59 percent of physicians under the age of 40 were employed, versus 46.0 percent of physicians aged 40-54 and 33.3 percent of physicians 55 and above.
- Nearly one-third of physicians are in practices with more than 10 physicians, including 13.5 percent in practices with more than 50 physicians.
- Multi-specialty practice physicians were more likely than single-specialty practice physicians to report that their practices were hospital owned—44.6 percent compared to 23.0 percent.

It may not be related, but newly minted residency graduates are likely to carry some significant debt, most of which is a carry-over from medical school. According to a *Medscape* survey of 1,745 residents across 24 specialties, some 68% of residents have a considerable amount of medical school debt (exclusive of any other debt): $50,000 or more. Well over one third (37%) of residents have over $200,000 in debt, and over one fifth (22%) have $100,000-$200,000. Another 9% have $50,000-$99,999, and 10% have less than $50,000. A fortunate 22% of residents have no debt. It is understandable that someone who owes >100K might be more attracted to working for others rather than embarking on a private practice.

State Compensation Insurance Fund goes after docs

If you have been living under a rock (or more likely concentrating on taking care of your patients and your practice) you may have missed the goings on between the State Compensation Insurance Fund and Michael R. Drobot who ran a hospital and a device company that SCIF claims defrauded them in the treatment of many work comp patients. Mr. Drobot has pleaded guilty to a number of counts and faces prison time yet to be determined. As part of the action, SCIF has been allowed by the courts to include as defendants in their suit against Drobot a number of persons who they claim aided and abetted the Drobot scheme by cooperating with Drobot to carry out care of patients at the Drobot facility and use his implants in return for payments SCIF says constitute illegal kick-backs. The people added to the defendant list are:

Dr. Jack Akmakjian.
Dr. Gerald Alexander.
Dr. Ian Armstrong.
Chiropractor Michael E. Barri.
Dr. Faustino Bernadett.
Jason Bernard.
Dr. Mitchell G. Cohen.
Dr. Timothy Hunt.
Chiropractor Alan C. Ivar.
Chiropractor Edward Komberg.
Dr. Assad Michael Moheimani.
Dr. Randy Rosen.
Dr. Philip A. Sobol.
Dr. Lokesh S. Tantuwaya.
Dr. Jacob Tauber.

This action by SCIF promises to be a long and drawn out one. Defending the accusations will likely be costly and may well not be covered by med mal insurance. It would appear that SCIF's suit is civil not criminal in nature making a guilty verdict result in a monetary award to SCIF but no incarceration. How the Medical Board of California will react to a guilty verdict is anyone's guess. ❖

Opinion for the Month:

There are only two compelling reasons to be a doctor. Over your career, you'll have a collection of great stories. And you'll know from whom to seek care when you become ill—*from the recently published book "Do No Harm" by John Marsh, a retired British neurosurgeon.*

Meetings of Interest for the next 12 months:

CANS BOD and Long Range Planning meeting, August 20-30, Sacramento, CA
Western Neurosurgical Society: Annual Meeting, September 10-13, 2015, Kauai, HI
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
California Neurology Society: Annual Meeting, November 13-15, 2015, San Francisco, CA
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, March 2-5, 2016, San Antonio, TX
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
CSNS Meeting, April 29-30, 2016, Chicago, IL
AANS/CNS Joint Pain Section Bi-Annual Meeting**, April 29, 2016,** Chicago, IL
AANS: Annual Meeting, April 30-May 4, 2016, Chicago, IL
Rocky Mountain Neurosurgical Society: 2016 Annual Meeting, TBA
New England Neurosurgical Society: 2016 Annual Meeting, TBA
AANS/CNS Joint Neurotrauma and Critical Care Section 2016 Meeting**, TBA**

Any **CANS** member who is looking for a new associate/partner/PA/NP or who is looking for a position (all California neurosurgery residents are CANS members and get this newsletter) is free to submit a 150 word summary of a position available or of one's qualifications for a two month posting in this newsletter. Submit your text to the CANS office by E-mail (emily@cans1.org) or fax (916-457-8202)—Ed. ❖

The assistance of Emily Schile and Dr. 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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