# CALIFORNIA ASSOCIATION OF NEUROLOGICAL SURGEONS, INC. NEWSLETTER

APRIL, 1984 VOL. X, NO. 4


## PRESIDENT'S MESSAGE

David G. Scheetz, M.D.

Webster's Dictionary defines an association as a partnership and it is my hope as the current president of CANS that you will join me in continuing to make this partnership work.

It is a venture that time and dedication can make productive for both you as practicing neurosurgeons and the organization.

Our organization provides us with limitless resources to implement and expand the goals of past years. You, the members of CANS, represent the vital source of fresh ideas and energy. These talents are necessary if we are to begin new projects and confront critical issues wisely. The real 1984 has arrived, unlike George Orwell's prophecy, the future looks good because we *choose* it to be and are willing to work toward that end.

With this mind, I solicit your input, I applaud your interest and concern. Here's to us in 1984!

## ANNUAL SESSION REVIEW

The 1984 Annual Session was considered successful by doctors and their spouses attending the meeting at the Newport Beach Marriott Hotel and Tennis Club. The social program began with the welcoming cocktail party on Friday, March 9, and the program sessions began promptly at 8:00 A.M. on Saturday. The Business Meeting provided the election of officers, CSNS/JSEC and CMA House of Delegates delegates and alternate delegates. Five candidates were voted in to CANS active membership. A string quartet complimented the banquet on Saturday evening which was a pleasant event shared by all. The program sessions continued on Sunday morning. The meeting was adjourned on Sunday, March 11, at 12:00 Noon.

## ELECTIONS

**The 1984-85 Officers are:**

| | |
|---|---|
| President | David G. Scheetz, M.D. |
| President Elect | George Ablin, M.D. |
| First Vice President | Frank P. Smith, M.D. |
| Second Vice President | Bert G. Leigh, M.D. |
| Secretary | N. Edalatpour, M.D. |
| Director - Northern Cal. | Paul D. Forrest, M.D. |
| Director - Southern Cal. | Morris D. Loffman, M.D. |
| Consultant | Philipp M. Lippe, M.D. |
| Historian | Brvon C. Pevehouse. M.D. |

## NEW ACTIVE MEMBERS

| | |
|---|---|
| Sidney W. Gross, M.D. | Santa Monica |
| James Henry Mahnke, M.D. | Orange |
| V. Roy Smith, M.D. | Fresno |
| Ivar Szper, M.D. | Long Beach |
| Franklin C. Wagner, Jr., M.D. | Sacramento |

## CSNS/JSEC DELEGATES AND ALTERNATE DELEGATES

**Three Year Terms**

**Delegates:**

John R. Clarke, M.D. — Frank P. Smith, M.D.
Philipp M. Lippe, M.D. — George Ablin, M.D.
Michael H. Sukoff, M.D.

**Alternate Delegates:**

Douglas M. Enoch, M.D. — Ulrich Batzdorf, M.D.
Morris D. Loffman, M.D. — N. Edalatpour, M.D.

## CMA HOUSE OF DELEGATES

**Two Year Terms**

| | |
|---|---|
| Delegate | George Ablin, M.D. |
| Alternate Delegate | Sidney Tolchin, M.D. |

## NOTIFICATION OF CHANGE OF ADDRESS AND NEW EXECUTIVE SECRETARY

New Address: CANS
P.O. Box 1395
Roseville, CA 95661

Executive Secretary: Deborah Smith

## Abstract of Presentations at CANS Annual Meeting

**A. 1. Diagnostic-Related Groups (DRG's) Overview**
Dr. Philipp M. Lippe

In his presentation, Dr. Lippe gave historical background as to how the concept of DRG's came into reality. He described the original study-trial program maintained at Yale University Medical Center, New Haven, Connecticut in the years 1968-1979. He explained how the exact components of the system could be studied by referring to the Federal Register on the matter, and that there is a pamphlet provided both by the AMA and the CMA regarding the subject matter,which at the present time has been enacted only for the Medicare pro-

gram. It was explained that the basic concept involved reimbursement for professional services to hospitals on a fee-for-services in a given diagnosis problem, rather than on the amount of care given. This provides great impact on patients as well as on the physicians, in order that quality care may be given without increasing the expenses that would ordinarily be provided for the diagnosis in a given case. This means that patients in the Medicare DRG system should have all medical economy measures, including pre-admission testing, admission on the day of surgery, and as many studies as possible on an outpatient basis, with discharge from the hospital as early as possible. With Medi-Cal patients, there is not the same pressure to get the patient out of the hospital as soon as possible, but there is a limitation in regard to doing any more studies or making any more expense items than actually necessary. For private patients, there is no pressure in terms of length of stay or the number of studies or procedures performed. Dr. Lippe pointed out that physicians' services may be reimbursed on a DRG basis, and that it is imperative for doctors to know as much as possible about DRG's and various committees that study the variations that are allowable. He advised that the doctors must work with the hospitals in providing an effective program.

2. **Professional Review Organizations**
Mr. Harlan Bennett, Executive Director of PSRO, San Jose, California.

Mr. Bennett provided detailed information about various procedures in relation to the DRG system. He warned about the problems in transferring the patient from a hospital to another area for hospital care. This could provide havoc for reimbursement of the original hospital. He stated that there are 467 different DRG's, plus three special purpose DRG's. He explained further that the DRG's are grouped into twenty-three categories, each known as an MDC, and that neurosurgery is MDC No. 1.

Each DRG is formed as related to diagnosis, treatment procedure, discharge, status and sex. Actually, the cornerstone of the program is designed to pay a fixed price per diagnosis of related groups for hospital services, with reference to Medicare inpatients. It was explained that a "grouper" is a computer program that determines the DRG number in an MDC. There are grouper exceptions, such as in relation to an unrelated operating room procedure given to a patient in a major diagnostic category, such as fracture of a hip sustained by a person who has been admitted for pneumonia. The exceptions are such problems as psychiatric hospital care, justifiable long-term care, and treatment given in children's hospitals.

The term "outlyer" was defined as a payment in addition to the DRG rate which could be made for cases exceeding the number of days and the dollar "threshold." Apparently the total proportion of "outlier" payments cannot be less than 5% or greater than 6% of total DRG related payments. There are elements of so-called "trim points" that require complex calculations.

Medical review systems relative to admission of the patient, any outlier claim, and various procedures may lead to payments to the hospital at a lesser amount than charged. Mr. Bennett cited one review of twenty-three cases where the hospital charges totaled $900.00, but the final allowance was $600,000. Obviously, this can cause a problem with balancing the hospital budget.

The imporance of the doctor providing the principal diagnosis was stressed, since this actually is related to the payment that can be made to the hospital. Also, it was noted that the diagnosis itself must reflect information in the patient's medical records. All surgical procedures must be defined as to whether they are therapeutic, rather than diagnostic, and whether they are related to the principal diagnosis.

3. **Hospital Administrators' View**
Mr. Michael Stephens - Hoag Memorial Hospital, Newport Beach, California

As additional material in historical background for development for new programs in Medicare provisions, Mr. Stephens commented that approximately fifty years ago, hospitals were looked upon as the "placed to die." However, following World War II, with the development of health insurance programs, financing became available for hospital care, and then the Federal Hill-Burton legislation provided funds for establishing hospitals where the care could be given. The Federal Medicare program was eventually developed, and the Federal government, as well as the various states, found that too much of their annual budget was going to provide the health care.

The DRG system was established as the program for distributing available money, or providing care to a given case with a given principal diagnosis. So far, Mr. Stephens has gained the impression that MDC No. 1 (neurosurgical cases) are consistent losers in the DRG program. He further stated that a few "outlyers" can be devastating for a small hospital budget. He has found that the major concern in California is related to the national payment schedule. He allows that the increased, and increasing costs of providing medical care in California will make it eventually impossible for California hospitals to operate

on a national DRG schedule. He reiterated what had been said by previous speakers, namely the importance of establishing the principal diagnosis, with good medical basis. One item mentioned was that gastroenteritis with dehydration allows for more payment to the hospital for care than the diagnosis of dehydration with gastroenteritis. He also stressed the need for cooperative working together between doctors and the hospitals to ensure quality care. He is convinced that hospitals must accept more input from doctors in decision making, with hospitals, boards, and doctors providing a united front.

4. **Physicians' Concerns:**

Brian S. Gould, M.D., San Francisco, California

Dr. Gould discussed what he considers to be the appropriate physician's approach to DRG's. He cited the goals of health care involving the patient's wish to get well, the payor's to reduce expense, and the hospital administrators' to manage their institutions in solvency — with physicians expected to aid all three. He further developed the concept that moderate health care delivery requires improved effectiveness, a national standard of care, and increasing intensity of technological systems. He emphasized the importance of computer science, to the extent that only computers can contribute the huge amounts of data needed to control health care, with all the records of laboratory studies, x-rays, and all items of health care, so that financial data can be related to the clinical performance. The data base ultimately will relate to types of patients treated in terms of diagnosis and the therapeutic services provided to each. He also mentioned the difficulties with maintaining a national payment scale for treatments, so that possibly there will have to be a national scale of hospital salaries. He provided warnings about conceiving that patient care is costing too much because we keep them in the hospital too long. A high-efficiency, substandard product is not desirable where decreased cost decreases quality of care, and might prove to be more expensive on a long term basis. He inferred that data showing various factors related to surgical care may actually provide errors that foul up the system. There must be fairness in the system outlining the data base for hospital charges.

B. **MEDATA**

Dr. William Clark, Medical Director of Industrial Accident Commission, provided background information relative to the Medata system, and various problems that can be avoided if the physician and/or his secretary-bookkeeper should take advantage of various opportunities that are available. He explained the importance of having correct numerical classification for fees being charged in Workman's Compensation cases, or actually in form of billing for third party coverage. So often, the charge may be made for a given operation, but then medical information supplied may indicate that that was not the operation actually performed. If it was felt that the surgeon had found some unusual or extenuating circumstances which made the operation more difficult, thereby justifying a greater fee than usual, he should provide the necessary explanation so that those paying the bill will have some adequate basis for this.

The very important part of this presentation was the opportunity for those attending to become acquainted with Dr. Clark in this manner. He certainly explained his position as being that of one who wished to be of help to all parties concerned, and he expressed a willingness to hear from any physician who might feel that some interpretation or arbitration of a fee problem might be in order. His comments were extremely well received.

C. **Contracting Agreements:**

1. **Overview** - Dr. Philipp M. Lippe

The general message provided by Dr. Lippe in regard to contractual agreements was one of advice that doctors "do not panic!" He stated that there has been a movement, as pointed out by Mr. Harry Schwartz, to have Medicare function the way industry does, in the concept that contract medicine will give health care for specific remuneration, subject to review. He pointed out that this was a matter of speculation.

Unfortunately, the response of physicians has been "frenetic." This was also described as "the lemming leap!" in response to formation of various professional service organizations. Whereas physicians assumed a stand-off position originally in reference to alphabet arrangements, it appears that 15-20% of all physicians have joined some type of health care program, mainly in urban areas. There are contrasts in different specialties, such as pediatricians who are involved in the range of 40%, whereas anesthesiologists have signed up at the level of about 4%. In reference to resisting panic, Dr. Lippe has advised: "Act — do not react. Act intelligently. Act decisively, cohesively, and legally."

2. **Staff Corporations** - Dr. Sidney Tolchin.

The interesting development in the past year in San Diego was described by Dr. Tolchin, where doctors felt obliged to go along with the PPO system in their own way, setting up a cohesive group of medical staff along the lines of Internal Revenue Service definition. This was arranged so that the group could go to hospital administration and ask for data base of charges, as well as discuss various turf

problems and establishment of equitable costs. A very definite perception developed as to what the group can do.

3. **Joint Hospital-Medical Group Contracting** - Dr. Frederick W. Pitts, Vice-President of "Preferred Health Network."

It was explained that many physicians had negative feelings about the development of health care programs following the legislative enactment of AB3480. This was considered to be the Proposition 13 of medical care. However, as more considerations developed, doctors in the Los Angeles area considered various types of PPO's, and finally developed a hospital-physician group contracting arrangement for providing health care. This involved not only many physicians, but also a network of eighteen hospitals within the program. The general program has been to provide total health care, with all specialties represented, on a fee-for-service basis. The goals have included maintenance of quality staff and continued attention to quality control. It is felt that there must be flexibility in regard to outpatient care and various means of providing subscriber services. There have been some disadvantages in terms of some fee negotiation, and some difficulties in establishing physician groups, leading to more meetings for solving the problems. However, Dr. Pitts pointed out many accomplishments to date, with the eighteen hospital-based organizations already in place gaining a strong utilization program, with physicians involved in all aspects of the program, including reviews of care, and even in the marketing of the program. He stated that there are now 12.5 million individuals enrolled in 278 HMO's nationwide, with 16% membership growth in the past twelve months. The general reaction has been that PPO's demand efficient use of resources, and that the system could serve to preserve the fee-for-service option, and may be the last chance to avoid a "total government-imposed system."

4. Mr. Leslie Smith, President, San Pedro Peninsula Hospital.

In explaining the basic concept of the "preferred health network," Mr. Smith explained that the hospitals chose a partnership with the providers so that they might have a quality network of care with cost effectiveness and geographic access to the care by the subscribers. He stressed the importance of maintaining stability and diversified services, and maintaining continued negotiations with physicians for optimal arrangements. He mentioned the competition developing from poor health care systems, but stated that the high standards would prove to be the best in the long run. He indicated the possibility of a statewide network for the program, and in particular the possibility of joining with the San Francisco Bay Area hospitals.

5. **Physicians' Liability: Practical and Business Aspects Re: Contracting** - Mrs. L. Savannah Lichtman, Vice-President and General Counsel, Norcal Mutual Insurance Company.

The practical aspects of problems in contracting for medical care were described in detail by Mrs. Lichtman. One of the key warning points was related to signing any agreement that might include a "hold harmless" clause. If a doctor signs the wrong chart, or fails to list an allergy, he may be only 10% liable for the total negligence claim, but actually, he might find himself 100% responsible because of having signed acceptance to a "hold harmless" clause. If you have insurance for malpractice, you may be required to cover for others who don't have insurance, so that you might wish to make sure all doctors concerned with your care have insurance coverage.

It was noted that there are various anti-trust implications in some contractual agreements. This might relate to referring doctors sending all of their patients to a participating provider, rather than to someone else in the community. The best interests of the patient must be considered in this regard. Patients must agree to being responsible for extra fees for care rendered outside the system.

It was suggested that in checking a contract, doctors should know whether doctors are going to be making various decisions, particularly where they might relate to medical defense. Most contracts mention utilization review, but they may not provide information to the patient that paying less may actually provide less medical care.

There was a description of the so-called "doctrine of informed refusal." As an example, a patient may be advised that she should have a Pap smear every year for seven years, but she refused each year. A claim may be made that the doctor did not tell her what could happen if she didn't have the Pap smear. In other words, if the patient refuses a procedure that you have recommended, you must document that you have told the patient why the procedure is necessary, and what might happen if the procedure is not done.

Various examples of possible malpractice issues were listed by Mrs. Lichtman. These included failure of the Medi-Cal program of the State of California to authorize continued hospital care, so that the patient developed a blood clot problem and "lost a leg." Also there was an account of the so-called Elam Decision, where a judgement was made against a hospital for failure to maintain proper screening of the hospital staff. This emphasized the need for guidelines relative to staff privileges,

status, and the necessity for the appropriate hospital committees to adhere to the guidelines.

The business aspects of contracting agreements should be clearly defined in the agreement. There should be identification of each party, and the obligations of each party. Doctors should not be satisfied with the statement that the Business Office "may" make certain payments for certain services. The proper term should be "will" do certain things. The question arises as to what is prompt payment? Definite description should include reference to what is an emergency? Provisions on utilization and quality of care are critical. Is the contract exclusive, and what are the measures to be taken if one should wish to terminate membership in the contract? In other words, do you have freedom to get out, and how do you do it? It should be stated whether or not malpractice insurance is required. Also, are there restrictive terms in regard to reimbursement? Determine whether you may bill a patient for services not covered within the contract. May you refuse to treat a patient? Are you required to be on a hospital staff? Will increased volume of patients adjust for decrease in fees? Is payment subject to withholding? Does your lowered fee become your standard fee? Oral agreements are worth nothing. And it should be remembered that everything is negotiable. It was emphasized that there is a continued need for enhanced physician-hospital understanding.

## REPORT TO THE SOUTHWEST QUADRANT

Philipp M. Lippe, M.D.

The Board of Directors (BOD) of the American Association of Neurological Surgeons (AANS) met in Chicago from December 9 to December 11, 1983. An overwhelming number of topics contained in an agenda booklet measuring 3" in thickness were discussed and effectively decided.

I am taking this opportunity to communicate to the State Neurological Societies and the delegates to the Council of State Neurosurgical Societies of the Southwest Quadrant in an attempt to provide information about some of the important issues which were addressed. Please feel free to communicate with me regarding these, and any other issues, which you wish to discuss.

In response to some feelings engendered by JSEC and a specific recommendation by the Long Range Planning Committee, the Board instructed the Bylaws Committee to develop proposed amendments to the bylaws concerning a mail ballot. It was decided that it would be more democratic to conduct a mail ballot for all elected offices, as well as for all amendments to the bylaws. Naturally, these proposed bylaw changes will be presented to the membership at the 1984 annual meeting for action. A two-thirds majority is needed to amend the bylaws.

The Fascicle on Trauma, as well as other fascicles, were discussed. In the past, JSEC has been vociferously opposed to the publication of these fascicles. The Board has decided to take no further action on any of the fascicles, and for all intents and purposes, they are "dead in the water".

The Board acted to endorse the creation of a new section on Sports Medicine. It also deferred any action on a proposed section on Neuroanesthesia.

The Board is in the process of developing a Code of Ethics for Neurosurgeons. This major work is in the hands of Dr. Bruce Sorensen of Salt Lake City.

The Board approved the 1984 budget. You will be pleased to learn that there is no plan for any increase in dues.

Plans for the 1984 annual meeting in San Francisco were presented by Dr. Robert Wilkins. It should prove to be a stimulating, educational and enjoyable meeting, and it is hoped that all members of the Southwest Quadrant will be in attendance.

The Board acted to authorize a new staff position for a Communication Director, who will assist the Board and the committees with communication and public relations matters.

With the assistance of legal counsel, the Board had approved modified guidelines for peer review.

As suggested by JSEC, the Board addressed the issue of DRG. Pertinent information regarding prospective payment systems as they impact on neurosurgery will be made available to all neurosurgeons in the near future.

The "Expert Witness Testimony File" was discussed at length. The Board authorized an indexing of this file and will, through the Professional Liability Committee, make the existence of the file known to the membership, and at the same time, request referral of additional pertinent material. The Board also instructed the National Office that under no circumstances is the original file to leave the office. All of these actions were taken in response to recommendations made by both the Professional Liability Committee and the Medical Legal Subcommittee of JSEC.

The Board once again asked that the manpower issue be addressed by the Committee on Health Care Systems, chaired by Dr. Russel Patterson. Dr. Lucien Hodges and myself are the other members of the committee.

On a lighter note, the Board participated in the formal dedication of the National Office. Former past presidents of the AANS and the Mayor of Park Ridge were in attendance. This was an inspiring and most enjoyable event, and I believe that all neurosurgeons can be proud of the fact that they now have a "home" in Park Ridge.

Last, but certainly not least, the matter of a Southwest Quadrant Representative to the Board of Directors was discussed. As you all undoubtedly know, this has been a matter of great controversy. The bylaw amendments adopted at the 1983 annual meeting created four positions on the Board of Directors for Regional Directors, which were to be "phased in in an orderly manner". This wording has been subject to different interpretations. Since I was elected as a Director at Large, but subsequently designated by the Board to be the Representative from the Southwest Quadrant, there technically would not be any vacancy for a Regional Director in 1984. Consequently, it seemed likely that this situation would erupt in considerable debate at the business meeting of the 1984 annual session. In order to avoid divisive fragmentation over procedural issues, I have concluded that the interest of neurosurgery would be best served by my resignation as the Southwest Quadrant Representative. I, of course, would continue to serve as a Director at Large. I presented this concept to the Board and was gratified by their mature grasp of the situation and elegant willingness to achieve a point of compromise. It is my impression that under the circumstances described, the Nominating Committee will suggest only one Director at Large, thereby permitting the election of two Regional Directors, one from the Northwest Quadrant and one from the Southwest Quadrant. Enclosed is my formal letter of resignation, which has been tendered to the President. I trust that this decision on my part will be understood in the spirit in which it was taken and endorsed by all members of the AANS.

## UPDATE ON CURRENT ISSUES

Philipp M. Lippe, M.D.

**Committee on Negotiations:** Members of the Committee have continued to work during the past year in an attempt to establish a service base for the neurosurgical community in California. It is planned that a professional service organization (PSO) be formed for the purpose of providing assistance to neurosurgeons in California. This concept can be expanded in the future to encompass a larger base of activity.

**Hospital admissions for elective surgery** are being designed on paper by a number of third-party payors (including IPA's and HMO's) who have set definitive guidelines regarding elective surgery. In some instances, they have mandated outpatient surgery, in other instances, they have demanded same day admission for elective surgical procedures. In many instances, these third-party payor groups have been unwilling to discuss or negotiate differences of opinion. CANS, and other state specialty organizations, working within the specialty delegation, were instrumental in a CMA policy statement which reads in part "that the final decision as to the time of admission should be left up to the attending physician and that physician's consultants." The California Society of Anesthesiologists has been asked by the CMA to develop guidelines in this area.

**Delayed payment of health insurance claims** has been a perennial problem for neurosurgeons and other specialties. Legislation (AB2949) has been introduced and perhaps could be a suitable means of achieving prompt insurance payments. This bill outlines the potential for physicians and surgeons to receive payment of interest on billing amounts that have not been paid for a significant interval. The CANS Board of Directors has authorized the following steps:

1. Continue to work with the CMA in order to achieve appropriate remedy.
2. Provide CANS members with a claims assistance program which will facilitate prompt payment of properly executed insurance forms.
3. Seek to support AB2949 if appropriate, and to encourage other specialty societies to do the same.
4. Conduct a survey among CANS members which will provide a data base concerning claims processing.

**Chemonucleolysis:**

Post marketing surveillance reports that of 30,000 patients treated with Chymodiactin, there were 21 *serious* neurological adverse reactions. These include five cases of cerebral hemorrhage, eleven cases of paraplegia, three cases of seizure activity, one case of Guillain-Barre syndrome, one case of hemiparesis. These cases have all been documented by Smith Laboratories, Incorporated, and detailed case histories are available on request.



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