

AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS

BULLETIN

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PHYSICIANS UNDER FIRE

WAGING THE WAR ON FRAUD AND ABUSE

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American Association of Neurological Surgeons



AANS BULLETIN

The quarterly publication of the American Association of Neurological Surgeons

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Neurosurgical Representation

Exploring the Growing Need for Grassroots Advocacy

To become the 70th President of the American Association of Neurological Surgeons (AANS) is an honor, and I pledge my utmost to merit that position. The individuals who have preceded me in office have set high standards, and I will do all that is in my power to not only uphold the traditions of excellence of the AANS, but to work feverishly to carry our organization into the 21st century.

AANS: The Representative Body

AANS founders took the name of the pre-eminent neurosurgeon of the day, Harvey Cushing, as the name of their Association. When it was transformed into the AANS in 1965, it assumed a larger role, and became the medical specialty society representing the broadest spectrum of Board-certified neurosurgeons in the U.S. Over time, the AANS assumed an even greater representative role and began appointing quadrant representatives from the Council of State Neurosurgical Societies (CSNS) to represent and meet the needs of its grassroots members. Slowly, the AANS became the spokesperson for organized neurosurgery.

A number of years ago, to enhance the nomination to the Board of Directors, the AANS Bylaws were revised to include more AANS members to serve on the Nominating Committee and to remove the AANS President from serving on that committee. This served not only to make the process more democratic, but to help avoid the possible undue influence of the President.

Last year, representatives from the AANS/CNS specialty Sections were seated as Ex-Officio members to the Board of Directors, along with the Chair of the CSNS, the Chair of the Young Neurosurgeons Committee and the Editor of NEURO SURGERY://ON-CALL®. In addition, the

President of the Congress of Neurological Surgeons serves in a Liaison capacity to the Board of Directors, along with the President of the Royal College of Physicians and Surgeons (Neurosurgery) of Canada, and the President of the Mexican Council of Neurological Surgery, A.C. This restructuring has enhanced the interchange of information and made the AANS even more democratic.

Advocating the Role of Neurosurgery

Like the AANS, the neurosurgical workforce is undergoing a transformation. Presently, neurosurgery represents less than 1 percent

Stewart B. Dunsker, MD, is the 2000-2001 AANS President.



of the total physician workforce. However, despite being such a small specialty, neurosurgeons must undergo the most rigorous training, deal with the sickest patients and overcome the most difficult complications. Neurosurgeons also must make the time to deal with the political processes in hospitals and legislatures, and advocate the role neurosurgeons play in the medical community.

Likewise, the AANS has labored to educate third-party payors and decision-makers about the role of the neurosurgeon and the disorders that he or she treats, and recently published a special supplement in *USA Today*. The AANS will continue to expand its efforts through a variety of communication initiatives, including a grassroots spokespersons network and a series of prepared newspaper columns on neurosurgical topics.

Volunteers at the county and state medical society levels are needed if we are to advance the specialty and get the voice of neurosurgery heard.

Although we can work on national policies and carry the message to Capitol Hill, most of the work will be carried out on a grassroots level. In that arena, the effectiveness of a neurosurgeon at the local level cannot be overstated. Neurosurgeons are constantly asked for their opinions at the county and state society levels and that information is carried to the national level through both the American College of Surgeons and the American Medical Association, as well as into state legislatures. The ability to leverage our effectiveness is crucial, and that power rests in the hands of the individual practicing neurosurgeon—you and me.

To that end, I ask each and every one of you to join with me in representing the future of our specialty at the state and local level. Your involvement will help facilitate what we accomplish on Capitol Hill. More important, your involvement will have a great influence in changing legislation and ultimately improving the state of neurosurgical practice. As Tip O'Neil, former Speaker of the House of Representatives, said, "all politics is local." That statement applies to all of us—think about it. ■

Stewart B. Dunsker, MD, is a practicing neurosurgeon at The Mayfield Clinic, Professor of Clinical Neurosurgery, Vice Chairman of the Department of Neurosurgery and Director of the Division of Spine Surgery at the University of Cincinnati.

NEWSLINE

NewsMembersTrendsLegislation

FROM THE HILL

NEW AANS MEMBER BENEFIT

Save up to 35 percent on medical supplies and pharmaceuticals through a new purchasing program administered by Henry Schein, Inc. The program features items tailored for neurosurgical practices, with contract pricing specifically for AANS members. Henry Schein, Inc. boasts a 99.9 percent fulfillment rate with virtually no backorders, superior service and convenient ordering options.

A catalog of items most used by neurosurgeons has been mailed to members. When ordering, identify yourself as an AANS member and save on such items as pharmaceuticals, exam room supplies and equipment, diagnostic equipment, surgical instruments, and more. To view the various products and wares offered through Henry Schein, Inc., visit the AANS Online Marketplace at www.neurosurgery.org/aans



- **“Quality Health Care Coalition Act” Passes in the House Judiciary Committee.** On March 30, 2000, HR 1304, the “Quality Health Care Coalition Act,” passed in the House Judiciary Committee by a vote of 26-2, setting the stage for a final vote on the House floor, which is expected to occur as the *Bulletin* goes to press. The bill, which now has more than 220 co-sponsors, will allow physicians to jointly negotiate the terms and conditions of their contracts (including fees) with health care plans, without violating the antitrust laws and without joining a labor union. During the mark-up of the bill, several amendments passed modifying the original legislation, including:

- The bill will “sunset” after three years. The General Accounting Office is directed to study the impact of the bill prior to the end of year-three, so that Congress can decide whether to extend it for a longer period of time.
- The bill will not apply to negotiations with any federal health programs.
- Physicians can’t use the negotiating authority to unlawfully exclude the coverage of services or participation by limited license practitioners.
- The bill will not authorize strikes.

The AANS, along with the American Medical Association (AMA) and several other medical specialty societies, will work to identify a Senate champion for this measure.

- **AANS Seeks Legislative Changes to Medicare Practice Expense Law.** The AANS, along with several other medical specialty societies, including the American College of Surgeons and the Association of American Medical Colleges, is seeking legislative changes to the current practice expense law. Under the law, the Health Care Financing Administration (HCFA) has developed a methodology that will reduce neurosurgeons’ Medicare income by approximately 12 percent (relative to 1998 fees) when the new practice expense values are fully transitioned in 2002. The compromise proposal would stop the transition at the current values in place for 2000. If adopted, neurosurgeons’ income would only decrease by 4 percent (far better than the 25-50 percent reductions proposed by HCFA in 1997).
- **Congress Holds Hearing on National Practitioner Data Bank. AANS Joins the AMA in Opposing Legislation That Would Open the Malpractice Data Bank to the Public.** The AANS, along with several other medical specialty organizations, joined the AMA in sending a letter to Congress opposing the opening of the National Practitioners Data Bank to the public. The House Commerce Committee recently convened hearings to consider whether the public should have access to information relating to medical liability settlements and verdicts. The letter stated that malpractice data generated by the data bank is incomplete, unreliable and misleading, and that malpractice claims do not correlate with findings of negligent medical care. Furthermore, the letter noted that data on malpractice settlements would not, by itself, be a useful tool by which the public could measure the competence of a physician.

NEWSLINE

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NEURO NEWS

NEUROENDOVASCULAR TRAINING STANDARDS

Program requirements for residency education in neuroendovascular surgery/interventional neuroradiology were recently established and have been approved by the American Association of Neurological Surgeons, AANS/CNS Section on Cerebrovascular Surgery and the Society of Interventional and Therapeutic Neuroradiology. According to the program requirements, training must include the management of patients with neurological diseases, the performance of neuroendovascular surgery/interventional radiology procedures and the integration of neuroendovascular surgery/interventional radiology therapy into the clinical management of patients. The training program is not meant to duplicate or replace the approved Accreditation Council for Graduate Medical Education program in diagnostic neuroradiology.

- **AANS Gets New Home in Rolling Meadows.** As of May 1, 2000, the AANS officially took up residence in Rolling Meadows, Illinois. The move to the new building brought most AANS business operations under one roof and will allow the AANS to operate more efficiently. The new facility will open its doors to members and invited guests on Friday, July 21, 2000, from 5-7 p.m., when the AANS celebrates with a special open house. If you are interested in attending this celebratory event, contact Barbara L. Morrison, PhD, CAE, at (888) 566-AANS.

The AANS' new address is 5550 Meadowbrook Drive, Rolling Meadows, Illinois 60008. Phone: (847) 378-0500; fax (847) 378-0600. The toll-free phone number—(888) 566-AANS—remains the same, as do all e-mail addresses.

- **Gerald D. Fischbach, MD, Wins the AMA Nathan Davis Award.** The AANS and CNS nominated Gerald D. Fischbach, MD, Director of the National Institute of Neurological Disorders and Stroke, for the AMA Nathan Davis Award and were pleased to learn Dr. Fischbach won in the category of Federal Branch Employee Appointed by the President. The Nathan Davis Award recognizes individuals who have promoted the “art and science of medicine and the betterment of public health.” Since beginning his medical career, Dr. Fischbach has dedicated his life to research and the advancement of public health through scientific discovery. He is a leader in neurobiology, and has focused much of his research on the biology of regeneration, which has enormous potential for restoring neurological function in the damaged nervous system. The award will be presented on July 18 at a gala banquet in Washington, DC.
- **AMA Establishes new On-Call Physician Task Force.** In response to ongoing problems related to the availability of on-call physicians in emergency departments, the American Medical Association recently established the On-Call Physicians Task Force. John A. Kusske, MD, AANS Vice President, will represent the AANS on the task force, which is charged with making recommendations on: 1) The responsibilities of physicians on-call to the emergency department; 2) Mechanisms for payment for care to on-call physicians; and 3) Enforcement options for medical staff on-call requirements, while recognizing Emergency Medical Treatment and Active Labor Act (EMTALA) requirements.
- **AANS Voices its Position on Cervical Decompression for Chronic Fatigue Syndrome.** On a recent segment of ABC-TV's news magazine program “20/20,” medical editor Dr. Tim Johnson reported that cervical decompression surgery can help treat some chronic fatigue syndrome and fibromyalgia sufferers, who may, in all actuality, suffer from Chiari syndrome. The segment stressed that operations should be considered only for patients with abnormal findings on MRIs of the base of the skull and neck, and that treatment should be considered experimental. The AANS is concerned that, at present, there is no scientific evidence that chronic fatigue syndrome is a neurological disorder or that it requires surgical intervention. Therefore, the AANS recommends that scientific clinical trials evaluating the co-existence of Chiari and chronic fatigue syndrome be undertaken to determine any possible relationship between these two disparate entities. In the absence of clear data on this issue, the AANS does not support the use of cervical decompression for chronic fatigue syndrome, and has issued a position statement on this issue. For the full text of that statement, visit the AANS Web site at www.neurosurgery.org/health/news/publicposition.asp.

Physicians Under Fire

Waging the War on Fraud and Abuse by John A. Kusske, MD

Health care law enforcement is using a stunning arsenal of federal laws to target physicians for fraud and abuse.

Congress has armed health care law enforcement officials with a stunning arsenal of federal laws which, along with state laws, are directed at finding, punishing and deterring fraud and abuse. To much dismay, physicians are among the main targets. The laws are complex, the potential penalties severe and the regulations are changing on a daily basis—making it essential that neurosurgical practices keep up-to-speed with these rapidly shifting rules.

These laws broadly proscribe activities, some of which may have been undertaken in good faith. Significantly, these statutes also have provided the Office of Inspector General (OIG) with extremely broad powers to penalize or exclude physicians from the Medicare and Medicaid programs by mandating the exclusion of all providers convicted of program-related crimes. Granting this authority to the OIG has significantly reduced physicians' procedural rights.

Under Examination: The Program

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a national Health Care Fraud and Abuse Control Program (the Program) under the joint direction of the Attorney General and the Secretary of the Department of Health and Human Services (HHS). Acting through the Department's OIG, the Program is designed to coordinate federal, state and local law enforcement activities with respect to health care fraud and abuse.

According to the HHS 1999 Annual Report, the federal government won or negotiated more than \$524 million in judgements, settlements and administrative impositions in health care fraud cases last year. The report also states that a National Health Care Task Force has been organized to promote information sharing and collaboration among the many federal, state and local entities involved in combating health care fraud.

The Program's central role is the prevention of health care fraud and abuse. The Program's efforts include the promulgation of formal advisory opinions to industry on proposed business practices, industry-specific program compliance guidance, special fraud



alerts, corporate integrity agreements with providers who settle allegations of fraud, and beneficiary and provider education and outreach. HHS states that the Program has reaped significant benefits. For example, the most recent audit of Medicare payment errors showed a \$10.6 billion, or 45 percent drop, in improper fee-for-service payments over the last two years.

Strict Laws, Steep Penalties

Two reports were issued in 1997 that fueled the increased federal focus on fraud enforcement activities. The General Accounting Office (GAO), in March 1997, issued its report "Medicaid Fraud and Abuse—Stronger Actions Needed to Remove Excluded Providers From Federal Health Programs." Soon after, the first full-scale audit by the OIG of the Health Care Financing Administration (HCFA) found an estimated \$23 billion in improper payments under Medicare fee-for-service in 1996. This information emboldened Congress to act and produced even more heavy-handed enforcement laws.

Unfortunately, procedural safeguards are limited when physicians are facing the possibility of sanctions. The system dispenses

Continued on next page

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with the right to a full trial with a criminal burden of proof, as well as the right to a jury, and replaces it with a “streamlined” administrative mechanism whereby the OIG may exclude a physician upon its finding that facts exist to support its determination. A jury is not provided in OIG hearings.

To be sure that physicians comply with fraud and abuse regulations, the penalties are severe (imprisonment). Similarly, the hardship imposed by large fines is well known. What is not as clear is that an exclusion sanction can be devastating. An exclusion sanction goes to the heart of a physician’s practice and reputation. It directly impacts a physician’s ability to maintain medical staff privileges, to contract with managed care plans, to obtain professional liability insurance and to maintain relationships and patterns of practice for the referrals of any patients whatsoever.

Pursuant to an amendment in the Medicare and Medicaid Patient and Program Protection Act, 42 U.S.C. §1395y(e), the law prohibits any Medicare provider or practitioner from billing for services rendered at the direction or on the prescription of a physician who has been excluded from the Medicare program. Such a sanction may destroy a physician’s ability to practice medicine.

Compounding the problem is the OIG, who is expressly authorized to exclude any individual who commits an act that is punishable as a criminal offense or subject to a monetary penalty. (42 U.S.C. §1320a-7(b)(7).)

Uncovering Fraud and Abuse in Physician Practice

The OIG learns of alleged fraud and abuse through a variety of sources. Investigations are often triggered by complaints from beneficiaries, competitors, employees (or former employees), former spouses or information received from fiscal intermediaries and undercover agents. The OIG is actively soliciting reports of suspected fraud and abuse via “Special Fraud Alerts,” which inform providers of an “Inspector General Hotline”—a service that offers a confidential means for reporting individuals suspected of violating federal statutes. (The hotline can be accessed at 800-HHS-TIPS.)

Furthermore, the False Claims Act (FCA), 31 U.S.C. §3729, is a significant enforcement tool. The Act permits whistle blowers who bring actions on behalf of the federal government to recover damages sustained by the submission of false claims, to recover up to 30 percent of the total penalty imposed. Prosecutors prefer this enforcement tool, as it allows the government to collect treble damages for false claims violations, and often carries stiffer penalties than the fraud provisions set forth in the Medicare and Medicaid laws.

Moreover, the FCA does not require the government to prove that wrongdoers acted intentionally to defraud the government. Instead, the prosecutors need only show that the wrongdoer has actual knowledge that the information is false or acts in reckless disregard or ignorance of the truth or falsity of the information.

Moreover, guidelines were proposed by the Department of Justice (DOJ) to make it tougher to bring FCA actions in response to congressional pressure. However, the initial assessments of how the

DOJ is operating this new guidance is disturbing. A Government Accounting Office (GAO) report recently stated that “The DOJ’s process for assessing the U.S. Attorney’s Office compliance may be superficial.” Accordingly, the GAO recommended that the DOJ improve its oversight of U.S. Attorney General Offices.

Patient’s Role in the Battle

Beneficiaries (patients) have been enlisted to report information concerning individuals (physicians) and entities involved in violation of federal health care fraud and abuse provisions. In fact, patients can receive monetary rewards for information that leads to the recovery of Medicare funds. Congress further enlisted the help of beneficiaries by mandating that each explanation of benefits form contain a notice that states they are entitled to an itemized statement and that they can report any errors or questionable charges.

Since April 1, 1999, this notice has provided patients with a statement of their right to request an itemized form for Medicare items and a description of the program to collect information on Medicare fraud and abuse. As part of the program, the OIG has established a toll-free telephone number for the receipt of complaints and information about waste, fraud and abuse or billing of services under Medicare.

“The Program is an overarching budget item that pays for health care investigation and prosecution by the DOJ, FBI, OIG and HCFA.”

HCFA also provides a lengthy list of fraud tips for beneficiaries, which can be found on their Web site (www.hcfa.gov/medicare/fraud/suspici2.htm). In addition, HCFA and the American Association of Retired Persons (AARP) are actively training volunteers to seek out fraudulent billing practices.

Federal Medicare and Medicaid law provides for both civil and criminal sanctions for those

activities that violate the provisions that Congress loosely categorized as “fraud and abuse.” A number of these provisions go far beyond the traditional concepts of “fraud.” Neurosurgeons should be sufficiently familiar with these laws in order to avoid the risk of getting sanctioned. Civil sanctions of engaging in Medicare and Medicaid fraud and abuse come in three forms: 1) mandatory exclusion, 2) discretionary exclusion, and 3) civil monetary penalties. Criminal provisions are contained within 42 U.S.C. §1320a-7b and prohibit a variety of acts and practices.

For example, a provision of the statute may make it a felony for any person, including a physician, to intentionally fail to disclose that he or she has received overpayment from a federal health program, even if the provider was not responsible for causing the overpayment. Such individuals, if convicted, may be guilty of a felony and be fined up to \$25,000, imprisoned for up to five years, or both.

Spotlight on False Claims

Congress has identified five separate activities, which may constitute “false claims” and may be punishable as a criminal offense. Some examples of conduct, which are prohibited under this law include: misrepresenting the services actually rendered, such as increasing the level of an office visit, or falsely certifying that certain services were medically necessary when they were not. Proper documentation and coding of evaluation and management services (E&M) is crucial to avoid these problems. Violations of the FCA carry a civil penalty of between \$5,000-\$10,000 for each false claim submitted, plus three times the amount of damages incurred by the government, as well as the cost of a civil action.

Moreover, the HIPAA defined several new federal criminal offenses applicable to activities involving both public and private health plans. Health care fraud is now a specific federal offense that Congress has defined as “knowingly and willfully defrauding any health care benefit program or obtaining, by any means, false or fraudulent pretense, money or property owned by or under the custody and control of any health care program” (18 U.S.C. §1347). Persons who violate this law face imprisonment, fines, or both.

According to the *Physician Compliance Alert*, the Clinton budget proposal for FY 2001 points toward an increasingly intense fraud and abuse campaign. Most of the increases follow HIPAA mandates, but several new initiatives would clamp down on providers in the name of cutting fraud and abuse. The Program is an overarching budget item that pays for health care investigation and prosecution by the DOJ, FBI, OIG and HCFA. The budget would rise to \$950 million under the President’s proposal, up 9.5 percent from 2000. One new policy proposal included in the budget envisages putting 100 government auditors on-site at Medicare contractors. With this occurring, it is only a matter of time, according to many experts, before an honest billing mistake is labeled as fraud.

Model Compliance Program

The OIG is now developing a model physician compliance plan. The agency states that it intends to incorporate in its plan a scaled back version of the seven core elements it included in previously published compliance guidelines for hospitals, clinical labs, third-party billing companies and others. Neurosurgical practices around the country might consider drafting their own plans now, especially since the government is aggressively prosecuting fraud and it may be several months before the OIG model is available.

Neurosurgical practices would be well advised to develop compliance plans that address the following elements:

- Authority, oversight and commitment to compliance by an individual or a committee are key. The effectiveness of a compliance plan is measured by outcome, not process. Without a committed staff that fully understands how the plan governs their daily lives, the program won’t reasonably deter wrongdoing.

- Training and education is another element. Training should be provided to physicians and office managers, for their actions impact the accuracy of claims.
- Standards of procedures to assist in compliance should be addressed and include policies on federal and state fraud and abuse laws, as well as reimbursement principles involved with coding.
- Monitoring and auditing the standards and procedures should be done by the practice.
- Mechanisms to enforce and discipline should be in place.
- Response and prevention is accomplished by a reasonable review of current employees and contractors. This will help prevent employing or doing business with individuals who have a propensity to engage in inappropriate activities.
- The compliance program should be tailored to meet your needs, especially since no one compliance program fits all.

Practices also can obtain direction from OIG’s *Compliance Program Guidance for Third-Party Medical Billing Companies*. The risk areas outlined in this publication include 17 different items, including: billing for items or services not actually documented; unbundling; up-coding; inappropriate balance billing; inadequate resolution of overpayments; lack of integrity in computer systems; failure to maintain the confidentiality of records; knowing misuse of provider identification numbers; outpatient services rendered in connection with inpatient stays; duplicate billing in attempt to gain duplicate payment; billing for discharge in lieu of transfer; failure to properly use modifiers; billing company incentives that violate the Anti-Kickback Statute; joint ventures; routine waiver of co-payments and billing third-party insurance only; and discounts and professional courtesies.

What Does This Mean For You?

Neurosurgeons must understand that the fraud and abuse laws are an ever-present reality, which must be understood and dealt with. Physicians with the best of intentions may find a compliance program necessary, since the laws and regulations are complex and constantly changing. By initiating a compliance program, neurosurgeons can ensure that their co-workers understand the applicable requirements, and their responsibility to adhere to them. Each neurosurgeon needs to make an assessment as to whether to adopt a formal program by considering, among other issues, the size of the group, the ability of the group to commit and live by a plan if established, and the confidence level in what currently is in place. To do less, at this time, does not seem to be prudent. ■

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Flagging Fraud and Abuse

HCFA Initiates Data Bank

CHERIE L. McNETT

On March 6, 2000, the Health Care Financing Administration (HCFA) officially activated the Healthcare Integrity and Protection Data Bank (HIPDB). This new data bank was mandated by the 1996 Health Insurance Portability and Accountability Act, which called for the creation of a national health care fraud and abuse data collection program for the reporting and disclosing of certain adverse actions taken against health care providers, suppliers and practitioners. At present, data bank information is available to federal and state government entities, health care providers, practitioners, suppliers and health plans, but not to the general public.

According to the HCFA HIPDB fact sheet, "HIPDB will primarily be a tracking system that may serve as an alert function to users indicating that a comprehensive review of the practitioner, provider, or supplier's past actions may be prudent. HIPDB information is intended to be used in combination with information

from other sources in making determinations on employment, affiliation, certification or licensure decisions."

Reporting to the Data Bank

The following information is included in the data bank:

- Civil judgments against a health care provider, supplier or practitioner in federal or state court related to the delivery of a health care item or service;
- Federal or state criminal convictions against a health care provider, supplier or practitioner in federal or state court related to the delivery of a health care item or service;
- Actions by federal or state agencies responsible for licensing or certifying health care providers, suppliers or practitioners;
- Exclusion of a health care provider, supplier or practitioner from participation in federal or state health care programs; and
- Any other adjudicated actions or decisions that the Secretary establishes by regulation.

Only federal or state governmental agencies or health plans can provide reporting information to the data bank. Subjects of reports must be sent copies of any new reports, as well as subsequent amendments or deletions free of charge. Self-queries also can be made to the National Practitioner Data Bank (NPDB) at a cost of \$4. (The NPDB and HIPDB are part of the government's efforts to eliminate the financial burden of fraud and abuse.) Law enforcement agencies are allowed to use the system's Interactive Search Capability at a cost of \$10 per query. Final adverse actions must be reported to the NPDB within 30 days of the action, or the date when they were made aware of the action. Entities that fail to report will be subject to civil monetary penalties of up to \$25,000 for each unreported action. There is an appeals process for challenging reporting content.

Ramifications for Neurological Surgeons

The immediate effects of this new data bank are numerous. Health care facilities and plans have increased liability for credentialing physicians and other health care practitioners who have adverse data bank reports. Further, with growing incentives for economic credentialing, it is foreseeable that cases of "delisting" surgeons from managed care plans for economic reasons could become a reported incident under the guise of professional competence. Finally, although the rules implementing the new data bank specifically exclude settlements that do not include any findings of liability, it fails to recognize that, in many cases, physicians are forced to make settlements rather than pursue lengthy and costly trials.

For More Information

Copies of the statutory authority and the implementing rules can be found on the NPDB Web site at www.npdb-hipdb.com. ■

OIG URGES PROVIDERS TO SELF-DISCLOSE IMPROPER CONDUCT

The Inspector General recently sent an open letter to the health care community stating that health care providers who promptly self disclose improper conduct to the government may be eligible for favorable treatment in the resolution of their cases, including less rigorous corporate integrity agreements. In particular, the letter stated, "The Office of the Inspector General is committed to creating an atmosphere that encourages health care providers to voluntarily come forward to the government when they uncover evidence of fraudulent conduct within their organization." The letter noted that if a self-disclosing provider has demonstrated that its compliance program is effective and agrees to maintain that program as part of a False Claims Act settlement, the OIG may not even require a corporate integrity agreement. The decision whether to impose a corporate integrity agreement is influenced by a number of variables, including the scope and seriousness of the misconduct, the risk of recurrence, whether the disclosed matter was identified and reported as a result of the provider's compliance measures and the degree of the provider's cooperation during the disclosure verification process. To view the complete open letter, visit the "What's New Link" on the OIG Web site at www.hhs.gov/oig.

AANS Member Benefits Abound

Risk Management Tools

DEIA R. LOFENDO

Continued pressures by the federal government and private health insurers on the practice of medicine, particularly in the area of physician reimbursement and managed care, have made potential fraud and abuse sanctions a stark reality for many practicing neurosurgeons.

The AANS has recognized this, and recently stepped forward with a series of programs and services aimed at providing its members with risk management tools. Key to these efforts is the refocus of the AANS' coding and practice management courses, the creation of a coding hotline, and the development of fraud and abuse and professional liability insurance programs.

Refocused Coding and Practice Management Courses

Earlier this year, the Association's Education and Practice Management Department responded to AANS members' interest in hearing more on CPT and ICD-9 coding, Medicare contracting issues and subspecialty case coding, by redesigning its coding and reimbursement courses. The courses took on a new name and a new focus, and are now aimed at providing AANS members, and their staffs, with practical risk management information and the tools needed to increase reimbursement while avoiding liability.

- **Mastering Expert Techniques in Neurosurgical Coding:** This beginner level course, for office staff only, is designed to familiarize attendees with appropriate billing and coding documentation procedures. The course begins with an overview of medical terminology and continues with an in-depth explanation of the reimbursement process, including a discussion on commonly misunderstood CPT codes and documentation guidelines for office, clinic and inpatient visits. In addition, participants have the opportunity to join in neurosurgical case discussions and gain a greater understanding of the coding and reimbursement cycle.
- **Managing New Reimbursement Challenges in Neurosurgery:** This course for physicians, office staff and allied health workers begins with an overview of calculating revenue value units and ICD-9 and CPT coding principles, then continues with a discussion on Medicare contracting, subspecialty case coding and E&M coding documentation. Also included are discussions on how to code ancillary staff services correctly.

As an adjunct to this course, the AANS offers "Designing Better Business Systems"—a half-day course that reviews key practice systems; identifies points of management distress; highlights market-

ing, staff training and development, financial systems and compliance planning; and discusses the tools needed to integrate and manage practice systems and increase overall productivity.

Coding Hotline

The AANS Coding Hotline provides members with convenient access to expert CPT coding advice at discounted rates. The hotline is staffed by Physician Reimbursement Systems, Inc., a long-time provider of similar services to a number of medical specialty societies.

For a modest charge, members can call (800) 972-9298 with any type of coding question, claim denial or regulation issue. In return, members receive immediate access to coding specialists who are specifically trained in procedural coding for neurosurgery. These specialists have direct access to a frequently updated database that is organized by procedural code, payor and state. The hotline's hours of operation are Monday through Friday from 7 a.m.-4:30 p.m. (MST).

Medicare and Medicaid Fraud and Abuse Insurance Program

AANS Medicare/Medicaid Fraud & Abuse Legal Expense Reimbursement, offered through Ophthalmic Mutual Insurance Company, pays legal defense costs in the event that a physician, or his or her practice, becomes the target of a fraud and abuse proceeding. The policy provides full prior-acts coverage for proceedings or investigations relating to billing records dated prior to the coverage effective date. The policy has a limit for individuals of \$25,000, which covers the attorney's fees and associated legal expenses, and is subject to a \$1,000 deductible. Members of physician groups have combined aggregate limits based on the size of the group in accordance with the Aggregate Limits Schedule. For more information on this U.S.-only program, or to apply for coverage, see the brochure enclosed with this issue of the *Bulletin*.

Professional Liability Insurance

AANS has selected The Doctors' Company (TDC) to offer a discounted professional liability insurance program to its members. TDC is the nation's largest doctor-owned insurer, and the only doctor-owned carrier that operates on a national basis. The TDC program will provide a 10 percent discount on the annual premium as a membership benefit of the AANS, with an additional discount available for claims-free experience. Physicians insured with other claims-made carriers may convert to TDC without purchasing costly tail coverage from their current carriers. In addition, TDC will provide substantial discounts for new physicians, coverage for locum tenens, choice of liability limits, national portability and free retirement tail coverage. (For more information, see page 28.)



To register for an AANS-sponsored course, or to learn more about the services described above, call (888) 566-AANS or visit www.neurosurgery.org/aans.

Taking Charge

Neurological Surgeons Take On Managed Care

I am a private practice neurosurgeon at Cedars-Sinai Medical Center in Los Angeles. Frustrated by the nature and degree of managed care penetration and the “divide and conquer” mentality of many health care plans, I, along with several of my colleagues, decided to take charge of our specialty by developing effective methodologies to handle managed care. Together, we formed a network of neurosurgeons, called West Coast Neurosurgical Associates, Inc. (WCNA), and have targeted managed care contracting.

Presently, the WCNA network includes 86 neurosurgeons in three states (California, Arizona and Michigan) and services 1,730,000 contracted lives (nearly half of which are exclusive). These contracts include fee-for-service arrangements, case rates and, to a small degree, capitation. WCNA is presently developing neurosurgical networks in other states under the name of the American Neurological Surgeons Association (ANSA).

Fewer Specialties

Neurosurgical practices span the spectrum of organizational structures from the solo practitioner, still common in the West, to the large, fully-integrated groups of neurosurgeons prevalent in the East. Although specialists generally participate in all kinds of organizations, the common multi-specialty group has become more driven by primary care physicians in the West, with fewer specialists. In a mature managed care market, Health Maintenance Organizations (HMOs) or payor independent practice associations (IPAs) are interested in obtaining particular specialties through a capitated risk arrangement, rather than employing specialists.

Compounding the problem are prima-

ry care physicians, who have aligned together to control access to specialists through the gatekeeper function, while at the same time driving specialists' fees lower and lower. Specialists are being asked to take less reimbursement and yet are encouraged by the utilization departments of HMO's to decrease bed days, improve utilization and be more cost-effective.

In California, there are neurosurgeons who currently have a capitated contract that pays for a fee-for-service equivalent of

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less than 50 percent of Medicare allowable. These physicians have little incentive to see such patients in a timely fashion, provide the highest quality of care or reduce hospital stay. With reimbursement at its current level and rapidly dropping, there is very little incentive for neurosurgeons to do anything that adds value to the HMO.

In this respect, the current HMO delivery system is upside down. The primary care gatekeeper models contend that they control facility costs, which are approximately 50 percent of the total health care dollar. However, the specialists, whose professional fees account for nearly 20 percent of the health care dollar, collectively control as much as 91 percent of the facility dollar. When you combine the specialists' 20 per-

cent of the health care dollar for professional fees, and the hospitals' 50 percent of the health care dollar, specialists control nearly 70 percent of the total health care dollar—this is in stark contrast to the 10 percent of the health care dollar primary care physicians receive for their professional services.

Primary care-driven groups have taken the risk for medical practices, in some cases for both professional and facility expenses. These groups have managed their risk by managing access to specialists and specialty care. Currently, managed care is largely managed access. At one health plan in Southern California, the average annual salaries for primary care doctors are \$120,000 to \$130,000, with bonuses of an additional \$100,000 to \$150,000 per year for reducing the utilization of specialists, tests and hospitalization. There you have it—the public debate surrounding physicians receiving money and not delivering care.

The Food Chain

This is not to say that there is no room for better management of technology and facility utilization. The question is who is in the position to exert the most influence on the efficient and effective utilization of current medical resources. The answer should be specialists; however, for several reasons this is not the case, and specialists are reduced to the bottom of the food chain. Managing risk is the only way that specialists can move up the negotiating food chain and actively manage the risk passed to them by HMOs and other payors.

The current power brokers of health care will never invite specialists to the health care table until they perceive specialists as their organizational peers. Therefore, neurosurgeons must be organized and work together. As specialists, we can do the following:

- Participate in larger entities that spread risk over a broader base;
- Use more sophisticated systems and management techniques toward practice profiling and facility utilization tracking;

- Increase shared management staff;
- Develop diagnosis-related or disease state outcomes; and
- Provide for economies of scale and operating efficiencies.

Effective Models

One popular organizational structure to get specialists more involved in managed care operations is the Physician Hospital Organization (PHO). Experience has shown that PHOs are organized by hospitals to help keep the hospital beds filled, and to help the hospital maintain a position of strength.

An effective model for accommodating managed care and other practice pressures is the fully-integrated single specialty group or practice roll-up. As specialty reimbursements continue to be reduced, finding ways to decrease practice expenses is increasingly important. A fully integrated group is a good way to achieve economies of scale on various levels. To be fully integrated, physicians merge their practices into one large group and combine their gross incomes, as well as their expenses.

The integrated group then takes advantage of economies of scale in such areas as consolidating billing and collections; group cost and profitability analysis; central purchasing of malpractice and general liability coverage and supplies; employee benefits consolidation; patient satisfaction survey instruments; and a central data repository for outcomes studies. This integrated group also can take advantage of more traditional capital raising activities, such as debt instruments, private placements or announcing an initial public offer.

It can be difficult, however, to get several physicians who have competed privately for many years to join together in a fully-integrated group. If physicians are able to successfully integrate, they can present themselves as a unified group, deal with contract negotiations in a managed care setting and implement the cost saving mechanisms referred to previously.

The single-specialty independent physician association (SSIPAs) is another effective model of forming an alliance between specialists to accommodate managed care. The SSIPA model represents a regional affiliation of doctors within the same specialty, facilitated by the development of a professional corporation to hold contracts. Each physician within the specialty signs a provider services agreement to serve as an independent contractor and provide health care to the contracted lives.

SSIPAs are generally non-exclusive arrangements that allow specialists to join other IPAs and deal primarily with managed care contracts. This enables the private practitioner to effectively accommodate risk-bearing contracts within the context of the group, while continuing to work with private insurance and Medicare patients separately. There are antitrust issues related to SSIPAs that are not issues with integrated groups, but the Department of Justice has shown trends of relaxing antitrust regulations with regards to SSIPAs. This model may be a very comfortable "courtship" for those specialists who are uncomfortable with jumping directly into a comprehensive, career-long commitment represented by the integrated group model. After working together in a network or SSIPA model for a certain amount of time, specialists can always decide to further integrate.

Starting with the SSIPA model is a good way to begin thinking and working as a team, regardless of a desire to integrate at a later date. Sometimes groups of physicians desire to be fully integrated, but do not succeed because some of the physicians are not ready for that level of commitment. The market will not be kind to those physicians, regardless of their good intentions.

As individual neurosurgeons begin to work together, they should be careful not to create a competitive environment within their specialty. The "divide and conquer" strategy used by the payor community has been widely successful at grinding down rates for specialty services. The formation of SSIPAs, or networks designed to drive

out the rest of the specialists in a geographic area, can create dramatic price competition and are often counter-productive.

Management Teams

It is critical that neurosurgeons understand the importance of management. It's not possible for a physician or a physician's office staff to have the sophistication to provide utilization management, quality assurance data reporting, length of stay data, outcome studies or encounter data on physician services to the HMO in a valuable way, nor is it cost effective for a specialist in private practice to do this.

Make sure that members of the management team are professionals in managed care, with experience working with the primary care community. These individuals know how to satisfy the primary care groups' needs, while protecting the specialists' interests. They also know the primary care groups' capabilities and how the dollar flows through the system.

If the specialty network is prepared and has a sophisticated level of management to guide it, it will likely succeed. Make sure network development is inclusive, and avoid the "country club" model that includes only close friends or special cliques. In addition, take advantage of "safe harbors" by participating in risk sharing contracts with HMOs.

A single-specialty IPA's organizational flexibility will add a new dimension to health care delivery systems. With the infusion of management sophistication, information systems and operational economies of scale, these networks will add new balance to the delivery of medicine, with true peer review and aligned incentives.

Moreover, in an era of market pressures to reduce the overall cost of medicine, the single-specialty IPA can help facilitate the market, while preserving the interests and values of specialists, as well as lead to other contracting, joint venture and integration opportunities. ■

High Tech, High Costs

Part Three: Fostering Neurosurgical Innovation

BY ROBERT E. HARBAUGH, MD

In the first article in this series ("High Tech, High Costs," Vol. 8, No. 4), I argued that new technology is the primary driver of increasing health care costs in the developed world. The second article ("High Tech, High Costs," Vol. 9, No. 1), reviewed various proposals for health care reform and discussed the impact such proposals would have on developing and deploying new technology. In this article, I want to address the importance of fostering neurosurgical innovation in a health care environment that may become increasingly hostile to technological development.

A Brief History

In the last 25 years, we have witnessed an explosion of technological innovations for diagnosing and treating patients with neurosurgical diseases, including: computed tomographic scanning; magnetic resonance imaging; the operating microscope; digital subtraction angiography; hyperthermia; local delivery of chemotherapeutic agents and gene therapy; stereotactic radiosurgery systems; endoscopic neurosurgery; image-guided neurosurgery; thermography; tissue transplantation for degenerative brain disease and stroke; neuroendovascular procedures; intrathecal drug delivery systems; chymopapain injections for disc herniations; and cerebral perfusion pressure monitoring, to name a few.

Some of these innovations have not been of significant value, but many have unquestionably improved the diagnosis and treatment of neurosurgical patients. Neurosurgeons have become accustomed to a dizzying pace of technological progress, but this is not inevitable. Leaders in government, the health care industry and neurosurgery need to critically think about what has spawned this era of innovation and how we can foster further technological advances in the future.

Factors Influencing Technological Innovation

Many factors influence the pace of technological innovation. These include patient needs and desires, market forces, federal policies on device approval and reimbursement, product liability decisions and the availability of medical and surgical specialists, particularly those at academic medical institutions.

The rapid development of technology in the recent past can be attributed to a uniquely favorable constellation of these factors. Patients expressed a strong desire for access to the newest medical technology. Therefore, institutions and physicians could obtain a competitive economic advantage by offering the latest technological innovations. Federal approval and reimbursement policies for the use of new technology were lenient and product liability con-

cerns were relatively slight. Reimbursement policies favored specialty and procedure-related care. This fostered an environment in which physicians, health care institutions and device manufacturers could all profit by collaborating on the development and deployment of new technology.

Changing Environment

For good or bad, many of these factors are changing. Although patients continue to want the latest technology to be employed in their care, they are concerned about the rising costs associated with such care. In any given year, only a small percentage of the popula-

tion needs health care for acute illness. Even fewer require surgical specialty care. Decision-makers in business, the health care industry and government are, therefore, under considerable pressure to make health care more affordable.

Oversupply and subsequent underutilization of many sophisticated technologies also has made it less economically attractive for institutions to compete by increasing their technological capabilities. Lenient policies on reimbursement have been curtailed and more

stringent documentation of benefits is being required for product approval. High profile product liability cases (e.g., silicone breast implants and pedicle screws) have raised concerns about the use of medical devices.

Most important, resources are being diverted from the specialty care of acute disease to primary and preventive care, causing academic medical centers to be placed under extreme economic pressure. Every neurosurgeon that I know in the academic community has experienced increased demands for clinical productivity at the expense of research productivity. These changes in the health care environment must eventually result in a change in the pace of technological innovation.

As I indicated in the second article in this series, proposed reforms of the health care system will likely exacerbate these problems. In enacting any reform, we must be careful not to destroy the milieu that has resulted in the dramatic technological advances of

"Changes in the health care environment must eventually result in a change in the pace of technological innovation."

the recent past. It is usually not a good idea to kill the goose that lays the golden eggs, even if she does require a lot of feed.

The Process of Technological Innovation

The process of technological innovation is often serendipitous. Technological progress proceeds by small iterative steps with no well-marked course. Some paths lead to dead ends. Some produce unexpected results and open up new avenues of investigation and refinement. It is a dynamic process that is inherently unpredictable and arises from the collaboration of individual investigators, academic medical centers, venture capitalists, small businesses and large corporations.

The development of microneurosurgery is a good example. The vision and dedication of surgical pioneers like R. M. Peardon Donaghy, MD, and M. Gazi Yasargil, MD, were essential. They needed the time and support of the academic community to develop the techniques and equipment responsible for making neurosurgical procedures safer and more effective. Funding from decision-makers in small and large businesses, who thought they could make a profit by producing microsurgical instruments and operating microscopes, was essential. Had the research and development costs been prohibitive or the chances for device approval slim, it is unlikely that the funds needed for investment would have been available.

The introduction of the operating microscope to the neurosurgical community resulted in the ever-increasing refinement in equipment and techniques, and a dynamic feedback process between neurosurgeons and manufacturers. Innovative applications of the new technology were developed. All of this occurred without any prospective, randomized study documenting the benefit of microsurgical technique and with little interference from regulatory agencies. Can anyone make a legitimate case that neurosurgical patients would be better served had this development been curtailed? Could the benefit of microneurosurgery have been documented or predicted 40 years ago? I don't think so.

Determining the Value of Technological Innovations

There are those who believe that by empowering regulatory agencies to rule on the value of technological innovations we will impose order on technological progress. It is my belief that no person or group is wise enough to predict which new technological innovations will be of value. If the process of technological progress outlined above is accurate, evaluating new technology early in its evolution may fail to demonstrate significant benefits that become apparent only after considerable refinement.

For instance, endovascular balloon occlusion of intracranial aneurysms proved to be a procedure of limited value. Nonetheless, endovascular procedures were refined by the introduction of new occlusive devices, improved catheter delivery systems, better angiographic imaging and other innovations. Bureaucratic determination of the value of endovascular treatment early in its evo-

lution might well have resulted in the disapproval of this approach for cerebrovascular disease. Such disapproval would almost certainly have truncated the subsequent refinements that have occurred in this area of neurosurgical care. Similar arguments could be made for many neurosurgical devices and procedures. We need to keep this in mind as we think about how to protect the environment of neurosurgical innovation in the 21st century.

Call to Action

We, as neurosurgeons, must recognize the crucial role academic medical centers and medical specialists play in developing new technology. The diversion of funds from specialty care to primary and preventive care may give us the biggest bang for the health care buck in the short run, but we will pay the price in the future. Organized neurosurgery, through the Washington Committee and other venues, must make this case forcefully to government agencies and to the public.

We need to critically evaluate our own practices in order to provide the most cost-effective neurosurgical care possible. Neurosurgeons can deliver higher quality and lower cost care by refining our indications for diagnostic studies, surgical intervention and high cost hospital care. Indiscriminate applications of new technologies have resulted in the explosion of medical care costs, and we cannot assume that more technology produces better outcomes. We will be required to document improvements in health care outcomes before device approval and reimbursement for new technology is approved. We, as neurosurgeons, need to face this fact and become more involved in designing and carrying out outcomes studies that take into account the concerns discussed above. Only neurosurgeons understand the intricacies of neurosurgical care, and if we are not involved in technology assessment it will be to our detriment. ■

“We, as neurosurgeons, need to face this fact and become more involved in designing and carrying out outcomes studies.”

Robert E. Harbaugh, MD, FACS, is Professor of Neurosurgery and Director of Cerebrovascular Surgery at Dartmouth-Hitchcock Medical Center and Chair of the AANS/CNS Committee for the Assessment of Quality and the AANS/CNS Outcomes Subcommittee.

This is the third in a series of four articles that highlight how technology is driving the cost of medical practice. To view the first two articles in this series, visit www.neurosurgery.org/library/bulletin/summary.html

Dawning of a New Decade

Heightening Awareness of Musculoskeletal Conditions

The next 10 years will mark the dawning of a new decade—the Bone and Joint Decade (BJD). An international project centered in Lund, Sweden, the BJD was established to heighten awareness and provide research advantages for all disciplines associated with musculoskeletal disorders. Since people do not usually die from musculoskeletal disorders, public awareness is not as high and, therefore, less money is allocated for research in this area, compared to other more “visible” disorders.

Nevertheless, the burden that these conditions impose on society may be more significant than previously thought, and the primary goal of the BJD will be to heighten awareness of the facts associated with the “burden of musculoskeletal diseases.”

As of March 22, 2000, 20 countries and 16 states in the U.S. have joined this effort and established their own “National Action Network.” In addition, the United Nations joined the ever-increasing list of supporters and President Clinton has been petitioned to sign a BJD declaration (although this is perhaps unlikely, due to other compelling influences and the reluctance on the part of the Office of the President to issue commemorative proclamation by body part).

In the United States, the American Academy of Orthopaedic Surgeons

(AAOS) is spearheading the U.S. National Action Network Steering Committee for the BJD. It is very loose regarding its political structure, especially regarding the oversight of its associated disciplines, including spine. Other disciplines include: 1) inflammatory joint disease; 2) osteoarthritis; 3) osteoporosis; 4) extremity trauma; and 5) pediatrics.

The BJD National Action Network Committee has encouraged these disciplines, including spine, to “take the ball and run with it” in aggressively developing a “Decade of the Spine” concept beneath its umbrella. It is clear that two “Decade” declarations, particularly if they are conceptually related, should not coincide. Therefore, the “Decade of the Spine” concept may take on a name such as the “Era” or “Age” of the spine. To broaden the appeal and inclusiveness of the Bone and Joint effort, the AAOS is considering to focus instead on the “Burden of Musculoskeletal Disease” effort, rather than the narrower BJD approach.

A Council on Spine Surgery (COSS) Subcommittee, headed by Ron Dewald, MD, and composed of Steve Garfin, MD; Arnold Menezes, MD; Courtney Brown, MD; and Andrew Cole, MD, is pursuing issues such as logo design and the possibility of having a joint meeting between the

National Association of Spine Surgeons and the AANS/CNS Section on Disorders of the Spine and Peripheral Nerves to celebrate the spine in mid-decade.

AANS Supports the BJD Project

The AANS Board of Directors recently voted to endorse the BJD project and to further explore a mechanism by which a spine program (“Spine Decade” concept) could be initiated and developed to elevate the spine and, more specifically, the role of the neurosurgeon in the diagnosis, treatment and prevention of spinal diseases and disorders.

To that end, the AANS approved the creation of a special AANS/CNS Spine Focus Task Force. Edward C. Benzel, MD, will Chair the task force, which will have representatives from the AANS, CNS, Spine Section, Council of State Neurosurgical Societies and the Washington Committee, and will be charged with developing recommendations on the creation and implementation of a comprehensive spine focus initiative. In conjunction with this initiative, organized neurosurgery is considering pursuing this concept for the spine under the loose umbrella of the BJD National Action Network Committee.

Lend Your Support

Such an initiative could effectively heighten awareness regarding disorders of the spine, as well as increase funding for spine research. Furthermore, it could heighten the awareness of the lay public regarding the role of the neurosurgeon in managing spinal disorders.

Through this project, neurosurgeons clearly have an opportunity to “take the ball and run with it.” Enthusiastic support is encouraged by all members so that the momentum of the new “Decade” can be established. ■

Edward C. Benzel, MD, Director of Spinal Disorders at the Cleveland Clinic Foundation, and Katie O. Orrico, JD, Director of the Washington Office, contributed to this report.

This article is an update to a column that appeared in the December 1999 issue of *Spine News*.

AANS TO HOST DECADE OF THE BONE AND JOINT LUNCHEON

On June 7, 2000, the AANS, along with several other medical specialty societies, will host a luncheon in Washington, D.C., kicking-off the Bone and Joint Decade. The luncheon will serve as a forum to educate Congress and federal officials about the initiative and will include the presentation of a letter drafted by President Clinton and endorsed by the Vatican and the United Nations in support of the Decade movement. In addition, an AANS-sponsored presentation on the spine will be conducted. Look to future issues of the *Bulletin* for more information on the AANS' involvement in the BJD.



The Debate Wages On

Will Patients Finally Obtain a Bill of Rights?

The debate over whether patients should have a “bill of rights” offering basic protections from health plan abuses has finally reached a critical mass on Capitol Hill. In October of 1999, the House of Representatives passed a strong patient protection measure in dramatic fashion. After rejecting eleventh hour efforts by the Republican leadership to pass their weakened version of managed care reform, 68 Republicans crossed party lines to join with the Democrats to pass bipartisan managed care legislation by a vote of 275-251. The measure passed by the House was sponsored by Charlie Norwood (R-GA) and John Dingell (D-MI).

Passage of this legislation was a significant victory for physicians and their patients, as the insurance industry and business interests have waged a multi-million dollar campaign this year to defeat the Norwood-Dingell bill. However, the Senate passed a much weaker patient protection measure in July of 1999. The ultimate result will depend on whether a House/Senate Conference Committee can resolve the considerable differences between the two bills, and whether the President will sign the compromise bill.

In any event, the conference is likely to extend into 2001. Following is a comparison of the House and Senate legislation.

Areas of Similarity

There are several issues in the bills where agreement by both bodies is likely. They include:

- **Gag-clauses:** Both bills ban the use of “gag clauses,” which prohibit physicians from discussing certain treatment options with their patients due to financial considerations. Patients should never have to

question whether their physician may be withholding significant information due to contractual obligations with health plans.

- **Point of Service:** Both bills allow patients in managed care plans to have the opportunity to choose an out-of-network “point-of-service” option, allowing them to be treated by the provider of their choice if they are willing to assume any added costs associated with this option. The Senate bill has an exemption for small businesses with 50 or fewer employees that is objectionable.

- **Access to Specialty Care:** The final bill will likely guarantee timely access to any qualified participating specialist, with appropriate clinical expertise, who is available to accept the patient for care. If an appropriate in-network specialist is not available, a patient must have timely access to out-of-network specialists at no additional cost.

- **Access to Emergency Room Services:** Both bills require the health plan to provide emergency care coverage to patients for symptoms that would reasonably suggest to an average person that their health could be at serious risk, including severe pain. Certain services necessary to treat and stabilize the patient also may be covered in the final bill.

- **Internal and External Appeals:** The final agreement is likely to provide patients with notice of and the right to fair and timely internal and external appeals. The external appeals process will probably require an independent reviewer with clinical expertise in the area where the review is being conducted.

- **Information Disclosure:** Both of the bills require that patients be provided with all of the information relating to a health plan’s benefits and procedures, including all appeals processes, limitations and exclusions.

Areas of Difference

There also are several areas in the bills where the two government bodies disagree. They include:

- **Financial Incentives:** While the House bill prohibits financial relationships between a health plan and a provider that could serve as an inducement to reduce or limit access to medically necessary services, the Senate bill has no such provision.

- **ERISA Reform:** The Employee Retirement Income Security Act (ERISA) of 1974 preempts state laws that allow individuals to sue for wrongful death or injury resulting from the medical decisions of insurance companies. The House bill strikes the federal preemption responsible for this loophole and allows patients to sue HMOs. The Senate bill contains no ERISA reform.

- **Scope:** The Senate bill only covers 48 million Americans in self-insured ERISA plans, while the House bill extends patient protections to all 161 million working Americans.

Role of the AANS

The AANS, through its membership in the Patient Access Coalition, continues to be an active participant in this debate. The Coalition has clarified its “principles” to better fit the current legislative activity, and representatives from the AANS continue to meet with Congressional staff and Members of Congress on this issue.

A Call to Action

To end this debate, it is essential that every neurosurgeon contact their Members of Congress and urge them to work with the Conference Committee to develop meaningful patient protection legislation. For your convenience, NEUROSURGERY://ON-CALL® has established a free link providing instant e-mail communication to Members of Congress. Visit N://OC® (www.neurosurgery.org) today, and tell Congress that you want an end to HMO abuses. ■

Get Connected

Eight Ways to Stay Informed With Online Tools and Personalized News

Is your in-box piled high with unread clinical journals, socioeconomic publications and financial and management magazines? If so, you are not alone.

Given the variety of administrative burdens and managed care paperwork required of practicing neurosurgeons, most don't have time to keep up with breaking news from multiple sources. At the same time, staying abreast of clinical and pharmaceutical news, as well as information about the changes e-healthcare and the Internet are bringing to physicians' practices, are paramount. Why? Because patients have easy access to this information, and many are bringing it with them into the exam room in greater and greater numbers.

Let the Web Work For You

The Internet is an unsurpassed tool for accessing all kinds of clinical and business information. "Push" and other personalization technologies enable you to receive exactly the news you want to read. An understanding of the major commercial health portals and search engine results can help enhance exam room conversations with Web page-toting patients.

Personalized News Portals

MySchwab™
www.myschwab.com

Individual.com™
www.individual.com

Medscape's® Neurology and
Neurosurgery Channel
www.medscape.com/Home/Topics/
neurology/neurology.html

To maximize the use of online tools and personalized news in your practice, put three or four of the following tips to work for you:

1. Visit commercial health portals. It's no secret that Americans have jumped on the Web in droves to search for health and wellness information. Of the approximately 110 million Americans online, CyberDialogue, an Internet customer relationship management company, estimates that 72 percent have searched for health and wellness information. Surgeons should be well informed about where these consumers—many of whom are your patients—are going for information.

Begin by visiting some of the major commercial health portals and reviewing what they say about back pain, herniated disks, brain tumors, stroke, and other conditions you frequently treat. These commercial portals advertise heavily, both on television and the Net, and are driving millions of consumers and patients to their sites every month.

Gomez Advisors is an advisory firm that analyzes Web services, and the company recently evaluated commercial health portals. Go to www.gomez.com and start your review of commercial health portals by visiting those with the best overall scores (in order): OnHealth.com, WebMD.com, drkoop.com and HealthCentral.com.

2. Familiarize yourself with other places patients go for information on neurological disorders. Anticipate that a patient who is searching for information about neurosurgery may go to several search engines and type in common keywords such as: brain surgeon, spine surgeon, neurosurgeon or brain cancer. Further, it's likely that those who do such searches will probably visit only the first 10-20 sites listed. Some

patients may even skip the search engine and simply type in those words as a Web site address. To that end, surgeons must become familiar with the search engines, sites and keywords that fuel patient searches. Information from these sites is very likely to arrive in patients' hands when they come to see you. If you can help them ferret out the good from the bad, you will look very Net savvy.

Studies show that, of the patients who search for health and medical information online, more than 90 percent refrain from making treatment decisions until they consult a physician. Helping patients navigate through the information they find on the Web is simply a new facet of the physician-patient relationship.

3. Customize a news portal. If you don't have time to sit down with the morning newspaper, a customized news portal can be an extremely useful online tool. Portals such as MySchwab™, a partnership between Charles Schwab and Excite™, allow you to control the news you want to read and easily access tools such as stock quotes, Internet Yellow Pages, maps, a daily planner, and more.

Customizing a news portal is easy. For example, go to www.myschwab.com, click on "Content" in the "Personalize My Schwab" box, and select the type of news you want to have "pushed" each day: top stories, international, health, pharmaceutical, Internet, entertainment, etc. Then, click "Edit" on the "MyNews" section, and customize the industry and company news you want to see. Determine the layout you want for your personalized portal, make it your log-on page, and voila—you have a completely customized daily news source.

Other companies offer similar services; review several before deciding which one you want to be your main news source.

4. Sign up for clinical and management e-newsletters. An e-newsletter is a communication tool that you receive in your e-mail box instead of your postal mailbox. It typically contains brief summaries of stories, along with a hypertext link on which

you can click to get more information. There are e-newsletters for nearly every interest you can imagine: clinical, health management, financial news, health and wellness, women's interests, and more.

Signing up for an e-newsletter is easy—simply enter your e-mail address and any other information the e-newsletter sender requests (name, address, etc.).

A few e-newsletters of interest to neurosurgeons may include:

- **AANS E-mail List** (www.aans.org/listserve/subunsub.html): Information and communication with other neurosurgeons; lists are segmented by subspecialty.
- **Medscape's Money & Medicine** (<http://moneymedicine.medscape.com>): Bi-monthly breaking health news and information about protecting assets, managing risk, practice management, managed care and technology.
- **KZAlert for Neurosurgery** (www.karenzupko.com): Bi-monthly practice management, e-healthcare and specialty-specific information.

5. Access clinical information about neuroscience topics. Better than leafing through stacks of journals or performing online clinical searches, accessing professional neurosurgical portals can make the job of clinical research a snap. The AANS Web site (www.neurosurgery.org/aans) offers easy access to journals, search tools, and clinical meetings. Other clinical sites include NeuroGate (www.neurogate.com), and Medscape's Neurology & Neurosurgery page (www.medscape.com/Home/Topics/neurology/neurology.html).

6. Keep abreast of fraud and abuse and other regulatory issues. Understanding regulatory issues is an important component of managing your practice, and information and guidelines change regularly. Stay informed by asking your manager to visit key Web services that maintain federal statutes, HCFA guidelines, and downloadable

Looking for a More Comprehensive Search Engine?

Next time you or your practice manager wants to search for something on the Internet, try a mega-search engine such as DogpileSM instead of "branded" search portals. While the mega-engines don't allow you to personalize them or buy products, they do offer convenience by pulling categories and links from multiple search portals. At DogpileSM, for example, you only have to enter keywords once, and the engine serves up results from eight different "brand name" search portals.

data that's important for your practice to stay compliant. The following sites offer credible and practical information:

- **Medicare's Fraud and Abuse Page** (www.hcfa.gov/medicare/fraud/default3.htm): Everything you want to know from the agency that oversees and initiates the policies.
- **OIG's Compliance Page for Third Party Billing** (www.hhs.gov/progorg/oig/modcomp/thirdparty.htm): This information is especially useful if you outsource billing to a service or to your hospital's MSO.
- **American Medical Association** (www.ama-assn.org/physlegl/legal/doc1b.htm): The AMA's practical overview of issues as they relate to business and management, the physician-patient relationship and compliance plans.
- **McDermott, Will & Emory** (www.mwe.com/news/indexhlu.htm): This national law firm offers safe harbor and compliance information. Sign up for the e-newsletter and receive regular tips and news.

7. Stay informed about the e-healthcare revolution. The e-healthcare landscape changes daily. If you want to stay in the loop about the companies, venture capitalists, and partnerships that are leading the change, visit the various Web services and sign up for e-newsletters that offer the most information.

For example, Managed Care News Web (www.managedcarenewsweb.com) offers

the e-newsletter *E-Health News Today* in *E-Health Business*. KarenZupko & Associates, Inc. (www.karenzupko.com) maintains a page within this site that has breaking e-healthcare news and links to companies that help physicians manage their practice.

8. Monitor what's in the pipeline. If you are a neurosurgeon who likes to know about the leading edge of technology and business, go directly to the news source that serves up breaking industry news and press releases each day. InternetWire (www.internetwire.com) posts company press releases for a variety of industries, including health care. BusinessWire (www.businesswire.com) posts both Internet and non-Internet news stories. Both services allow you to search its archives using keywords.

What Does This Mean For You?

Stop feeling guilty about all those journals piling up in your in-box, and use the Net as your main news tool. Visit the commercial portals and search engines that your patients have likely been to. Set up a customized news portal as your log-on page and subscribe to several clinical and business management e-newsletters. If you spend 15-20 minutes per day reading your personalized news on the Internet, you'll become more informed about the clinical, practice management and regulatory news that is critical to running your practice. ■

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Perils of Inaccurate Coding

Tips on Avoiding Fraud and Abuse Charges

Renewed attention has been drawn toward fraudulent coding by recent activities of the Office of the Inspector General (OIG). Four early investigations of teaching hospitals through PATH (Physicians at Teaching Hospitals) audits resulted in settlements in excess of \$65 million. With investigations moving toward individual physician's practices, it is important to review common areas of miscoding, up-coding, and unbundling to reduce one's risk of an audit.

Reducing Risk

Evaluation and management (E&M) coding has received extraordinary attention by auditors. A combination of confusing rules, resistance to implementation and the interpretation of better defined rules (retroactively) has led to the common identification of errors when auditing outpatient records. Principal areas of misunderstanding have included differences between new patients and consultations, as well as determining which level of service was provided.

Identification of a consultation requires several components. First, a physician must request your service. Second, there must be written documentation of this request (described as a "request for consultation" rather than a "referral"). Last, the findings and recommendations from the consultation must be communicated back to the requesting physician in the form of a chart note. Documentation of the written request can come from either the requesting physician or the consultant. Although the consultant may initiate diagnostic tests or treatment, a transfer of care of the patient precludes a consultative service.

Since reimbursement of consultations can be one-third greater than for a new

patient, this may attract auditors. However, as subspecialists, neurosurgeons typically use consultative codes more often than primary care physicians do.

Additional attention has been given toward up-coding the level of service. Although the work for a given level of service is frequently performed, the documentation must support the billed level of service. The three key components of documentation include the history, examination and medical decision.

For example, the level of service is determined using a complex grid that identifies the number of historical questions asked, the number of examination items performed and the number, complexity, and risks of diagnostic and management options considered. Profiles of physician utilization have identified "outliers" whose coding frequency differs from the norm.

Some physicians have responded by either undercoding or artificially creating a "normal" distribution of code usage. Although it may not be fraudulent to "underbill" for a higher level of service provided, it does result in reduced reimbursement for outpatient services that make up a greater proportion (approximately 25 percent) of total practice income. Since neurosurgeons typically see more complex patients and treatments often carry significant risks, one might expect a greater utilization of higher levels of service by a neurosurgeon.

Unbundling: An All Too Common Error

Although less attention has been given to surgical coding, there are common areas of miscoding from unbundling that have been identified. The term "unbundling" refers to coding additional procedures considered integral components of an already coded primary procedure. The Correct Coding

Initiative has led to software that precludes payment for unbundled codes; however, some carriers may not use such systems. It is important to realize that payment for services does not legitimize incorrect coding. In fact, insurers are increasingly reviewing past claims for unbundling in an effort to recover overpayments.

Common illustrations of unbundling can be identified in most areas of neurosurgery. For example, ventricular decompression (61107) is considered a part of major craniotomies. Similarly, frame placement (20660) is considered a part of stereotactic procedures (61720-61793). Moreover, dose-planning was considered in valuing stereotactic radiosurgery (61793) and should not be coded separately as 61795. Although fluoroscopy for localization or instrumentation placement is included in major spinal procedures, the use of computer-navigational systems can be coded separately as 61795. Finally, posterior lumbar interbody fusion (22630) includes the laminectomy, facetectomy and discectomy (63047, 63030) required for the arthrodesis.

Neurosurgeons should note that there is an acute awareness of fraud and abuse in coding, with physicians fearing financial and criminal penalties. Although many instances of miscoding likely reflect incorrect interpretation of the rules, the OIG does not accept ignorance as an excuse.

However, the OIG does acknowledge that the application of coding requires continuous education, and has looked favorably upon serious attempts at education through self-instituted compliance programs. Since the physician is ultimately responsible for correct coding, it behooves all practices to recognize the importance of accurate coding and utilize the educational programs provided by medical specialty societies, such as the AANS. To learn more about AANS-sponsored courses on coding and reimbursement, see page 9 or call (888) 566-AANS. ■

Gregory J. Przybylski, MD, is Assistant Professor of Neurosurgery at Thomas Jefferson Medical College and a faculty member for the AANS-sponsored coding and reimbursement courses.

Building Blocks of Medicine

Working Towards a Canadian Model of Integration

Presently, Canada does not have integrated health care, but rather a series of disconnected parts—a health care industry comprising hospitals, doctors' offices, group practices, community agencies, private sector organizations, public health departments, and so on. While each Canadian province is experimenting with different types of organizational structures and processes to enhance service delivery and ensure improved health care to the population, regional authorities and their variants do not possess the basic characteristics of integrated health care, such as physician integration.

In contrast, most developed countries are currently emphasizing the integration health care components as a solution to many of the challenges facing national health care systems. Evidence from the international experience with integrated systems has relevance in the Canadian context. These lessons from other countries, juxtaposed against Canadian health care objectives, can be applied to developing a model of integrated health care truly unique to Canada.

Progress Towards Integrated Health Care

By the late 1990s, most Canadian provinces (with the exception of Ontario) had adopted some form of regionalization in which responsibility for the allocation of resources and the control of costs was transferred from the provincial to the regional level. However, regionalization is not true integration since regional health authorities do not have responsibility for physicians and pharmaceuticals, which are two critical components of the integrated system.

There is relatively little literature directly related to performance of integrated health systems as a whole. However, there

are lessons and ideas that can be extrapolated from material that has been published. They include:

- Traditional fee-for-service payment models and managed care plans show no overall difference in terms of satisfaction or quality of care.

- Under managed care, access may be adversely affected for specific populations.

- Bringing together hospitals, physicians and payors at the corporate level has no relationship to the local patient-care level.

- The goal of integration is best achieved in a series of incremental steps.

- There is no "one best way" to achieve coordination. A variety of strategies must be tried in different communities.

- Development of collaborative and interorganizational relationships among providers has met with limited success.

- Little consideration has been given to the coordination of services at the community and individual levels.

- There have been very few systematic attempts to monitor and evaluate integrated health systems as they have evolved.

- There is not a single capitation formula that is appropriate in all settings.

Strategies for Moving Ahead

Given these lessons learned, where does Canada go from here? Although there is no one model for achieving coordinated care at the community level, following are six inter-related strategies that can be adapted to different circumstances to improve the patient-care experience.

1. **Focus on the individual.** Greater attention needs to be given to one's experience with the health care system.

2. **Start with primary health care.** Primary health care is one of the building blocks of

integrated health care. It is the first level of care and should be the first point of contact with the health services system.

3. **Share information and exploit technology.** Health care in Canada has been slow to embrace the broad advances in information management. Yet, to achieve more integration of care, improve processes and enhance collaboration among providers, information must be shared across the system.

4. **Create virtual coordination networks at the local level.** Virtual networks that facilitate coordination without the necessity of sharing assets can and should be developed.

5. **Develop practical needs-based funding methods.** Models for appropriate needs-based funding must be developed and agreed upon by the stakeholders. Canada should be at the forefront of research and development into new methods of funding health care.

6. **Implement mechanisms to monitor and evaluate.** Systematic mechanisms need to be developed to monitor and evaluate the impact of large-scale organizational change.

Conclusion

In the mid-1990s, provincial governments and providers were deterred by the magnitude of change implied by a move towards integrated care. Now that there is some international experience with integrated care and a greater appreciation of its strengths and weaknesses, it is time to move ahead with the Canadian tradition of incremental change. If we focus on the individual, start with primary care, share information and exploit technology, create virtual coordination networks at the local level, develop practical needs-based funding methods and implement mechanisms to monitor and evaluate, we believe that progress will be made in creating a genuine and effective model of integrated health care in Canada. ■

This article was written by Peggy Leatt, PhD; George H. Pink, PhD; and Michael Guerriere, MD, MBA, and reprinted with permission from *HealthCarePapers*—"New Models for the New Health care," Vol. 1 No. 2. To view this article in its entirety, visit www.longwoods.com.

Spotlight on the Washington Committee

Exploring the Role of Neurosurgery's Advocacy Arm

One of the most critical functions the AANS performs on behalf of its members is representing the interests of neurosurgeons before the federal government. The principle mechanisms for carrying out this function are through the Washington Committee for Neurological Surgery and the Washington Office. Under current AANS Bylaws, the committee, which is jointly funded with the Congress of Neurological Surgeons (CNS), is officially charged with: 1) Monitoring the activities of the government affecting neurological surgery; 2) Notifying neurosurgical leadership of these activities; 3) Recommending actions to be taken on behalf of the AANS and CNS; and 4) Making comments or taking action as directed by the parent organizations.

The activities of the committee, however, are not limited to its interface with the federal government. The committee also serves as the primary mechanism to address

health policy and practice issues that may not directly involve the federal government. In addition, the committee frequently serves as the sounding board for new ideas and programs for the benefit of the neurosurgical community and its patients. For example, program ideas such as "Think First," "Decade of the Brain" and the "Cost Containment Project" were first generated by the Washington Committee.

A Brief History

In 1975, the AANS and CNS decided to become actively involved in the federal government's rapidly expanding role in formulating, legislating, implementing and regulating health care policy. Dissatisfied with the representation on a number of issues by the American Medical Association and the American College of Surgeons, the neurosurgical leadership of the AANS and CNS felt that more direct involvement in Washington would give

neurosurgery more influence on important issues impacting the specialty. The pioneer committee consisted of Louis A. Finney, MD; Donald H. Stewart, Jr., MD; Russel H. Patterson, Jr., MD; and Charles A. Fager, MD, who, after an extensive search, contracted with Charles L. Plante, a former Senate aide, to provide part-time Washington representation services. One of Mr. Plante's requirements in accepting the job was that the AANS and CNS establish a small committee that would consist of senior members of the parent organizations who had an interest and expertise in health policy and federal affairs. Hence, the Washington Committee for Neurological Surgery was officially formed in 1976.

In its early years, the committee limited its activities to specialty-specific issues, such as federal funding for neuroscience research, professional liability reform and neurosurgical manpower. Over the past 20 years, however, the committee's agenda has

Working For You...

The following outlines the many issues that the Washington Committee addresses on an ongoing basis at all levels of government.

REIMBURSEMENT

- Medicare Physician Fee Schedule
- Relative Value Updates
- CPT Coding
- Medicare Conversion Factor
- Medicare Coverage Policy
- Medicare Reform
- Chiropractic Payment
- CRNA Supervision

- Hospital In-Patient and Out-patient Reimbursement

ACADEMIC CENTERS/TRAINING

- Graduate Medical Education
- Physician Workforce, Including Manpower Studies and Legislative Initiatives
- Physician Certification/Recertification
- PATH Audits
- Collective Bargaining of Residents
- Biomedical Research Funding, Programs and Policies

NEUROSURGICAL PRACTICE

- Patient Protection Legislation
- Health Plan Consolidation

- Antitrust Relief (*i.e.* Campbell Bill)
- Medical Records Confidentiality
- Emergency Medical Services Including EMTALA Regulations, Legislation and On-Call Physician Reimbursement
- Fraud and Abuse, Including HCFA and Inspector General Regulations/Enforcement Policies
- E&M Documentation Guidelines
- Tort Reform
- National Practitioner Data Bank Regulations
- Agency for Healthcare Research and Quality (AHRQ) Outcomes and Guidelines projects

- Physician Accreditation Initiatives
- Food and Drug Administration Issues

PUBLIC HEALTH

- Organ Donation Initiatives
- Injury Prevention Initiatives
- Medical Error Prevention
- Trauma Systems Development, Including Federal Grant Program Funding

expanded to include nearly all health policy issues that either directly or indirectly have an impact on neurosurgeons.

Continued pressures by the federal government and private health insurers on the practice of medicine, particularly in the areas of reimbursement and managed care, heightened the need for a proactive presence in Washington, D.C. In 1996, the AANS and CNS decided to establish a full-time presence. Since 1997, organized neurosurgery has had a permanent, full-time Washington, D.C. office with a staff of four. At present, they include: Katie O. Orrico, JD, Director; Cherie L. McNett, Senior Manager of Regulatory Affairs; Lori Shoaf, Senior Washington Associate; and Cynthia Spriggs, Administrative Assistant.

Washington Committee Members

The Committee is composed of six members, three appointed by the AANS Board of Directors and three appointed by the CNS Executive Committee. In addition, the President and President-Elect of the AANS and CNS serve as Ex-Officio members and the committee includes Liaison representatives from Sections and committees.

The current Washington Committee volunteers include: A. John Popp, MD, Chair; James R. Bean, MD; Robert E. Harbaugh, MD; L.N. Hopkins, III, MD; John A. Kusske, MD; Troy M. Tippett, MD; Stewart B. Dunsker, MD; Stan Pelofsky, MD; Daniel L. Barrow, MD; Issam A. Awad, MD; Robert E. Florin, MD; Lyal G. Leibrock, MD; M. Ross Bullock, MD; Kim J. Burchiel, MD; Lawrence S. Chin, MD; Richard G. Fessler, MD; Steven L. Giannotta, MD; Julian T. Hoff, MD; and Marion L. Walker, MD.

Decision-making Process

The committee meets four times each year in Washington, D.C. At these meetings, the committee considers a wide range of issues and recommends what action, if any, should be taken by the AANS and CNS. Final decisions on these recommendations are made by the leadership of the

parent organizations and are then implemented by the committee members and/or staff. Before any action is carried out on a specific piece of legislation or federal regulation, the committee consults with representatives from the Sections, state societies and other experts within neurosurgery. Because the federal process timetable is unpredictable and sometimes requires rapid decision-making, the Washington Committee and staff have some latitude to act as necessary.

Expanding Role

The ever increasing involvement of federal and state governments, health insurers and employers in the practice of medicine has created increased pressure on the AANS and CNS to expand their role in socioeconomic matters. The Washington Committee is undergoing some structural change to ensure the AANS and CNS remain influential in the formulation of health care policy affecting neurosurgeons and their patients. At the committee's recommendation, the AANS and CNS leadership recently approved the creation of several new activities that will be facilitated by the Washington Committee.

First, is the creation of the new AANS/CNS Coding and Reimbursement Committee. This new committee, Chaired by James R. Bean, MD, has consolidated and reorganized the former AANS Reimbursement Committee and the AANS/CNS CPT Coding Task Force into a single functioning entity. It is critical that all of our efforts in the reimbursement arena are conducted in a coordinated fashion. This new structure will allow the AANS to ensure that neurosurgical services are valued and reimbursed in a fair manner.

Second, is the creation of the Neurosurgical Devices Forum. Chaired by Richard G. Fessler, MD, the Forum will provide a mechanism for improving communication between neurosurgery, the Food and Drug Administration and other governmental agencies, the device industry and the public on issues related to neu-

rological devices. The purpose of the Forum is to improve access to, and make more efficacious use of, neurological medical devices, diagnostic technology and related products.

Finally, the Washington Committee has established a new process for enhancing its representation of Section specific issues. Several Sections—Spine, Tumor, Cerebrovascular and Trauma—have made direct financial contributions and have appointed a Liaison, who is invited to attend all Washington Committee meetings. A regular reporting and information sharing process is now in place, enhancing the ability of the AANS to represent the Sections before the federal government.

Keeping Members Informed

To keep members informed about the Washington Committee's activities, its members and staff make frequent reports to the leadership, Sections, state neurosurgical societies and the membership at large. The Chairman and Washington Office Director attend and make reports at the meetings of the AANS Board of Directors, the CNS Executive Committee, the AANS/CNS Joint Officers, the Sections and the Council of State Neurosurgical Societies. The committee also provides a Washington Update at special symposia held at the AANS and CNS Annual Meetings. Throughout the year, committee members and staff are frequently invited to speak at state neurosurgical society meetings. Finally, the committee communicates its activities through the *AANS Bulletin*, the *AANS/CNS Changing Times in Neurosurgery* fax broadcast newsletter, and through periodic "e-blasts."

Into the Future

Neurosurgery clearly has both a present and future role in the establishment and implementation of health care policy. The Washington Committee will continue to evolve so that the AANS will remain an effective advocate. ■

Katie O. Orrico, JD, is Director of the Washington Office.

An Era of Discovery

Exploring Advances Looming on the Neurosurgical Horizon

GERALD D. FISCHBACH, MD

This is an extraordinary time in neuroscience. Molecular, cellular and systems approaches are providing discoveries that were unimaginable only a few years ago. At the molecular level, we have seen the three-dimensional structure of an ion channel at atomic resolution. We have discovered an astounding diversity of neurotransmitters, neuromodulators, neurotrophic factors and their cognate receptors by molecular cloning. In addition, remarkable structural and functional similarities are emerging between genes and proteins in humans and those in flies, worms and yeast. Clues to many neurological disorders will be uncovered by studying these simpler organisms.

At the cellular level, we are unraveling the complex regulatory pathways and discovering common mechanisms, such as “cell suicide” programs, that contribute to many disorders, both acute and chronic. We have much clearer ideas about how neurons integrate diverse influences and express their conclusions in activity via the modulation of individual ion channels.

At the systems level, multi-electrode recordings and non-invasive imaging have shown relations between systems not previously suspected, and are bringing questions related to attention, awareness, planning, movement, mood, and even consciousness into sharper focus.

One might think that with each new discovery, scientists working at different levels of analysis would have less to say to one another, as technical jargon becomes less penetrable. Remarkably, quite the opposite appears to be happening—new discoveries have begun to unify neuroscience rather than drive it apart. As our understanding converges in new opportunities for treating human disorders, neurosurgeons must take an active leadership role.

What Does This Mean for Neurosurgery

Certainly, exacting and innovative neurosurgical approaches are essential to new therapies. More precise localization of lesions has revolutionized the treatment of Parkinson's disease and epilepsy, among other disorders. Deep brain stimulation is one of the most promising therapies for movement disorders to emerge in years. Cell therapies, whether with adult progenitors, embryonic cells or engineered cells, hold enormous promise. So, too, does gene therapy, if we can overcome the problems of control and delivery. Implantable devices may soon predict the onset of seizures and deliver precisely timed and localized drugs to prevent them. Targeted therapeutics may seek out and destroy tumor cells. Neural prostheses that rely on direct cortical control are no longer science fiction. The horizon is unlimited.

Considering this limitless horizon, how should the next generation of academic neurosurgeons be trained? Surely they must

be experts at their trade. They also must understand the neuroscience that will provide therapeutics of the future. At the very least, they must be informed collaborators.

In some cases, practicing neurosurgeons will be leaders in the laboratory as well. Although it is easier to clone a gene, modify a protein, record from small single neurons, and observe the function of large ensembles of neurons than ever before, time must be allowed in training programs to become familiar with these approaches. The National Institute of Neurological Disorders and Stroke (NINDS) is committed to helping, by planning and creating novel funding mechanisms.

As the NINDS emerges from the Decade of the Brain and marches into the 21st century, we plan to celebrate the accomplishments of brain research over the past 50 years, and to peer into the future. We invite AANS members to offer suggestions for specific events to kick-off a neuroscience festival beginning in April of 2001.

New Neuroscience Research Center

One effort that we hope will crown the celebration is the creation of a National Neuroscience Research Center at the National Institutes of Health (NIH). This effort, culminated by new research facilities, will bring molecular and behavioral scientists together to emphasize the major themes of brain research, including neurodegeneration, neural repair and plasticity, synapses and circuits, cognition and behavior, neurogenetics and the neural environment. The emphasis will be on translational research and the hope is to speed the translation of basic discoveries to useful therapeutics.

Our plan is for the Center to become a resource for the entire country, by sharing resources (animals, imaging, behavioral, etc.) and offering unique training opportunities. We hope to seed the community in much the same way that the NIH did in the 1960s and 1970s. We need your support in this effort. Public support has never been higher and we have witnessed a remarkable increase in the NIH budget over the past two years. At this pace, the budget will double (compared to the 1998 level) in the next three to four years. The increase in the budget cannot be spent on more of the same. We have an obligation to plan in the coming years. To do this effectively, we need input from the neurosurgical community. ■

Gerald D. Fischbach, MD, is Director of the National Institute of Neurological Disorders and Stroke.

Meet Your President

Stewart B. Dunsker, MD, Prepares for an Exciting Year at the Helm

DEIA R. LOFENDO

Stewart Ben Dunsker, MD, was recently elected President of the American Association of Neurological Surgeons (AANS). An active member of the AANS since 1973, he has served as a member of the Board of Directors (1992-1999), as Treasurer (1996-1998), as Vice President (1998-1999) and as Chairman of the Bylaws Committee (1986).

Dr. Dunsker has been a practicing neurosurgeon at The Mayfield Clinic (Cincinnati, Ohio) since 1970, and also is Professor of Clinical Neurosurgery, Vice Chairman of the Department of Neurosurgery, and Director of the Division of Spine Surgery at the University of Cincinnati. In addition, he serves as Director of the Department of Neurosurgery at The Christ Hospital in Cincinnati.

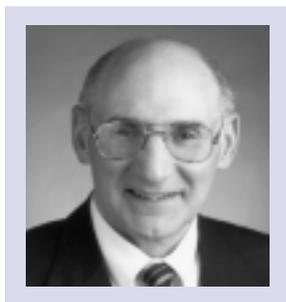
After completing his bachelor's degree from Harvard College, cum laude, in 1956, Dr. Dunsker went on to earn his medical degree from the College of Medicine at the University of Cincinnati. He completed an internship at the University of Illinois, one year of residency in internal medicine at the University of Cincinnati, and a tour of duty in Germany, where he served in an ARMY artillery battalion. He then joined the neurosurgery program at Washington University (St. Louis, Missouri) for his residency, and became Board certified in 1972.

Dr. Dunsker has served as President of The Ohio State Medical Association, The Ohio State Neurosurgical Society, and The Society of University Neurosurgeons. He also has served as Vice Chair of the American Board of Neurological Surgery, Vice President of the American Academy of Neurosurgery, Co-founder and Chairman of the Section on Disorders of the Spine and Peripheral Nerves, and as a Delegate to the American Medical Association.

An author of numerous publications, Dr. Dunsker has served on the editorial boards of *Neurosurgery*, *Spine* and the *Journal of Spinal Disorders*. Dr. Dunsker and his wife, Ellen, are the parents of Shiela Yessenow, a Business Development Officer at Fifth-Third Bank in Indiana. Following are some brief comments from Dr. Dunsker as he embarks upon his year as President of the AANS:

What is the role of the AANS? The role for the AANS is to speak for neurosurgery about neurosurgeons. The AANS should work for the betterment of patients, as well as AANS members. The AANS will continue to advocate for its members in Washington D.C., bring them more educational programs and represent them in the house of medicine.

What is the role for the AANS in relating to neurosurgeons? One of the core missions of the AANS is to provide its members with



Stewart B. Dunsker, MD

continuing medical education. To help members in this area, the AANS is developing courses in different regions of the country and creating new books and publications to meet its members' growing needs. The AANS also is reaching out to educate the public, media and third-party payors that neurosurgeons do more than just brain surgery. One example of this was

the recent AANS supplement, *Neurosurgery Today*, published in *USA Today*.

What would you like to accomplish during your presidency? I would like to bring better balance between the needs/desires of our members and the resources of the AANS. There are ever-increasing needs and services that would benefit the members; however, delivering those services is costly. Presently, AANS dues make up only 16 percent of revenues—one of the lowest percentages in the association industry. We have been able to generate revenue from other areas to benefit our members, but I would like to do more.

What message would you like to convey to AANS members? The AANS has a long and proud tradition in medicine. We must continue to fight for our patients so that insurance companies and government bureaucracy does not exploit them. With education and the same determination that enabled us to become physicians and neurosurgeons, we can help our patients win this fight.

Where do you see the AANS in five years? The AANS is, and will continue to be, at the forefront of North American neurosurgery. Although the primary focus of the AANS has centered on neurosurgery and politics in the U.S., there will be an increasing emphasis on international relations and affiliations. The neurosurgical world is becoming smaller and we need to enhance our international communication.

What are some key issues facing neurosurgery? First, insurance companies are focused on generating profits at the expense of good health care. These fiscal restraints imposed by insurance companies are popular and pass all the tests of cash flow. The AANS must work to help preserve the quality of medicine and health care.

Second, the government underpaid physicians by \$3 billion last year and does not intend to reimburse them. The AANS has joined with other medical specialty groups in filing a suit on this matter and must continue to fight for appropriate reimbursement. ■

To contact Dr. Dunsker, e-mail him at dunsker@aol.com

2000 AANS Meeting

This Year's Venue was the Preeminent Educational Gathering for Neurosurgery

BY DEIA R. LOFENDO

From April 8-13, more than 7,200 neurosurgeons, neuroscience nurses, physician assistants and technical exhibitors from across the globe convened in San Francisco for the 68th Annual Meeting of the American Association of Neurological Surgeons. Packed with hands-on practical clinics, first-rate scientific symposia and a wealth of socioeconomic information, this year's meeting set the standard as the premier neurosurgical conference.

Steven L. Giannotta, MD, Annual Meeting Chair, and Paul C. McCormick, MD, Scientific Program Chair, assembled a spectacular program, which included 18 scientific sessions, 44 practical clinics, more than 80 breakfast seminars, 129 oral abstract presentations, and 550 poster presentations. In addition, a record-setting 688 technical and institutional exhibits showcased the latest neurosurgical instrumentation and equipment.

The meeting also marked the "first" for several events, including the launching of the AANS' new logo and the publication of an eight-page consumer educational insert in *USA Today*. The goal of this pioneering educational tool was to provide an overview of neurosurgical practice—in particular, the role neurosurgeons play and the surgical and non-surgical care that they provide. The insert reached more than five million readers, and select articles were posted on several of the nation's top health sites, including NEUROSURGERY://ON-CALL®, WebMD and DrKoop.com.

PROGRAM HIGHLIGHTS

Saturday. The AANS Annual Meeting officially got underway on Saturday, April 8, following two days of AANS Board meetings and the Council of State Neurosurgical Societies Semi-annual Assembly (for a list of resolutions passed by the Assembly, see page 33). Saturday's program included a vast array of hands-on clinical courses, as well as a special luncheon sponsored by the American Neurological Surgery Political Action Committee (ANS-PAC), that featured keynote speaker Tom Campbell (R-CA). He discussed the House Judiciary Committee's recent passage of HR 1304, the "Quality Health Care Coalition Act," and explained how the bill will help level the playing field between health plans, physicians and patients. He also thanked the neurosurgical community for their overwhelming support.

Sunday. Paul C. McCormick, MD, led Sunday's program with a full-day symposium titled, "The 21st Century Neurosurgical Organization: Strategic Management of Neurosurgical Practice in a Competitive Market Environment." During this special symposium, a



1) John A. Jane Sr., MD, PhD (left) receives the Decade of the Brain Medal from outgoing President Martin H. Weiss, MD. 2) Incoming President Stewart B. Dunsker, MD, (left) congratulates Merwyn Bagan, MD, MPH, Humanitarian Award recipient. 3) (Left to Right) Martin H. Weiss, MD; Rep. Tom Campbell; Stewart B. Dunsker, MD; Russell L. Travis, MD; and A. John Popp, MD. 4) Doris Kearns Goodwin delivered the Cushing Oration.

panel of consultants, CEOs and neurosurgical practice managers examined the challenges and opportunities for neurosurgical practice within an increasingly competitive health care environment.

Monday. Monday's program set the stage for the official opening of this year's scientific sessions. Leading the program was W. French Anderson, MD, who delivered an interesting presentation titled, "Human Gene Therapy." Dr. Anderson, an international expert in the field of molecular genetics, discussed the expanding role gene therapy will play in the neurosurgical community in the near future.

Also on Monday, Martin H. Weiss, MD, 1999-2000 President of the AANS, delivered a thought-provoking presentation in which he discussed the evolution of North American neurosurgical societies and the legacy organizations, such as the AANS, must create.

"We are the beneficiaries of a distinguished legacy left to us by our predecessors; it is our responsibility to sustain this legacy," said Dr. Weiss. "This professional legacy cannot evolve without recognizing the educational, scholarly, scientific and socioeconomic needs of our membership and the discipline. These are vehicles that allow us to move forward and without which we cannot survive."

Dr. Weiss also spoke of a need to educate the public and the media on the role of the neurosurgeon and the importance of med-

ical care. "We must educate the public to the realization that, although health care must be available, it must be participatory. We must educate the youth of this country about the need to purchase health insurance when it is available to them. At the same time, we must define and promulgate the responsibilities of our patients to their health care, as well as the responsibilities that we have to our patients and the system. Our responsibility to our patients demands that we recognize that the overriding principle of our professional lives is to help the patient get better."

Dr. Weiss concluded by recapping where the field of neurosurgery has been and envisioning the road it has yet to travel. He also thanked the membership for their strong support and commended the Board of Directors and AANS National Office staff who "served diligently to meet the objectives of the Association."

Tuesday. Tuesday's program kicked off with the Schneider Lecture delivered by John A. Jane, Sr., MD, PhD, Chair and David D. Weaver Professor in the Department of Neurological Surgery at the University of Virginia (Charlottesville) and Editor of the *Journal of Neurosurgery* and *Journal of Neurosurgery: Spine*. Dr. Jane, who was recognized at the meeting as this century's last Decade of the Brain Medalist, discussed "The Orbit and Paranasal Sinuses—the Role of the Neurosurgeon."

The highlight of Tuesday's program was the Cushing Oration delivered by acclaimed historian, Pulitzer Prize winning author and former Harvard professor, Doris Kearns Goodwin. Speaking to a full audience, Mrs. Goodwin examined "Leadership in the New Millennium." In her talk, she discussed her experience working in the White House and explored the life of President Lyndon Johnson both in and out of the White House. She also identified three qualities that made President Johnson a success and said that those qualities were essential for any leader.

According to Mrs. Goodwin, such qualities include: 1) A good leader must desire to create partnerships on both sides of the aisle with special interest groups. "Your strongest supporters must be with you on your take off to be with you on your landing;" 2) A good leader must understand the importance of "good timing"; and 3) A good leader must recognize his or her supporters/partners and call

MEDIA EFFORTS SHOWCASED NEUROSURGERY

During this year's meeting, the AANS Communications Department served as an information clearinghouse for the media, providing expert information about neurosurgical practice and arranging interviews with Annual Meeting presenters. Through such efforts, neurosurgical spokespersons appeared on several national network programs, including ABC-TV's "Nightline," on health care Web sites such as DrKoop.com, WebMD, and Medscape, and in the pages of national and local print publications, such as the *San Francisco Chronicle*, *Medical Tribune* and more.

Mark Your Calendars!

2001 AANS Annual Meeting
April 21-26, 2001
Toronto, Ontario, Canada

to the attention of others the work that such entities have done on the leader's behalf. "More important, a good leader must bring a sense of purpose to his or her followers and have the confidence and courage to make things change. Such can be said of the leaders of the AANS."

Wednesday. Special Lecture III marked the highlight of Wednesday's program. The lecture, given by John E. Wennberg, MD, Director of the Center for the Evaluative Clinical Sciences at Dartmouth Medical School and co-founder of the Foundation for Informed Medical Decision Making, examined neurosurgical outcomes. Wednesday's program also included a special talk by Victor Fuchs, PhD, Henry J. Kaiser, Jr., Professor Emeritus in the Department of Economics and Health Research and Policy at Stanford University. Dr. Fuch's talk set the stage for a socioeconomic symposium in which he examined "The Future of Medicare."

Also on Wednesday, the AANS hosted, for the first time, hometown radio interviews. Nearly 50 AANS members gathered in the registration area to work with a trained media interviewer and discuss topics ranging from Parkinson's disease and spinal cord injury to fetal stem cell research and stroke prevention. The interviews were broadcast to 761 radio stations across the nation. The news segments reached more than 15 million people.

Thursday. As the meeting came to close on Thursday, the AANS hosted three top-notch special courses focusing on surgical techniques for a variety of intracranial approaches; the surgical management of movement disorders; and sports neurotrauma. The latter course featured football legend and Assistant Coach of the Oakland Raiders, Willie Brown, and explored the assessment and management of sports-related head and spinal cord injuries, including return-to-play guidelines.

Social Events Make a Splash

While education was the number one goal at this year's meeting, congeniality and socialization came in close seconds. The AANS welcomed members with a spectacular Opening Reception on Sunday, April 9. The gala event was the perfect place for members to rekindle old friendships, while roaming bands of "live art" and life-size recreations of sculptures and paintings by renowned artists introduced members to the sights and sounds of California. Later in the week, the AANS hosted a one-of-a-kind gourmet wine-tasting event. The "Taste of California," held in lieu of the AANS Annual Reception and Banquet, treated members to fine wine and culinary treats.

The AANS Meeting ended with members bidding their final farewells and promising to meet again to share ideas, friendship and Annual Meeting excitement in Toronto in 2001. ■

The AANS wishes to thank all of the corporations that supported the 2000 Annual Meeting through direct donations and sponsorships. To view a complete listing of this year's sponsors, visit www.neurosurgery.org/meetings.



Think First

Injury Prevention Education: Children of All Ages Are Taught to Think First

BILL BIEBUYCK

The Think First Foundation is proud to be the neurosurgical community's voice in helping to meet our shared goal of spinal cord and brain injury prevention education. With your support, Think First has educated more than six million young people since its inception in 1990.

For our message to continue to be heard, our programs must continue to:

1. Provide interesting, relevant and timely curriculum to kids and teens;
2. Provide comprehensive, effective training to key chapter personnel; and
3. Enhance name recognition and revenues through friend-raising.

Curriculum Revision

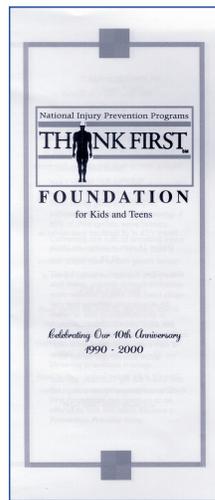
The Think First for Kids curriculum is an excellent injury prevention tool offered to kids in grades 1 through 3—an age where our studies tell us that injury prevention education can be most effective. However, as is true with all educational resources, it should be periodically updated and fine-tuned to remain interesting and relevant. The Think First Foundation Executive Committee reviewed suggestions in this area and, as such, has made minor changes to the curriculum and re-printed those materials.

The Think First for Kids curriculum was first developed in 1995. While these recent revisions have helped, more costly and time-consuming revisions are needed if we are to continue to get our message across to the ever-changing mindset of six-, seven-, and eight-year-olds. As funds become available, a major overhaul of the curriculum will get underway.

While it is painful to acknowledge, the need for violence prevention education has become relevant and timely. In fact, it seems that there is almost a daily reminder of this need. Since major attention to this curriculum is dependent upon funds, committee work is underway in outlining the curriculum in this area.

Training Programs

The Think First Foundation recently adopted a new training program. Under the program, the Foundation offers one-day sessions at training centers conveniently located throughout the United States, including San Diego, California; Phoenix, Arizona; Portland,



Oregon; Cheyenne, Wyoming; Columbia, Missouri; Shreveport, Louisiana; Charleston, South Carolina; Indianapolis, Indiana; Marquette, Michigan; and Buffalo, New York. At the training centers, instruction and assistance are offered with program development, implementation and evaluation. A complete packet of materials, including a curriculum, video, posters and comics, as well as an instruction guide, is provided to attendees.

Since its inception in the fall of 1999, 24 groups have trained under the new program, bringing the total number of chapters and satellite programs to 201 in the United States alone. Plans are under-

way to initiate new international programs, and join those already underway in Australia, Mexico, Canada, Chile and Singapore.

More convenient locations and reduced training fees are making it easier for those who are interested in forming new Think First chapters. With these new chapters in place, the Foundation's life-saving message can be provided to many more children.

Friend-Raising

Talk is cheap, but so very helpful for an organization dependent upon voluntary contributions. To that end, talk about us to your friends and associates. We know that you realize the importance of injury prevention education—make sure that others do, too. A new promotional brochure has recently been completed and is an excellent tool for introductions (see illustration). A supply of these brochures placed strategically in your office or carried along in your briefcases for distribution, can quickly make a new friend for Think First. Contact us and ask for your supply today.

The role of the neurosurgeon in friend-raising for the Think First Foundation will provide tremendous pay-offs in name recognition. Name recognition, in turn, leads to the generation of funds for our programs and, ultimately, to the accomplishment of our shared goal—prevention of traumatic injuries and the unnecessary loss of life. ■

Bill Biebuyck is Chief Executive Officer of the Think First Foundation. Think First Foundation shares offices with the AANS at: 5550 Meadowbrook Drive, Suite 110, Rolling Meadows, IL 60008; phone: (800) 844-6556; e-mail: thinkfirst@thinkfirst.org; Web site: www.thinkfirst.org.

Spokespersons Network

Members Rally to Establish National Network

Today, neurosurgeons are not the only ones treating patients for neurological disorders. Numerous medical specialties have penetrated the field through patient consultations and diagnoses for conditions such as low back pain, carpal tunnel syndrome and Parkinson's disease, to name a few. As such, there is a much-desired need for the AANS to define itself, its membership and the specialty of neurological surgery.

"The public is in need of accurate and up-to-date information about the field of neurosurgery in order to make intelligent and informed decisions about physician choice and patient care," said AANS Public Relations Chair, Ronald E. Warnick, MD. "As the spokesorganization for neurological surgery and Board-certified neurosurgeons, the AANS is in a position to take on this educational role."

To assist in this nationwide public education effort, a national AANS Spokespersons Network is being established to enhance the image of neurological surgery. The Network will take a proactive approach in educating the media and public about the scope of the specialty. Spokespersons will work with the media to maintain and enhance the image of neurosurgery and AANS members, and implement the communications priorities established by the AANS Board of Directors and AANS Public Relations Committee.

Calling All Representatives: Join Our Network

A cross-section of leadership and grassroots members located in states and major cities across the country will be recruited for participation in this new initiative. The Network will be comprised of a specially-trained group of neurosurgeons who are

experts in various aspects of neurological surgery, including stroke, Parkinson's disease, epilepsy, spinal cord injuries, back pain, sports-related injuries, lumbar spinal stenosis, brain tumors, neurotrauma, pain management and pediatric neurosurgery. This diverse group of neurosurgical experts will provide the media with a wide variety of medical professionals to call upon. The spokespeople will be available to assist media representatives with their stories, provide additional background materials and offer knowledge about the everyday practice of neurosurgery.



In addition, the Network representatives can provide expert perspectives on a broad range of neurosurgical topics, including details of surgical procedures, the patient-physician relationship, neurosurgical procedural statistics, technological advances in the field, the most up-to-date surgery techniques and the Association's position on legislative and socioeconomic issues impacting patient care. The spokespeople selected will be experienced in working with the media and will serve as valuable resources for print, radio and television outlets.

The Network representatives also will work closely with the AANS Communications Department to provide reporters with support materials for their neurosurgery-focused stories. The three primary objectives of Network members include:

- 1) Building relationships with influential individuals in key media outlets;
- 2) Working proactively to improve the image of the profession; and
- 3) Influencing public opinion by disseminating solid and consistent AANS messages.

All Network members must be certified by the American Board of Neurological Surgery, be a member of the AANS for at least three years, have attended at least two AANS Annual Meetings in the last four years and agree to serve on the Spokespersons Network for a minimum of two years. Media training seminars, which will be conducted at future AANS Meetings, will serve to hone and refine Network representative's media interviewing skills.

Duties and Responsibilities for Spokespersons

The primary duties of the Spokespersons Network representatives will include:

- working with the AANS Communications Department to promote key public education topics at the local level that are consistent with the Association's national media efforts;
- working with national media outlets to promote AANS policies, programs and statistics; and
- remaining current on AANS issues, position papers and other material distributed by the AANS National Office staff.

To learn more about the Spokespersons Network, look to future issues of the *Bulletin*, or contact Heather L. Monroe, AANS Communications Manager, at (888) 566-AANS. ■



New AANS Member Benefit

AANS Offers Discounted Professional Liability Insurance

AANS members now have the opportunity to receive discounted professional liability insurance through The Doctors' Company (TDC)—the insurer selected by the AANS to protect its members' professional liability interests.

Founded in 1976 by doctors, for doctors, to provide top-quality professional liability insurance to medical colleagues, TDC is the nation's largest physician-owned medical malpractice insurer that operates on a national basis. TDC is dedicated to providing AANS policyholder-members with risk management information that aids in the delivery of quality medical care within the diverse and ever-changing field of modern medicine. TDC has a "consent to settle" provision in the AANS membership insurance policy that assures that TDC must obtain the insured physician's consent before a proposed claim settlement is approved.

"TDC's understanding of liability issues includes areas specific to neurosurgery," said Manuel Puebla, President of TDC. "With four surgeons on our Board of Governors, including a neurosurgeon, TDC has expertise in neurological trends and unique insights in claims handling. We are a good fit for the AANS."

Meeting Your Needs

TDC is dedicated to protecting the interests of AANS policyholders by instituting highly selective underwriting standards. The AANS program will enable member policyholders to participate in underwriting and claims reviews through a TDC Neurosurgery Advisory Committee, and claims against AANS members will be peer-reviewed by Board-certified neurological surgeons.

As an added benefit, TDC also offers MediGuard to AANS members. This free policy feature provides reimbursement for legal services for Medicare/Medicaid, licensing, and credentialing reviews and actions, and also provides physicians with access to legal experts in their geographical region. In addition, AANS members also will have immediate access to risk management information on a nationwide telephone hotline. Customer service, regional claims and risk management representatives also will be available to assist with AANS members' inquiries.

"We are thrilled to offer our members such an extensive professional liability insurance package," said John A. Kusske, MD, Chair of the AANS Professional Liability Committee and AANS Vice President. "This program will provide our

members with more time to work with patients, and less time to worry about liability issues."

The TDC program will provide a 10 percent discount on annual premiums as a membership benefit of AANS, with additional discounts available for claims-free experience. Physicians insured with other claims-made carriers may convert to TDC without purchasing the costly tail coverage from their current carriers. Physicians may purchase a TDC policy dated retroactively to the first day of the original claims-made policy.

More Information

The TDC program also will provide substantial discounts for new physicians, coverage for locum tenens, choice of liability limits, national portability and free retirement tail coverage. (See sidebar below for more details.)

To learn more about this program, call TDC at (800) 421-2368 for an application. Or visit www.thedoctors.com, the TDC Web site for an online application and premium quote.



About the Program

The entire AANS professional liability insurance package includes the following:

- A 10 percent AANS member discount;
- Additional discounts of up to 25 percent for claims-free experience;
- Discounts up to 75 percent for physicians entering practice within three years of completing residency or military service;
- Discounts for part-time physicians (20 hours or less per week);
- Free extended leave options for maternity and family leaves, sabbaticals or illness;
- TDC-exclusive MediGuard legal reimbursement coverage for Medicare/Medicaid, licensing and credentialing reviews and actions;
- Discounts for group practices;
- Voluntary deductible discounts for individual physicians in groups (even without participation of all group members);
- Entity coverage for solo corporations of two or more doctors (additional premium);
- Liability coverage options of up to \$2 million per claim and \$5 million per annual aggregate (higher limit options available), excluding states with patient compensation funds; and
- National availability of TDC coverage and quarterly premium options with no interest or carrying charges.

Survey Says ...

Members Value Neurosurgical Books and the Internet

AANS members say they highly value the books published by the Association, counting neurosurgical books as a valuable service for members. They also are seeing increasing numbers of patients who are mining the Internet for health care information and using that information as background for consulting with their physicians.

YOUR OPINION COUNTS!

Make sure your voice is heard. Complete the Annual Meeting survey enclosed with this issue of the *Bulletin* and fax it to the AANS before the June 30 deadline!

These are among the notable results of the member survey distributed with the spring 2000 issue of the *AANS Bulletin*. The survey combined five questions soliciting members' opinions about AANS books with a second set of six questions on how

patients are using the Internet. At press time, 135 surveys had been returned.

The results from the first section of the survey will help guide the AANS Publications Committee, chaired by Warren R. Selman, MD. The AANS typically publishes six books annually, including volumes expanding the Neurosurgical Topics series and historical and reference texts. A significant majority of respondents—nearly 75 percent—reported buying between one and five neurosurgical books annually; 16% said they purchase six to 10 neurosurgical books each year, and 6% buy more than 10 neurosurgical books annually.

The survey asked about the topic areas in which respondents would be interested in buying books (see figure 1). More than 50 percent of the respondents indicated that they would be likely to purchase operative atlases, as well as books on spine topics. The AANS Neurosurgical Operative Atlas series

was launched in 1992; Volume 9, the newest in the series, was introduced in April.

Additional AANS books published this year include the Neurosurgical Topics book *LINAC* and *Gamma Knife Radiosurgery*, edited by Isabelle M. Germano, MD, and *Neurosurgical Classics II*, compiled by Robert H. Wilkins, MD, and Gloria K. Wilkins. Two new books will be available this summer: *Neural Prostheses*, edited by Robert J. Maciunas, MD, and *Contemporary Management of Spinal Cord Injury: From Impact to Rehabilitation*, edited by Edward C. Benzel, MD, and Charles H. Tator, MD.

Many respondents indicated interest in publications on practice management. In response, the AANS introduced a new line of practice management publications produced by noted publishers, including the AMA and Conomikes, Inc.

The Value of the Web

The Internet is growing quickly as a source of health care information for patients, according to the respondents. Nearly 60% of the respondents said that, in 1999, up to 15% of their patients researched their conditions on the Internet. Almost 25% of respondents said that between 16 and 30% of their patients had consulted the Internet about their conditions (see figure 2).

The survey also revealed that about 35% of the respondents have a Web site for their practice, and another 34% plan to develop a Web site within the next year. With that in mind, the AANS has announced a new member benefit in partnership with Medem, an Internet health information site sponsored by the AMA and several medical specialty societies. AANS members can register for a practice Web site to be hosted by Medem that can include customized practice information, information about the physicians in the practice, and selections from a content library provided by Medem's specialty society contributors, including the AANS.

For more information about AANS books call (888) 566-AANS or visit www.neurosurgery.org/aans. For information on Medem's Web services, visit www.medem.com.

FIGURE 1: BOOK TOPICS OF INTEREST TO MEMBERS

CLINICAL		Reference Books/Encyclopedias23.0%
Spine . . . . .	.63.7%	Stereotactic and Functional Neurosurgery 23.0%
Operative Atlases . . . . .	.52.6%	Self Assessment in Neurosurgery22.2%
Tumors . . . . .	.37.8%	PRACTICE MANAGEMENT
Cerebrovascular . . . . .	.30.4%	Coding Reference51.1%
Neurotrauma . . . . .	.24.4%	Medical Office Management22.2%
SPINE CONDITIONS		Headache23.7%
Low Back Pain . . . . .	.59.3%	PERIPHERAL NERVE CONDITIONS
Neck Pain . . . . .	.31.1%	Carpal Tunnel Syndrome25.2%
Spinal Cord Injury . . . . .	.20.7%	OTHER
CEREBROVASCULAR CONDITIONS		Brain Tumors50.4%
Aneurysm . . . . .	.34.1%	Surgical Procedures31.1%
Stroke . . . . .	.26.7%	Chronic Pain28.0%

Best of Times, Worst of Times

Recognizing the Value of Neurosurgical Research

In *A Tale of Two Cities*, Charles Dickens described “the best of times, the worst of times.” Neither applies today, but we are clearly in “strange times.” The United States is more prosperous than it has ever been. Governmental budgets are reaching all-time highs, including allocations for the National Institutes of Health (NIH), our primary biomedical research agency, which will exceed \$20 billion in 2001. At present, technological discoveries are occurring at warp speed and research discoveries make the news everyday.

Are these the best of times? Many would argue no, in part due to the growing number of academic health centers approaching bankruptcy. While there has been a progressive reduction in reimbursement for patient care, particularly for the “non-cognitive” specialties such as cardiac surgery and neurosurgery, our administrative burdens associated with patient care, insurance requirements and administrative regulation have all steadily increased. Are these the worst of times?

The Role of Research

Our lives as neurosurgeons revolve around four or five basic areas: patient care, administration (including office management), family, teaching and research. Given that there is only so much time in a day, certain priorities have to be established and something has to give. For some, family time suffers; for others, teaching. Ironically, administration rarely comes up short, and patient care can't be budgeted. Research is often last on the list of practicing neurosurgeons and is, thus, a vulnerable target.

What does it take to do research? The “essentials” are a good idea, time, money, space and mentoring. The practicing neurosurgeon intending to do research must

have each. However, time is certainly the most precious, given the current climate that requires neurosurgeons to work harder for less.

What Does it Take?

While discoveries are being made everyday by full-time researchers, there still remains a cadre of surgeons who are serious investigators, each requiring the “essentials” of research. Most neurosurgery residency programs require research training for at least one year; some do not because they lack time, money, mentoring and space. Those requiring resident exposure to investigation commit the essentials to sustain the effort. While the federal government has been the “deep pocket” for research funding, other corporate and philanthropic organizations also have provided financial support for research.

In fact, substantial grant support and nearly 40 achievement awards are available within our neurosurgical community. Most of the awards come from the American Association of Neurological Surgeons (AANS), Congress of Neurological Surgeons (CNS) or their subspecialty Sections, and range in cash awards from \$250 to \$35,000.

In addition, 13 research grants are available for neurosurgeons in training or soon out of their residency. The AANS/CNS Sections award seven of those grants and the remaining six are provided on a competitive basis by the AANS Neurosurgery Research and Education Foundation (NREF).

This past year, NREF awarded six new grants, three of which are two-year commitments for \$35,000-\$40,000 each, and the remaining three are one-year awards. NREF has committed itself to supporting 10 investigators per year. NREF's ability to support

researchers comes from the generous contributions of neurosurgeons, corporations or individual donors. In addition, the foundation has a \$5.5 million endowment.

Can Neurosurgeons Improve NREF's Efforts?

Most neurosurgeons cannot provide the time, space or mentoring to those in need of research training. However, many can provide financial support. It takes approximately \$700,000 of NREF's endowment to fund one research award (\$30,000-\$40,000 per year). Thus, major donors are the lifeblood of our annual fund-raising program. Bequests, gifts and “staggered” giving over several years are just a few of the mechanisms available for those who wish to support NREF's endowment.

Smaller gifts also are welcome. A gift in honor or memory of a loved one is an ideal way to show your gratitude to someone important to you and your career. While smaller gifts can be named and the purpose of the gift directed toward a fellowship, the continuity of the award disappears unless the donation adds to the endowment. For example, a donation of \$40,000 for a fellowship in honor of a former instructor can last no more than one year, since the money is spent by the investigator or fellow during that year. Establishing a fellowship “in perpetuity” requires a major gift of at least \$700,000 to sustain its continuity.

NREF must increase its endowment to ensure the continuity of research funding and maintain a long-term commitment to investigations that will improve our specialty. To that end, neurosurgeons must support research and development in our specialty—make your tax deductible contribution today!

To learn more about NREF, or to make a donation, please call Barbara Schwarz, NREF Director of Development, at (888) 566-AANS.



Julian T. Hoff, MD, is Professor and Head of the Department of Neurosurgery at the University of Michigan (Ann Arbor) and Chair of the AANS Neurosurgery and Research Education Foundation.

Increased Risk

Understanding the Impact of Fraud and Abuse

If the words “fraud” and “abuse” have not become part of your everyday language, they need to be. With the federal government’s continued focus on health care fraud and abuse, independent physicians and small group practices are at risk, as are larger integrated delivery systems. Over the past several years, the Office of the Inspector General (OIG) has recovered hundreds of millions of dollars as a result of their investigations, and it looks as if there is no end in sight.

Monitor Your Practice

Practices should meticulously monitor the following activities in an effort to avoid liability: medical necessity; coding at a level higher than your documentation supports (up-coding); double billing; and billing for services not rendered.

- **Medical necessity:** Document, Document, Document! If a service is not documented appropriately in a patient’s chart, it didn’t happen. Always include complete documentation of diagnosis and symptoms, warranting the performed services.

- **Coding:** Ensure that staff is appropriately trained on the intricacies of your specialty’s coding requirements and the rules and regulations associated with improper coding. Provide as much training and education as possible and create a culture that supports ongoing training for annual updates. Furthermore, perform periodic chart audits to ensure that documentation coincides with billed charges. Document the results and any improvements that you have implemented as a result of the chart audits to demonstrate your commitment to regulatory compliance.

- **Double Billing and Services Not Rendered:** Develop and implement a system that allows you to monitor when a bill

was sent and when the corresponding services were provided. If your practice is automated, your computer system should be able to track this information. Discuss options with your vendor and assign responsibility to a staff member.

Prevention is Key: OIG’s Seven Basic Elements

The best way to deal with the threat of an audit is to prevent one from happening in the first place. Take the initiative and address your practice’s activities before someone else does it for you. Initially, you should create a culture that does not tolerate non-compliant behavior. Discuss the issues with your staff and educate them on the importance of developing and adhering to a compliance program.

Although a compliance program needs to be specific to your practice’s needs, there are seven basic elements that are recommended by the OIG to avoid fraud and abuse sanctions. They include:

1. Record, in writing, all compliance policies and procedures. Be sure to address areas and elements that are specific to your practice and specialty.

2. Establish a compliance training and education program for the physicians and employees in your practice.

3. Appoint a physician or staff member responsible for implementing and monitoring the program.

4. Develop and implement a system to receive, respond and monitor allegations and complaints from your internal and external customers.

5. Establish evaluation tools and techniques to monitor compliance and address existing and potential problems.

6. Investigate and address all problems. Make it practice policy to discipline,

even dismiss, staff members who are non-compliant or foster non-compliance.

7. Provide protection for staff members who identify existing and potential compliance problems and issues. Create a culture that not only supports, but also rewards employees who identify potential liabilities.

Although implementing a compliance program may seem like an unachievable task due to staff and resource constraints, begin with small steps and always remember to document.

How the AANS Can Help

To assist its members, the AANS Education and Practice Management Department is in the process of developing programs to help AANS members become compliant.

- **2000 course schedule.** The AANS’ current course schedule is concentrated in coding and socioeconomic issues. Courses are: “Mastering Expert Techniques in Neurosurgical Coding,” “Managing New Reimbursement Challenges in Neurosurgery,” “Designing Better Business Systems” and “Anatomy and Terminology for Office Staff.” (See page 9 for course descriptions.)

- **Coding hotline.** The hotline provides AANS members with convenient access to expert coding advice at discounted rates. (For more information, see page 9.)

- **Compliance program development.** The Department of Education and Practice Management is in the initial stages of investigating resources for the possible development of a template compliance program.

- **Annual meeting programs.** At the 2000 Annual Meeting, the AANS provided members with an added benefit—a Consulting Corner and Strategic Management Symposium. Each focused on practice management issues.



For more information on AANS-sponsored practice management courses and services, contact June S. Wasser, Director of the AANS Education and Practice Management Department, at (888) 566-AANS or visit www.neurosurgery.org/aans/meetings/edp/pdpcourses.html

Reaching New Heights

AANS Membership Tops 5,800

NEW AANS MEMBERS

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David E. Adler
Mahmoud Al-Yamany
Nesher G. Asner
Behnam Badie
Frederick G. Barker
Marvin Bergsneider
Ajay K. Bindal
Deborah A. Blades
Spencer J. Block
John Brayton
Adam P. Brown
Paul J. Camarata
Gary J. Correnti
Brian G. Cuddy
Stephen J. Dalrymple
Rajiv D. Desai
Thomas R. Donner
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David M. Frim
Kimball S. Fuiks
Michael R. Gallagher
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John Peter Gruen
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Paul P. Huang
Matthew K. Hummell
Patrick D. Ireland
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Mark Jude Krinock
Joung H. Lee
Leon K. Liem
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Charles S. Theofilos
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Jamie S. Ullman
Peter B. Weber
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Active (Provisional) Members

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Christopher J. Abood
John K.B. Afshar
Rocco A. Armonda
Kurt D. Bangerter
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Mark A. Mittler
Mark D. Oliver
John K. Park
Bryan R. Payne
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Harold J. Pikus
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Peter A. Rasmussen
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For more information on the wealth of membership benefits offered through the AANS, contact the Member Services Department at (888) 566-AANS or visit www.neurosurgery.org/aans/membership.



CSNS Semi-Annual Report

Spotlight on Resolutions Passed

The Council of State Neurosurgical Societies (CSNS) met in San Francisco, California, April 7-8, 2000, to discuss a wide range of socioeconomic issues impacting neurosurgeons. Resolutions passed ranged from developing a survey of neurosurgeons regarding their opinions on the unification of neurosurgery to support for a joint coding and reimbursement committee.

Unifying Neurosurgery

Given the similar missions of the American Association of Neurological Surgeons (AANS) and Congress of Neurological Surgeons (CNS)—to provide education and social discourse to its members—attention was focused on the need for two administrative infrastructures. The Council passed a resolution to poll members of both groups on whether they wish to continue to have two organizations or establish one administratively merged association. The Council also passed a resolution asking that the current and Immediate-Past Chair of the CSNS participate in future Joint Strategic Planning deliberations.

Bipartisan Consensus Managed Care Act

A resolution in support of the “Bipartisan Consensus Managed Care Act” was passed with several provisions. The bill supports patients’ right to seek redress of legal grievances with HMO’s. The Council agreed the bill should include a provision that punitive damages should neither be distributed to the plaintiff nor the prosecuting attorneys. Rather, punitive damages should be distributed to address state medical needs, as determined by judicial authorities. By doing so, the patient’s right to quality med-

ical care will be assured while avoiding unnecessary litigation.

Pass Campbell Bill, Crusade Across America

A resolution was passed urging the AANS and CNS, in conjunction with the American Medical Association (AMA), to develop educational materials (brochures, slides, etc.) for physicians to advise the public, media and federal, state and local officials about the importance of HR 1304, the “Quality Health Care Coalition Act.” The bill will allow physicians to negotiate the terms and conditions of their health plans without violating antitrust laws.

The resolution, submitted by Donald J. Prolo, MD, also calls for the AANS and CNS to assist in the formation of state medical society Medical Crisis Committees on Public Education, as well as for the AANS and CNS delegates to the AMA to work with the American Medical Association to initiate a Medical Crusade Across America. The initiative, which will be held in cooperation with various medical specialty societies throughout the U.S., is aimed at urging Congress to pass, and President Clinton to sign, HR 1304.

Think First Foundation

Support for the Think First Foundation was an important topic, as evidenced in a resolution passed by the Council requesting the AANS and CNS leadership to renew their commitment to the Foundation and its mission of injury prevention. The resolution requests the leaders of both groups to: 1) Renew their level of financial support for the Foundation; 2) Assist the Foundation in identifying potential funding sources and help with the cultivation and

solicitation of major vendor proposals; 3) Maximize exposure of the Foundation with neurosurgeons and vendors at the national meetings of the AANS and CNS; 4) Encourage neurosurgeons to financially support the Foundation and launch new programs in their communities; and 5) Provide \$5,000 of support to the Think First effort.

Spine/Brain Injury Prevention Education

Given the growing number of brain and spinal cord injuries sustained by children each year, the Council passed a resolution requesting each CSNS representative to work with his or her legislator to implement a core curriculum that promotes stopping violent or risk-taking behavior among students in grades K-3 and 9-12. The curriculum should integrate the learning methods developed by the Think First Foundation and stress: reading and language; writing, including creative and formal techniques; mathematics, including statistical analysis and probability; anatomy and health; observational experience and deductive reasoning in predicting consequences and modifying behavior; and individual responsibility in promoting safety.

Emphasis on Coding and Reimbursement

The Council passed a resolution asking the AANS and CNS to expand and adequately fund the Physician Reimbursement and Coding Committee. The resolution calls for the leaders of the AANS and CNS to work with the Sections in identifying members to serve as liaisons to the committee and provide expertise in the area of coding and reimbursement.

Increase Speaker Diversity

Recognizing the main goal of the AANS and CNS Annual Meetings is to foster an exchange of new ideas, techniques and information, the CSNS passed a resolution to poll meeting attendees on their suggestion for speakers for future venues. Such feedback will be instrumental in enhancing the quality of future meetings. ■

Section News

Neurosurgical Focus Indexed Online

After an extensive review process, *Neurosurgical Focus* has received notification of acceptance for indexing on Medline and in Index Medicus. *Focus* is one of only eight Internet-based journals selected for this honor. Indexing will include all previously published and future issues. To view *Neurosurgical Focus*, visit www.neurosurgery.org/focus.



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Section on Cerebrovascular Surgery The Section on Cerebrovascular Surgery met in February of 2000 for what was the most well-attended CV Section meeting in its history. Some 500 physicians attended the meeting, which was jointly sponsored by the American Society of Interventional and Therapeutic Neuroradiology (ASITN).

Highlights of the meeting included an outstanding symposium on the management of arteriovenous malformations, which included a presentation on the techniques to minimize endovascular and surgical risks of AVM treatment; the Presidential Address by Section Chair Christopher M. Loftus, MD, FACS, which served as a call to action to the Section's membership and as a counterpoint to the provocative Luessenhop Lecture given by L. N. Hopkins, III, MD; outstanding presentations on advanced endovascular and microsurgical techniques for the treatment of cerebral aneurysms; a lively debate on the management of unruptured aneurysms; and a special lecture on the development of skull base approaches for posterior circulation aneurysms. Course meeting Co-Chairs, Warren R. Selman, MD, and Thomas A. Tomsick, MD, are to be congratulated for planning such an outstanding meeting.

To view the list of companies who provided educational grants to support the meeting, visit www.neurosurgery.org/sections/cerebrov/summary.html.

This article was modified and reprinted with permission from Cerebrovascular News, spring 2000.

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Section on Neurotrauma and Critical Care Critical care has long been an integral part of neurosurgery. The acute management of patients with head injury, subarachnoid hemorrhage, and spinal cord injury commonly involves time spent in an intensive care unit (ICU). Neurosurgeons have been instrumental in the development of ICU-based strategies that have led to improved outcomes, such as triple-H therapy for cerebral vasospasm and cerebral perfusion pressure for the management of head injury. As the population ages and more patients undergo elective pro-

cedures with significant cardiopulmonary co-morbidities, the utilization of ICUs by neurosurgical patients will likely increase.

Significant challenges are emerging, however, that will potentially impact the neurosurgeon's role in the ICU. Technological advances in critical care medicine are increasing the complexity and cost of ICU care. At present, ICUs account for nearly 30 percent of total hospital charges in the U.S., and this has led to the increased scrutiny of outcomes. As neurosurgeons continue to experience pressures on the amount of time that they can devote to critical care, the 85 accredited U.S. training programs in adult critical care medicine are graduating more than 100 new intensivists per year. A growing body of literature suggests that better outcomes and lower costs are achieved in ICUs run by intensivists.

How can neurosurgeons respond to these challenges? First, neurosurgeons must more efficiently triage those patients most likely to benefit from ICU care. The use of ICUs for routine post-operative care is often not necessary. In fact, it has been shown that patients undergoing carotid endarterectomy can often be managed in step-down units without invasive pressure-monitoring devices. Similar results have been shown for patients with spinal disorders, where the use of severity-of-illness scoring systems have been successful in identifying patients who do not require ICU care.

Second, neurosurgeons must take a more active role in critical care medicine. Physicians trained from the disparate fields of anesthesiology, internal medicine and surgery have driven the evolution of modern critical care medicine. This reflects the fact that there are many common themes in the physiology of critical illness.

For example, the ventilator management of Adult Respiratory Distress Syndrome is based on the same principles, regardless of whether the etiology is head injury, sepsis or aspiration. Similarly, the hemodynamic manipulation involved in triple-H therapy depends upon the use of the same monitoring devices and vasoactive medications used for the circulatory support of shock.

Neurosurgeons possess a specialized understanding of the nervous system that many intensivists do not. There is every reason to believe that this knowl-

edge, combined with an understanding of the physiology of critical illness, will enhance and optimize the neurosurgeon's care of critically ill patients.

Perry A. Ball, MD, and Michael G. Fehlings, MD, PhD, contributed to this article.

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Section on Pain At the 2000 AANS Annual Meeting, members of the Pain Section participated in a wide variety of pain-related practical courses and breakfast seminars, as well as a first-rate Section-sponsored scientific session. The session featured a symposium on minimally invasive procedures for pain management and open papers on a wide range of topics, including stimulation for the treatment of intractable craniofacial pain, the pathophysiology of neuropathic pain and neuroparalytic keratitis, and epidural analgesia for postoperative pain control.

It was during the Pain Section session that the William H. Sweet Young Investigator Award was presented to Alon Y. Mogilner, MD, for his study, "Functional Brain Imaging and Spinal Cord Stimulation: Localization of Cortical Activity With Magnetoencephalography."

This article was reprinted with permission from Pain News, April 2000.

Section on Pediatric Neurological Surgery At the recent Section on Pediatric Neurological Surgery scientific session, which took place at the AANS Annual Meeting in April, Donald H. Reigel, MD, was named the 2000 Donald D. Matson Lecturer. The Lectureship is presented annually to a distinguished clinician, teacher or researcher in any of the pediatric sciences.

Dr. Reigel is a former Chair of the AANS/CNS Section on Pediatric Neurological Surgery. He also is a founding member of the American Society of Pediatric Neurosurgeons and the American Board of Pediatric Neurosurgery.

A prolific writer and investigator, Dr. Reigel, along with E. Bruce Hendrick, MD, founded the *Journal of Pediatric Neurosurgery* in 1985. Dr. Reigel served as Managing Editor of this publication until 1998.

That same year, Dr. Reigel retired from the active practice of pediatric neurosurgery to devote his full attention to the Woodlands Project. As Executive Director of the Woodlands Foundation, a charity whose mission is to enhance and expand the life experiences for all children with disabilities or life-

Continued on next page

JNS Hits the Web

The Journal of Neurosurgery and *Journal of Neurosurgery: Spine* are now available to AANS members at www.thejns-net.org, beginning with the January 1999 issues. Full text articles and graphics are available in an easily searchable interface. Abstracts also are available and, within the next few months, abstracts dating back to 1990 will be online. All references in the *Journal of Neurosurgery* and the *Journal of Neurosurgery: Spine* will be linked to PubMed. Individual member account numbers, which grant full access to the site, can be found above member names on the mailing label for the *Journal* or on AANS invoices. Questions regarding member account numbers should be directed to the AANS Member Services Department at (888) 566-AANS.



NIAMS Study

A five-year, \$13.5 million study supported by the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) is getting underway. The study will investigate the relative merits of surgical versus non-surgical treatment for herniated lumbar discs, spinal stenosis and degenerative spondylolisthesis. James N. Weinstein, DO, MS, is the principal investigator of the study, which will include some 1,450 patients at 11 medical centers.

Patients enrolled in the study will be randomized and receive either surgical or non-surgical treatments. Outcomes will be based upon quality of life surveys, spine-related disability and resource utilization, and follow-up will occur over a two-year period.

The results of this study are eagerly awaited by health insurance agencies, who are estimated to provide somewhere between \$30-70 billion annually for the treatment of severe back pain. Clearly, the results of this study have the potential to impact the practice of almost every neurosurgeon. Our challenge will be to interpret the results fairly, and to defend the needs of our patients against the economic interests of third-party payors.

R. John Hurlbert, MD, PhD, contributed to this article.

EDITOR'S NOTE: The AANS is currently working with the Washington Committee to draft a letter to the Director of NIAMS regarding this study. In the letter, the AANS plans to express its concerns over the shortcomings of this trial; in particular, the study's biased investigation into the surgical treatment for back pain.

AANS/CNS Support the Utilization and Supervision of Mid-level Practitioners in Emergency Care Systems

Recently, concern has been raised that physician assistants and nurse practitioners are increasingly participating in the management of neurosurgical patients in emergency departments and intensive care units, without neurosurgical supervision. In particular, concerns have surfaced as to the involvement of mid-level practitioners in the placement of intracranial pressure monitors. The AANS and CNS recognize these concerns and have issued a position statement that can be found online at www.neurosurgery.org/aans/media/position.asp.

threatening illnesses, Dr. Reigel continues to assist young people with chronic diseases to reach their maximum potential.

This article was reprinted with permission from Pediatric Short Cuts, February 2000.

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Section on Disorders of the Spine and Peripheral Nerves For neurosurgeons looking to enhance their clinical skills and gain exposure to the latest surgical techniques emerging in the neurosurgical arena, the 16th Annual Spine Section Meeting provided all that and more. Gerald E. Rodts, Jr., MD, Annual Meeting Chair, and Timothy C. Ryken, MD, Scientific Program Chair, assembled an outstanding Scientific Program, complete with more than 150 scientific presentations and posters, three special courses and more than 60 exhibitors, as well as a golf and tennis challenge.

Special congratulations are extended to Neill M. Wright, MD (St. Louis, Missouri), winner of the 2000 Mayfield Award in Basic Science for his paper, "Bone Marrow Derived Mesenchymal Stem Cells Transduced With an Adenoviral Vector Carrying the Gene for Human BMP-2 Can Induce Anterior Spinal Fusion."

Congratulations also go out to Viswanathan Rajaraman, MD, FRCS (Newark, New Jersey), winner of the 2000 Mayfield Award in Clinical Science for his presentation, "Use of Intensive Care Units for Patients with Spinal Disorders," and Arnold H. Menezes, MD, recipient of the 2000 Meritorious Service Award.

Section on Tumors Given the rapid development of new therapies and diagnostic techniques for patients with brain tumors, the need for a comprehensive informational resource for clinicians and researchers with an interest in neuro-oncology is obvious. The *Select Review in Neuro-Oncology*, (www.neurosurgery.org/tumor/selectreview/), an online educational resource for the neurosurgical community with an interest in brain tumors, is an attempt to address that need. The review is a periodic summary of pertinent information in literature related to brain tumors. Individuals from across the country in 13 different disciplines, including the basic sciences, have pledged their support to this effort.

The *Review* is divided into four sections: journal article reviews, abstracts from various national meetings, invited comments from authors of selected articles, and original contributions from experts who summarize current areas of interest in neuro-oncology.

Periodically, specialists in multiple fields are asked to examine their own literature and then prepare concise summaries of the "select" articles thought to be most relevant to brain tumor research and treatment. These summaries are submitted online and edited before final release. These same individuals also are asked to identify and submit abstracts of particular interest from the various national meetings related to neuro-oncology. These are subsequently listed in a separate section of the site. All journal article summaries and abstracts are grouped according to specialty.

This article was reprinted with permission from Tumor News, spring 2000.

AANS Supports Discussions To Unify Neurosurgery

One of the topics of discussion and action at the recent Council of State Neurosurgical Societies meeting in San Francisco, was a resolution calling for a poll of the membership of the AANS and Congress of Neurological Surgeons (CNS) to obtain data indicating whether there should be two organizations or one merged organization. The resolution passed and the survey will be conducted in the near future.

The issue of unification has been a significant topic of discussion between the AANS and CNS leadership. Officers of the two organizations specifically met during the 2000 AANS Annual Meeting to talk about the importance of unifying neurosurgery.

AANS President Stewart B. Dunsker, MD, has written Daniel L. Barrow, MD, President of the CNS, informing him that the AANS "strongly supports discussions with the CNS to unify neurosurgery, and that the door is open to discuss any models and ways of accomplishing it."

AANS News

AANS Goes Digital, New Member Service Announced

The AANS is offering a new member service through its involvement with Medem—the e-health network created with the clinical leadership and expertise of the nation's leading medical specialty societies and the American Medical Association.

Medem, which recently appointed Nancy W. Dickey (former AMA president) as editor-in-chief, empowers the physician-patient relationship by providing patients with access to comprehensive health information and services, as well as other interactive tools through their doctor's own proprietary Medem Web site.

AANS' partnership with Medem is mutually beneficial to both the physician and society, allowing surgeons to heighten their practices' exposure and build upon their existing client base, as well as gain electronic access to the most current and credible clinical information from the Association.

"We believe that this strategic partnership with Medem will help our members streamline the management of their practices," said Martin H. Weiss, MD, AANS Immediate Past President. "We also are pleased with the opportunity to contribute editorial content to what is sure to become a valuable source of health information to patients."

To learn more on how to put this AANS member service to work for you, call the AANS at (888) 566-AANS, or visit Medem's Web site at www.medem.com.

AANS Donates Neurosurgical Texts

The AANS recently donated more than 2,600 neurosurgical publications to 93 residency programs throughout the U.S. The books, which included publications from the Neurosurgical Topics Series, Special Topics Series, Neurosurgical Clinical Presentations Collection and Historical Collection, will be used to enhance the educational materials presently available to neurosurgical residents in training.

The feedback from this effort has been positive and, according to Daniel L. Barrow, MD, CNS President, Emory University Residency Program Director and recipient of select books, "This altruistic service is greatly appreciated and represents a most valuable addition to our program's library."

Expanded Representation The AANS is working harder than ever to incorporate young neurosurgeons and female neurosurgeons into its programmatic efforts. "Over the past year, the AANS leadership has made a deliberate effort to reach out to these two constituencies, proactively encouraging members at every level of the Association to participate in AANS activities," said Stewart B. Dunsker, MD, AANS President. The AANS has invited the Chairman of the Young Neurosurgeons Committee (YNC), B. Gregory Thompson, Jr., MD, to participate in Board deliberations and also has appointed Gail L. Rosseau, MD, and Diane L. Abson-Kraemer, MD, to Co-Chair the AANS Membership Committee, thereby enhancing representation of these two groups within the AANS.

In addition, the AANS has appointed a National Office executive staff member to serve as a liaison to each of the AANS/CNS Sections, as well as YNC, WINS and CSNS. "This relationship was established so that the specific issues of each Section can be brought to the attention of the AANS in a very direct way."

Neurosurgery Targets Family Physicians

In April of 2000, the AANS and CNS co-sponsored a special exhibit at the Scientific Assembly of the American College of Physicians/American Society of Internal Medicine, which took place in Philadelphia, Pennsylvania. This project marked the fifth time that organized neurosurgery reached out to increase awareness of the scope of neurosurgical practice with referring physicians, who frequently serve as medial care gatekeepers.

The objectives of this year's booth were to highlight the neurosurgeon's role in treating Parkinson's disease and disorders of the cervical spine. Volunteer neurosurgeons Ghassan K. Bejjani, MD; John A. Boockvar, MD; Kevin D. Judy, MD; Grant P. Sinson, MD; and William C. Welch, MD, were accompanied by AANS staff representative Deia Lofendo in the booth to talk one-on-one with family physicians and internists. Based on the number of handouts and promotional items distributed, it is estimated that approximately 1,200 family physicians visited the booth during the three-day venue. The neurosurgery exhibit will be displayed next at the Scientific Assembly of the American Academy of Family Physicians, which will take place in Dallas in September of 2000.

In the News

At this year's AANS Annual Meeting, ABC-TV's news program "Nightline" visited the Moscone Convention Center to tape interviews with Association leaders and other AANS members, for a segment featuring a study reported in the April 12 issue of the *Journal of the American Medical Association*. The study examined the impact of physicians "gaming" the health care system, and the show highlighted physicians' sympathetic approach to providing quality patient care. Featured in the segment were neurosurgeons James R. Bean, MD; Gary M. Bloomgarden, MD; John A. Kusske, MD; and Sherry L. Taylor, MD. Kim Burchiel, MD, was also interviewed but did not appear.



Secretary's Report

Highlights from the Report Presented at the 2000 AANS Annual Business Meeting

In an effort to become reconnected with who we are and what we hold dear, I set out to re-examine our Association's mission and goals. As it happens, the AANS Board and National Office executive staff have been grappling with this very issue over the past few months, formally revising our mission and vision statements, as well as updating our goals and objectives. The fact that our mission statement did not change at all during this scrutiny is a testament to its timeless strength of purpose, stating as it does that we are "... dedicated to advancing the specialty of neurological surgery in order to provide the highest quality of neurosurgical care to the public." Keeping this lofty mission in mind puts us in a powerful position to achieve our goals.

It is impossible to acknowledge the thousands of volunteer hours contributed by AANS committee and task force members every day. To those of you who currently volunteer your time, and to those who are considering future leadership roles, I applaud you.

AANS Strategic Plan: Goals, Objectives and Activities

Goal: *Support Infrastructure and Governance. The AANS will enhance the organization by continually strengthening its infrastructure, governance and volunteerism.*

Objective: National Headquarters Infrastructure. **Activity:** Last year, following the departure of Robert E. Draba, PhD, I reported to you that a search was on for the quintessential AANS Executive Director. That search ended in late spring with the hiring of Dave Fellers, CAE, a 28-year veteran administrator of professional medical

organizations, with an unmatched record of success. Mr. Fellers came to us from the American Society of Plastic Surgeons and has already begun the arduous task of reorganizing the AANS National Office.

Another exciting development at our National Office was the recent move from Park Ridge to Rolling Meadows, Illinois, in early May.

Objective: Strategic Business Plan. **Activity:** For the first time since 1995, the AANS Board has updated its Strategic Business Plan. Included in this update are the results of the recent membership survey, which revealed that members view the *Journal of Neurosurgery*, the *Directory of Neurological Surgery* and the AANS Annual Meeting as the three most important benefits of AANS membership. The survey also indicated that our members want: 1) The AANS and CNS to consolidate their activities, 2) The AANS Code of Ethics to be enforced, and 3) The value of Board-certified neurosurgeons to be advocated to the general public.

In addition, a recent leadership survey identified our Board's commitment to positioning the AANS as the national spokesorganization for neurosurgeons, communicating to AANS members and working for fair reimbursement for neurosurgeons. The results of these two surveys will prove to be invaluable as we map out our strategies for the coming years.

Goal: *Make the AANS the Spokesorganization for Neurosurgery. Increase awareness by serving as the spokesorganization to the public, medical and third-party payor community, and ensure these target audiences recognize neurosurgeons as the primary providers of quality care to neurosurgical patients.*

Objective: Outreach to the media and educate the public and medical community about neurosurgery. **Activity:** For a modest contribution of \$100 each, members from around the country made it possible for the AANS to produce an eight-page, full-color, insert about neurosurgery in the April 7, 2000 issue of *USA Today*. The insert, which targeted more than five million readers, was sent to every member of Congress, posted on NEUROSURGERY://ON-CALL®, sent to corporate sponsors and members who supported the project, and distributed to primary care physicians at the recent Scientific Assembly of the American College of Physicians/American Society of Internal Medicine. In addition, articles from the insert appeared on Drkoop.com and WebMD, two highly-regarded medical Web sites. Continued member participation will prove vital to the success of this project, as each member is responsible for promoting and disseminating the insert to his or her local newspapers, television and radio stations, patients and referring physicians.

Objective: Establish Online Presence for Neurosurgery. **Activity:** The AANS Board recently voted to become participants in Medem, a Web site developed by the nation's leading medical specialty societies and the American Medical Association. One of Medem's major benefits is that it develops Web sites for individual physician practices in order to "brand" these practices and establish their presence on the Internet. Our leadership and staff also have been in negotiations with Drkoop.com and WebMD, in an effort to better position the AANS as the "digital voice for neurosurgery."

Goal: *Communications and Services for Members. Increase the value of membership in the AANS through communications with the membership and through the development of programs and services that enhance the practice of neurosurgery and better educate neurosurgical patients and their families.*

Objective: Professional Liability/Risk Management Programs. **Activity:** As a result of member interest, the AANS recently selected The Doctors' Company (TDC) to offer a professional liability insurance program to its members. This decision will ensure that AANS members who need liability and malpractice insurance will be able to obtain it from one of the strongest, most reputable liability insurance companies in the country. (For more information on TDC, see page 28.)

Objective: Publications and Online Communications. **Activity:** A Publications Business Plan was recently completed and will be utilized to restructure the Publications Program. In addition, *Neurosurgical Focus* has been officially accepted for listing/indexing on Medline and in Index Medicus—an illustration of this publication's superb quality.

Goal: *Educational Programming and Practice Development. The AANS will be the leader in providing and sponsoring clinical educational and practice management programming for neurosurgeons.*

Objective: Annual Meeting. **Activity:** This year's Annual Meeting program was outstanding, attracting more than 7,200 attendees. We had the honor of hearing acclaimed author and Pulitzer Prize winner, Doris Kearns Goodwin, deliver the Cushing Oration, as well as John E. Wennberg, MD, deliver a thought-provoking presentation on neurosurgical outcomes. In addition, we had a record number of abstracts submitted for presentation, proving once again that research is alive and well in the field of neurosurgery.

Objective: Continuing Medical Education Courses. **Activity:** The Professional Development Department has been restructured, and is now the Department of Education and Practice Management. The new focus of the department will center on professional development courses and areas where the AANS can assist its members in

practice management, outcomes and research.

Goal: *Support the Washington Committee. The AANS will strongly support the efforts of the Washington Committee to address advocacy for fair and equitable reimbursement, federal legislation and regulation.*

Objective: Coding, Reimbursement and Medicare. **Activity:** The Washington Committee continues to do an extraordinary job of advocating for AANS members. Equitable reimbursement policy continues to be a top priority, and currently the AANS is a plaintiff in three lawsuits involving the Health Care Financing Administration (HCFA).

The most recent of these suits, filed on December 30, 1999, on behalf of the AANS/CNS and several other medical specialty societies, was prompted by "practice expense methodology that disallows expenses for all clinical support personnel used in hospitals or ambulatory surgical facilities when these expenses are paid by the physicians employing such personnel. This action is in direct contravention of the law, which directs HCFA to account for the costs of all physician practice expenses in its methodology."

Goal: *Foundation Activities. The AANS will enhance the organization by continually strengthening its infrastructure, Board and committee governance and volunteerism.*

Objective: Basic and Clinical Research. **Activity:** The Research Foundation was recently renamed The Neurosurgery Research and Education Foundation. The change reflects the Foundation's expanded mission to be more involved with all of neurosurgery, while reinforcing how research is an important educational tool for the neurosurgeon. Funds are now available to support this broader mission, and co-sponsorship of research projects with each Section is currently under examination. The Foundation continues to increase its capacity to provide research grants for young neurosurgeons;

however, if it is to expand further, members must lend their financial support.

Concluding Thoughts

The goals, objectives and activities outlined herein are merely a smattering of what actually occurs at the AANS every day. To list everything that has been done and everyone who has contributed would be impossible, so we must be content to inspect these highlights and realize that every minute of every day, an AANS volunteer is working to make the field of neurosurgery more important, more respected and more exacting.

Finally, the ruminations over my three-year tenure as Secretary for this great organization have led me to a particularly frustrating and disappointing realization: the schism between the AANS and CNS is ever widening. As I pointed out earlier in this report, our membership survey indicated that members believe "neurosurgical organizations should seek to consolidate their activities." This is particularly ironic since the CNS just terminated its agreement with the AANS for its meetings management. Not only does this action produce a significantly negative impact on the AANS from a financial and personnel standpoint, but it also means that the CNS has put itself in a position of building its own infrastructure. This is duplication, not consolidation!

We must ask ourselves why we need two competing organizations that share the same noble principles, the same goals, the same volunteerism and (essentially) the same mission and vision, and realize that in 10 years we will most likely be unable to support two such organizations. I believe that now is the time to move together and not apart, and I am personally committed to accomplishing this goal. I would ask you to join me in building this bridge to our future. ■

Stan Pelofsky, MD, is former Secretary and current President-Elect of the AANS.

Neurosurgical Representation

Highlights From the Interim AMA House of Delegates Meeting

The American Medical Association (AMA) held its Interim House of Delegates (HOD) meeting in December of 1999 and took the following actions:

Medicare Payment Issues

Not surprisingly, issues involving Medicare payment, and the actions (or inaction) of the Health Care Financing Administration (HCFA) dominated the agenda. The HOD considered a variety of resolutions pertaining to HCFA that impact neurosurgeons.

- **Evaluation and Management (E&M) Documentation Guidelines.** The HOD directed the AMA to: 1) Reaffirm its commitment to the current E&M Code Guidelines and adopt a peer review outlier program instead; 2) Take appropriate action to have HCFA and its carriers suspend all present and future audits under the onerous E&M Code Guidelines; 3) If unsuccessful in achieving these goals with HCFA, seek an interim agreement with HCFA to allow physicians to utilize the guidelines proposed by the AMA in May 1999, as well as the 1995 and 1997 guidelines, until such time that there is a final documentation system approved by the AMA; and 4) Immediately pursue simultaneous legal and legislative action to force HCFA to stop its random pre-payment audit, and review activities until it completes and reports pilot studies of a peer review outlier program.

The HOD also considered a resolution recommending that the AMA explore the use of a coding scheme based on the time spent by a physician in the face-to-face encounter with a patient. There was considerable opposition for using encounter time as the primary method of determining an E&M service (the AANS opposes

this as well). This issue was referred to the AMA Board of Trustees for further consideration. The AMA E&M Documentation Guidelines Task Force is studying this and other issues. AANS member, Troy M. Tippet, MD, is a member of the task force, which will make additional recommendations to the HOD.

- **Practice Expense Payments.** In response to HCFA's decision to disallow the costs physicians incur when they use their clinical staff to perform services in non-office settings, the HOD directed the AMA to seek legislation directing HCFA to include in the RBRVS practice expense allocation all costs incurred by physicians, including those costs incurred in hospitals and ambulatory surgical centers. The AANS recently filed a lawsuit against HCFA on this issue.

- **Medicare Conversion Factor.** In December, the AMA filed a lawsuit against HCFA to recoup billions of dollars in physician Medicare revenue that has been lost due to faulty estimates in its spending projection formula. The AANS subsequently submitted a resolution requesting the AMA to implement a process whereby interested medical specialty societies could join the lawsuit. The HOD referred the matter to the AMA Board of Trustees for a decision. In February, the AANS, along with several other medical specialty societies, officially joined the suit.

Other Issues

- **On-Call Physicians.** The HOD received a report that addressed the reasons for the growing on-call physician shortage in emergency departments. The report examined possible solutions, including mandatory stipends for on-call physicians, and legislation requiring health plans to pay for

on-call services. Given the complexity of this issue, the HOD recommended that the AMA convene a task force with interested organizations to further explore the issues and to make additional recommendations. John A. Kusske, MD, AANS Vice President, and Brian T. Andrews, MD, former Chair of the AANS/CNS Section on Neurotrauma and Critical Care, will represent neurosurgery on the task force.

- **Pain Management.** Dominating the meeting's press coverage was the HOD's attempt to reconcile the AMA's support for states' rights to regulate pain management with its opposition of Oregon's physician-assisted suicide law and its support of the federal Pain Relief Promotion Act (the Hyde-Nickles bill). This bill outlaws physician-assisted suicide, but also establishes federal standards for pain management and palliative care. The bill passed in the House in October of 1999, with strong support from the AMA, and is currently pending before the Senate. In an effort to seek a compromise, the HOD directed the AMA to modify the provisions of the bill that would establish federal protocols and/or regulations for pain management and palliative care. The HOD also approved a new policy prohibiting the AMA from supporting any future legislation that allows the federal government to define appropriate medical practice.

Enhancing Neurosurgery's Voice

Neurosurgeons need to keep in mind that health care policy makers continue to view the AMA as the spokesperson for all physicians. We must take a proactive role in shaping AMA policy, so neurosurgery's concerns are considered in the process. The AANS now has two delegates to the AMA—Mark J. Kubala, MD, and George H. Koenig, MD, as well as one alternate—Adam I. Lewis, MD. The number of our delegates is directly tied to the number of AANS members who are AMA members. ■

Mark J. Kubala, MD, is a neurosurgeon in private practice in Beaumont, Texas, and the AANS delegate to the AMA's House of Delegates.

Reaching the Top

Baton Rouge Center Gives New Meaning to Multidisciplinary Practice

Name: The NeuroMedical Center (NMC)

Location: Baton Rouge, Louisiana

Services provided: Our services include adult and pediatric neurosurgery and neurology, neuro-oncology, clinical and interventional neuroradiology, physiatry, clinical psychology and neuropsychology.

Total doctors on staff: 26

Staff structure

The Clinic is one of the few private practice, multidisciplinary, neuroscience groups of its size in the country. The Neurosurgical Department includes areas of general neurological surgery, as well as subspecialty areas of cerebrovascular surgery, complex spine surgery, radiosurgery and pain surgery. The members of the Neurology Department subspecialize in movement disorders, epilepsy and sleep disorders, in addition to providing general adult and pediatric neurology coverage. Neurophysiological testing and ultrasound are based within the Neurology Department and the Department of Physical Medicine and Rehabilitation.

The NMC employs 130 support personnel, in addition to medical staff. All processes, from appointment scheduling to billing, address the importance of efficiency and reimbursement for the services that the NMC provides. Additionally, the Clinic utilizes eight physician extenders, which allow for the most efficient utilization of our doctors' time.

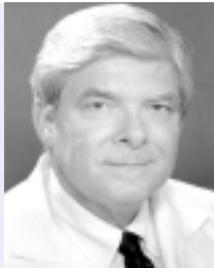
Back office management strategies

To accommodate the disparate earning capabilities of the various specialties within the Clinic and to control expenses, the NMC utilizes departmental cost accounting and functions day-to-day within the structure of an operating budget. Expenses

and revenue are projected annually through a budgeting process, and the budget is reviewed quarterly to ascertain clinical profitability. Overall, this allows each department some autonomy in the budgeting process, while controlling general and administrative expenses.

Within each department there also is a formula for calculating production-based revenue and shared revenue, thereby resulting in ample incentive to be productive, while encouraging participation in non-surgical patient care activity.

Thomas B. Flynn, MD, is President & Managing Partner of the NeuroMedical Center and an Active member of the AANS since 1971.



Biggest investment in recent years

Over the last year, the NMC established an in-house imaging center, requiring the largest capital commitment in recent years. It is successful because of a combination of quality service, competitive pricing and success in negotiating contracts with MCO's. Our in-house imaging services include magnetic resonance imaging, computed tomography and fluoroscopic imaging. We perform myelography in-house, as well as a large number of ancillary procedures, such as epidural steroid injections and other fluoroscopic-guided invasive procedures.

We are currently in the process of designing specifications for an integrated business and electronic medical record data processing system that will record clinical

information for studying outcomes, and other databases essential for contract negotiation. This process is expected to culminate in a sizeable capital commitment.

Advice to young neurosurgeons

To provide excellent patient care and receive adequate compensation for doing so, we must recognize that there is an ongoing revolution in the manner in which physicians and specialty surgeons practice. The playing field changes annually, but several things are apparent. First, the pinnacle of patient acceptance of managed care has passed. Second, business and industry—the ultimate “payors” for the majority of medical services—are attempting to find a better way to ensure that employees are given better service more cost effectively. In fact, many businesses are putting patient satisfaction above or equal to cost. The romance with managed care has chilled considerably.

Challenges of the future

Neurological surgeons will soon face significant reductions in reimbursement. We can't continue to see more patients and do more surgery, while chasing the reimbursement rainbow. One possible solution is to structure our practices to capture more revenue from services not related to direct patient care. This means closely assessing business opportunities that have traditionally been left to others and including in-house imaging into our practice. This will capture revenue and, at the same time, improve the quality of patient care. Group practices such as the NMC are well equipped to participate in this new paradigm.

Closing thoughts

The argument is frequently made that a multidisciplinary group practice, such as the NMC, carries with it a higher “overhead” than a single specialty group or solo practice. That is quite true. However, one must balance this fact against the staying power in today's practice environment when engaging in this debate. ■

EVENTS

Calendar of Neurosurgical Events

Annual Meeting of the Research Society of Neurological Surgeons

June 7-10, 2000
Salt Lake City, Utah
(801) 581-6908

Annual Meeting of the Japan Spine Research Society

June 8-9, 2000
Nagoya-City, Japan
81-562-93-2169

76th Annual Meeting of the American Association of Neuropathologists

June 8-11, 2000
Atlanta, Georgia
(507) 284-3394

Latin American Congress of Neurosurgery

June 11-16, 2000
Fortaleza, Ceará, Brazil
Fax: 55-85-224-7654

Canadian Congress of Neurological Sciences

June 13-17, 2000
Ottawa, Ontario, Canada
(604) 681-5226

17th Congress of the European Society for Pediatric Neurosurgery

June 17-21, 2000
Graz, Austria
43-316-385-2710

51st Annual Meeting of the Southern Neurosurgical Society*

June 21-25, 2000
Ponte Vedra Beach, Florida
(919) 684-6706

Cervical Spine Research Society European Section Meeting

June 21-24, 2000
London, United Kingdom
00-44-207-829-8714

35th Annual Meeting of the Rocky Mountain Neurosurgical Society*

June 24-28, 2000
Alyeska, Alaska
(702) 382-1960

World Congress on Medicine and Health, Medicine Meets Millennium

July 21 – August 31, 2000
Hanover, Germany
49-421-30-31-781

World Spine 1: First Interdisciplinary World Congress on Spinal Surgery

August 27-September 1, 2000
Berlin, Germany
49-30-857903-0

Annual Meeting of the Western Neurosurgical Society*

September 9-12, 2000
Mauna Lani, Hawaii
(805) 643-2179

44th OHOLO Conference: The Blood-Brain Barrier—Drug Delivery and Brain Pathology

September 10-14, 2000
Dead Sea, Israel
972-8-9381656

51st Annual Meeting of the German Society of Neurosurgery

September 12-16, 2000
Lübeck, Germany
49-451-500-2076

CNS Annual Meeting

September 23-28, 2000
San Antonio, Texas
(630) 323-5144

28th Annual Meeting of the International Society for Pediatric Neurosurgery

October 2-6, 2000
Istanbul, Turkey
90-232-4630591

62nd Annual Meeting of the American Academy of Neurological Surgery*

October 11-14, 2000
Colorado Springs, Colorado
(734) 936-5020

Neurology Outcomes Research: Current Science and Future Directions

October 15, 2000
Boston, Massachusetts
612-545-6284

International Conference on Risk Control and Quality Management in Neurosurgery

October 15-18, 2000
Munich, Germany
89-7095-2695 or 3556

16th Annual Meeting of Japanese Society for Intravascular Neurosurgery

November 17-19, 2000
Sendai City, Japan
Fax: 81-22-717-7233

4th World Stroke Congress

November 25-29, 2000
Melbourne, Australia
61-3-9682-0288

AANS/CNS Section on Pediatric Neurosurgery Annual Meeting*

December 6-9, 2000
San Diego, California
(888) 566-AANS

AANS Annual Meeting

April 21-26, 2001
Toronto, Ontario, Canada
(888) 566-AANS

**Jointly sponsored by the American Association of Neurological Surgeons*

AANS Department of Education and Practice Management 2000 Courses

• Innovations in Spine Surgery in the New Millennium: Who, When and How

August 3-6Memphis, Tennessee

• Anatomy and Terminology for Office Staff

September 14Las Vegas, Nevada

• Managing New Reimbursement Challenges in Neurosurgery

July 14-16Hyannis, Massachusetts
September 15-16Las Vegas, Nevada
November 10-12Montreal, Quebec, Canada

• Designing Better Business Systems

July 15Hyannis, Massachusetts
November 11Montreal, Quebec, Canada

• Mastering Expert Techniques in Neurosurgical Coding for Office Staff

August 16-17Cleveland, Ohio

• Neurosurgery Review by Case Management: Oral Board Preparation

November 5-7Houston, Texas

For more information on these courses, contact the AANS Department of Education and Practice Management at (888) 566-AANS, or visit www.neurosurgery.org/aans/meetings/edp/pdpcourses.html.

Dreams of Fraud and Abuse

The Great Carsoni ...

The flickering vintage television partially illuminated the darkened room. The image on the screen an instantly recognizable Johnny Carson in Swami garb—turban and robe covered with stars and crescent moons—the great Carsoni! The scene in medias res—spasms of laughter from the audience: an “answer” posed to Carsoni by Ed McMahon, followed by the Swami divining the question that fits the provided answer. “Next answer” commands the Swami. “Fraud and abuse” offers the straight man. “What does the government perpetrate on physicians and the practice of medicine” intones the Swami. Laughter floods the room until a man seated in the front row—obviously a physician because he wears a white coat with knotted cloth buttons—shouts “that’s not funny because it’s the truth.”

I awoke from the dream thinking about the impending deadline for this column. Well, perhaps the government was not committing fraud—a deception used to obtain unlawful or unfair gain, but abuse of the American health system was the kernel of truth contained in the dream.

All-fronts Attack

The interaction between medicine and government has become increasingly hostile. There appears to have been a purposeful effort, predominantly on the part of the executive branch of the federal government, to challenge and thereby change the field of medicine by a more aggressive, confrontational and seemingly abusive manner than experienced in the past. Purported reasons for these governmental actions include such diverse initiatives as “the public good,” “balanced budget” and “fraud and abuse.”

Some assert that the government’s fraud and abuse program is merely a way of enhancing federal income by inducing the health profession to not submit bills or to

undercode to avoid audit. Conflicting with this perception is the fact that the Medicare fee-for-service program made \$12.6 billion in overpayments for inappropriate billing last year and Physician at Teaching Hospital (PATH) audits have continued to be settled with large payments to the government. The success of these federal programs has encouraged state agencies and the private sector to increase their anti-fraud initiatives.

A. John Popp, MD,
Editor of the AANS
Bulletin, Chair of the
Washington Committee,
and Henry and Sally
Schaffer Chair of
Surgery at Albany
Medical College.



While the pervasiveness of the so-called “fraud fighter” is on the increase, the total number of criminal convictions for health care fraud was only 303 for 1999 (40 of which were physician convictions).

More chilling was the 461,975 calls received in 1999 on the Office of the Inspector General (OIG) fraud hotline. Only 2.6 percent of the calls, however, resulted in complaints against providers. The majority were simply seeking information or resources. Calling this a “fraud and abuse” hotline is provocative and inflammatory and it should have a different name.

Neurosurgeons are not exempt from this hostile milieu. However, putatively illegal or unethical practices such as up-coding, unbundling and inappropriate/unnecessary treatment become more understandable when it is recognized that these so-called fraudulent acts are frequently based on differing opinions between the

physicians rendering the service and the auditor’s interpretation of the provided level of service guided by Medicare Evaluations and Management (E&M) documentation guidelines. The challenge of documentation is made more difficult by the lack of an easily applied, concise system that accurately reflects the complexity of the decision-making process.

Preemptive Action by Neurosurgeons

It is my personal perspective that the aphorism “knowledge is power” has great meaning in this context. Neurosurgeons can be preemptive in avoiding miscoding by better understanding this unwieldy system. Beyond these obvious self-help initiatives, neurosurgeons should be aware that organized neurosurgery also is being preemptive in reducing neurosurgeons’ fraud and abuse risks. For example, the AANS has begun to sponsor a program for fraud insurance. In addition, the AANS/CNS Washington Committee supported the successful appointment of Troy M. Tippet, MD (a member of the Washington Committee), to the AMA E&M Task Force. Dr. Tippet will not only represent neurosurgery’s interests, but bring a rational, common sense approach to an area of major contention with HCFA.

The flickering television depicted an image of the U.S. President. He was dressed as a Swami. In medias res—the answer had already been posed— “Senior citizens at doctors’ offices with tape recorders and stopwatches?” The audience was poised on the edge of their seats for the impending humor of the question to be divined — “What is the next step in the government’s attack against medical fraud and abuse?” The entire audience laughed, including the man in the white coat with knotted cloth buttons. ■