

BULLETIN

AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS

The Socioeconomic and Professional Quarterly for AANS Members • Volume 13 No. 3 • Fall 2004

Is the Sun Setting on Medicare?

Grim Future, Few Bright
Spots Without Part B "Fixes"

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The AANS is dedicated to advancing the specialty of neurological surgery in order to provide the highest quality of neurosurgical care to the public.

AANS BULLETIN

The official publication of the American Association of Neurological Surgeons, the *Bulletin* features news about AANS and the field of neurosurgery, with a special emphasis on socioeconomic topics.

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PUBLICATION INFORMATION The AANS *Bulletin*, ISSN 1072-0456, is published quarterly by the AANS, 5550 Meadowbrook Drive, Rolling Meadows, IL 60008, and distributed without charge to the neurosurgical community. Unless specifically stated otherwise, the opinions expressed and statements made in this publication are the authors' and do not imply endorsement by the AANS. AANS reserves the right to edit copy to comply with publication standards and available space. Searchable *Bulletin* archives are available at www.AANS.org.

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When Medicare was enacted in 1965, bringing America's senior and disabled citizens access to modern healthcare, to many it looked like a new day had dawned. But the bright promise of that day has dimmed. With each passing decade regulation has spiraled while ever-expanding cost has come to threaten the program's solvency. Today the Medicare physician fee schedule influences reimbursement of most public and private insurers, darkening the outlook for doctors within the next decade when Medicare's physician fees are expected to fall more than 30 percent.



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The AANS and Its Core Value

The Continuing Education of Neurosurgeons

Learning is like rowing upstream; not to advance is to drop back.

—CHINESE PROVERB

The crown jewels of neurosurgical continuing medical education are the annual meetings of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons. These meetings are the primary vehicles through which neurosurgeons fulfill the obligation to acquire contemporary knowledge for the benefit of those entrusted to their care. It is difficult to imagine that this was not always so.

It was not until the beginning of the 20th century that surgery became more successful and its true importance was recognized, leading William Halsted to institute a surgical training program at Johns Hopkins which laid the groundwork for the future of American surgical science. Halsted's efforts led directly to Harvey Cushing and the origin of American neurosurgery. Neurosurgery, however, began slowly and it wasn't until 1919 when, following an address by Cushing on his remarkable experience with brain tumors at the meeting of the American College of Surgeons, William Mayo publicly declared that a new specialty had been born.

To this point, neurosurgery was a lonely and isolated field, practiced by only a very few pioneers who had been groping their way beset with difficulties that one can only imagine today. Craniotomies were performed and frequently tumors were not found. Few young men had sufficient courage to embark upon a specialty in which the results were so discouraging and which seemed to offer so little chance of success.

Spurred by his reception at the College of Surgeons meeting, Cushing suggested to



Robert A. Ratcheson, MD

Ernest Sachs of St. Louis the formation of a club that would meet regularly to discuss neurosurgical problems and compare results. It was left to Sachs to organize the first meeting. Eleven men were invited to attend, and only one, Walter Dandy, refused, likely because of ongoing animosity with Cushing. The first meeting of this group, the Society of Neurological Surgeons, the SNS, took place in the spring of 1920 in Boston. The organization met twice per year at each other's clinics, where patients were presented and operations observed and discussed. After each of the first three meetings, Sachs, as secretary and at the instruction of the members, wrote to Dandy again inviting him to join. After that, even as late as 1926, Dandy was approached personally by Cushing, but never became a member.

This organization was the beginning of neurosurgical CME, and in this instance, it is Dandy's absence that underscores its importance. Sachs considered Dandy's refusal to participate as being particularly unfortunate. In 1918, Dandy made his most important contribution to neurosurgery, ventriculography, which likely would have found earlier acceptance had he been able to promulgate his invention to other neurosurgeons through the meetings of the SNS. Because of Cushing's antipathy, its acceptance was retarded. Prior to its advent, less than 50 percent of tumors were found at operation, whereas afterward 95 percent could be located. The toll on neurosurgical patients, which occurred between ventriculography's invention and its ultimate acceptance, was truly unfortunate.

The founding of the SNS was a huge advance for neurosurgery. It had the results of cementing friendships and standardizing surgical procedures and methods. A growing correspondence among its members addressed technique, equipment, possible trainees and pathology. Sachs considered that his attendance at SNS meetings was an important factor in improving his results due to the insight it gave into what others were thinking and doing and also in preventing one from becoming self-centered and self-satisfied. Major advances such as "the Bovie" were first introduced at these meetings and neurosurgery continued to prosper and grow.^{1,2}

Continuing medical education is lifelong learning for the purpose of keeping us up to date. Most of our licenses are tied to having obtained CME credits, and in the near future, our ability to become recertified by the American Board of Neurological Surgery will clearly involve participation in and documentation of these efforts. Significant changes in medicine occur all the time. The half-life of medical information is less than five years and the average physician practices 30 years. The neurosurgeon must be able to incorporate into his skills new technology, sophisticated surgical techniques and improvements in the treatment of neurosurgical and neurological disease. With new knowledge and growing complexity, there is a potential for errors, a fact that has not escaped American's lawyers.

CME, as opposed to residency training, is specifically for the practicing neurosurgeon. Its elements include self-direction, internal motivation and a quest for specific knowledge, whereas traditional medical training is rigidly structured, lecture based and focused on the memorization of facts. Learning for the mature student is most successful when focused upon practical

Continued on page 18

NEWSLINE

News Members Trends Legislation

FROM THE HILL

PRESIDENTIAL CANDIDATES ADDRESS HEALTHCARE

If reelected, President Bush would focus on medical liability reform and implementation of health information technology, while Sen. Kerry sees liability reform as an access-to-care issue that if elected he would address by “preventing and punishing frivolous lawsuits” and opposing punitive damages in most cases, according to American Medical News. Verbatim policy statements from both candidates are online at www.ama-assn.org/amednews/2004/10/18/gvsb1018.htm.

For frequent updates to legislative news, see the Legislative Activities area of www.AANS.org.

- **CMS Promises Quicker Code Approval Process** The Centers for Medicare and Medicaid Services said Oct. 7 that revisions to the process it uses to update code sets will help bring new technologies and services to patients more quickly. The changes, which grew out of the Medicare Prescription Drug Improvement and Modernization Act of 2003, will begin with the 2006 coding cycle. “By working with patient advocates, healthcare payers, and the suppliers and manufacturers of medical products, we have been able to identify many opportunities for improvements in the current coding process to keep coding issues from slowing the dissemination of new and improved treatments,” stated CMS Administrator Mark B. McClellan, MD, in a news release. The Healthcare Common Procedure Coding System, HCPCS, includes level one Current Procedural Terminology codes and level two codes for products, supplies and services not covered by CPT codes. A same-year appeals process and a reduction in marketing data from six to three months for non-drug items are among the changes. Additional information is available at www.cms.gov.
- **Court Dismisses Antitrust Claims Against NRMP** A lawsuit filed against the National Resident Matching Program in May 2002 was effectively ended on Aug. 12 when a federal judge dismissed antitrust claims against the NRMP and its codefendants, including numerous teaching hospitals, medical organizations and medical schools. In his decision, U.S. District Court Judge Paul L. Friedman cited Section 207 of the Pension Funding Equity Act of 2004, which states that “antitrust laws do not prohibit sponsoring, conducting, or participating in a graduate medical education residency matching program, or agreeing to do so.” The class action lawsuit alleged that the defendants violated the Sherman Act by conspiring to “displace competition in the recruitment, hiring, employment and compensation of resident physicians,” and maintain similar wages and working conditions. On Aug. 13 the NRMP released a statement noting that “the court has acknowledged the legitimacy and purpose of the Match and [the NRMP] views the court’s decision as a victory for the entire academic medicine community.” The Pension Funding Equity Act of 2004 can be viewed at <http://thomas.loc.gov>, and Judge Friedman’s decision, *Jung v. AAMC et al.*, at www.dcd.uscourts.gov/Opinions/2004/Friedman/02-873.pdf.
- **Sen. Frist Supports Health Courts** In a July 12 address to the National Press Club, Senate Majority Leader Bill Frist, MD, outlined several health policy proposals, among them an ultimate goal of setting up “an expert medical court system with transparent decisions, limits on punitive damages, and scheduled compensatory damages to provide rapid relief to truly injured patients (instead of trial lawyers) and hold negligent doctors accountable.” Such health courts are advocated by Common Good, a non-profit organization that says it is dedicated to restoring common sense to American law. According to Common Good, a main feature of health courts would be judges dedicated to addressing issues of medical justice who would bring about greater consistency in rulings from case to case. A summary of Sen. Frist’s remarks is available at <http://frist.senate.gov>; information on health courts is available at <http://cgood.org/healthcare.html>.
- **CMS Tries Mediation to Ease Medical Liability Woes** In a bid to reduce claims against the Centers for Medicare and Medicaid Reform, Health and Human Services Secretary Tommy Thompson announced the “Early Offers” program on Sept. 21. “The department is making this program available so that patients who bring claims for injuries caused by negligence can be compensated fairly, in a timely manner, and without having to go to court,” he stated. The voluntary program allows 90 days for both HHS and a person who has filed a claim with the HHS to make an offer with an independent third party and settle the case for a specified amount. The news release is available at www.hhs.gov/news/press/2004pres/20040921b.html.

NEURO NEWS

END OF CME CYCLE

APPROACHES

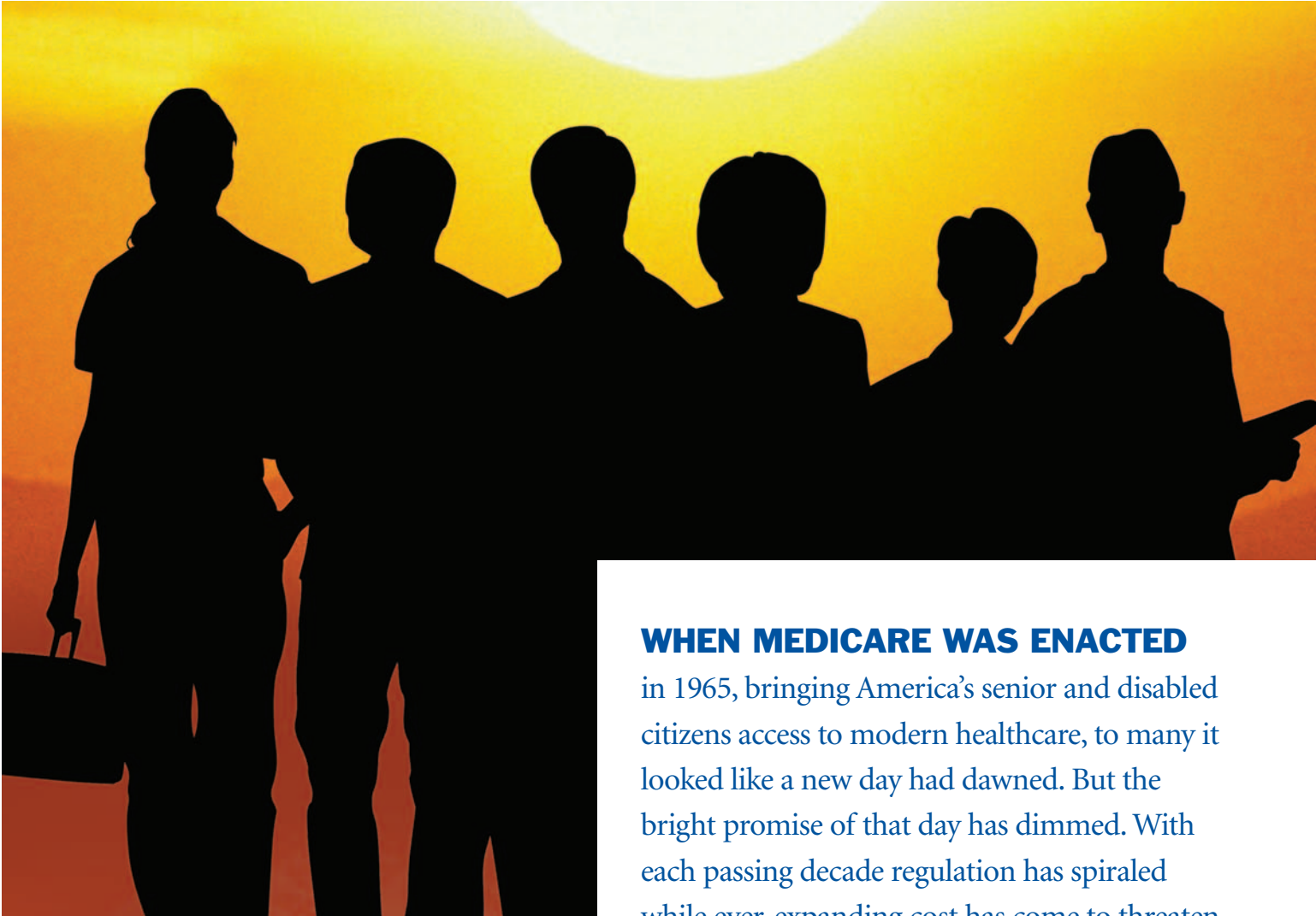
The current continuing medical education cycle ends Dec. 31 for AANS Active and Active Provisional members, who are required to document 60 neurosurgical credits between Jan. 1, 2002, and Dec. 31, 2004, to maintain membership. Additional information is available at www.AANS.org/education/cme.asp.

- **ICMJE Calls for Full Transparency Through Online Registries** On Sept. 8 the International Committee of Medical Journal Editors announced that as a condition of publication in any of its 12 members' journals, including *The Lancet* and the *Journal of the American Medical Association*, trials must be recorded in a public registry that is free and accessible to the public and run by a not-for-profit organization. The U.S. National Library of Medicine's registry at www.clinicaltrials.gov was cited as meeting the ICMJE's requirements. The registration requirement applies to clinical trials beginning enrollment after July 1, 2005; registration is extended to Sept. 13, 2005, for trials that began enrollment before July 1. The full text of the editorial can be found at <http://jama.ama-assn.org/cgi/content/full/292/11/1363>. In related developments, on Sept. 1 GlaxoSmithKline, manufacturer of Paxil and other pharmaceuticals, began publishing summary results of GSK-sponsored trials at <http://ctr.gsk.co.uk>. On Sept. 7 the Pharmaceutical Research and Manufacturers of America, PhRMA, announced a database at clinicalstudyresults.org for publication of clinical trials summaries since October 2002. Announcement of an international clinical trials registry is anticipated at the World Health Organization's November summit, according to American Medical News, www.ama-assn.org/amednews/2004/07/26/hlsd0726.htm.
- **All 2004 AANS Bylaws Amendments Approved** Several AANS Bylaws amendments, presented to the membership at the AANS Annual Business Meeting on May 3, were voted upon and overwhelmingly approved this summer. Ballots, sent to voting members on June 17, addressed five issues: 1) general editing of bylaws text to improve clarity; 2) addition of two new membership categories, Allied (surgical technologists) and International Residents/Fellows; 3) definition of a quorum for Board of Directors meetings as at least half of the sitting board members; 4) requirement of at least 4 percent of Active members' signatures to petition for a bylaws amendment; and 5) institution of electronic voting. All amendment issues were approved, with between 95.9 percent and 99.5 percent of members voting in favor of each issue. For background on the changes, see "Proposed Changes to Bylaws Reviewed: Both 501(c)(6) and 501(c)(3) Entities Are Affected," www.AANS.org, article ID 21846. The AANS Bylaws are available online at www.AANS.org/about/combined_bylaws_041.pdf.
- **High Incidence of Statistical Error Found in Journals** Two researchers attributed a high incidence of statistical error in highly regarded medical journals to errors in rounding, transcription, or typesetting. Emili Garcia-Berthou and Carles Alcaraz found that 11.6 percent and 11.1 percent of the statistical results published in *Nature* and the *British Medical Journal* respectively during 2001 were incongruent, and further that at least one statistical error appeared in 38 percent of the papers in *Nature* and in 25 percent of the papers in the *BMJ*. They concluded that statistical practice in scientific journals is generally poor and that the quality of papers in scientific journals should be more controlled and valued. The editor of the *BMJ*, Richard Smith, suggested in *Nature Science Update* that a step forward would be Internet publication of raw data, which would enable anyone to check the data. The article, "Incongruence Between Test Statistics and P Values in Medical Papers," is available at www.biomedcentral.com/1471-2288/4/13.
- **Sullivan Commission Reports "Missing Persons" in Healthcare** A report released Sept. 20 finds a nationwide lack of racial and ethnic diversity in medicine, nursing and dentistry that "may be an even greater cause of disparities in health access and outcomes than persistent lack of health insurance." *Missing Persons: Minorities in the Health Professions*, available at www.sullivancommission.org, identifies three overarching principles and 37 recommendations for increasing diversity in health professions.

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IS THE SUN SETTING

Grim Future, Few Bright Spots



WHEN MEDICARE WAS ENACTED

in 1965, bringing America's senior and disabled citizens access to modern healthcare, to many it looked like a new day had dawned. But the bright promise of that day has dimmed. With each passing decade regulation has spiraled while ever-expanding cost has come to threaten the program's solvency. Today the Medicare physician fee schedule influences reimbursement of most public and private insurers, darkening the outlook for doctors within the next decade when Medicare's physician fees are expected to fall more than 30 percent.

ON MEDICARE?

Without Part B “Fixes”

Barbara Peck, JD

Medicare physician payment policy has endured its share of challenges and controversies since 1992 when the U.S. Congress implemented volume control measures in an effort to cap Part B spending. However, never before have such large cuts in physician reimbursement been predicted. Congress has stepped in several times in the last three years to override the system and provide a short-term “fix.” As a result of these temporary fixes which do not address the system’s underlying problems, Medicare physician reimbursement will fall more than 30 percent between 2006 and 2012, while at the same time costs for providing services are expected to rise more than 19 percent.

While the 2005 Medicare Physician Fee Schedule that has been released includes an approximate 1 percent increase in reimbursement for neurosurgeons, legislative action must be taken in early 2005 to prevent a landslide of cuts beginning Jan. 1, 2006. Just as for the medical liability reform campaign, neurosurgeons will need to be active and involved in this effort.

In preparation, neurosurgeons and their practice administrators can benefit by increasing their knowledge of the complicated system of physician payment under Medicare. To that end, this article comprehensively reviews Part B payment complexities and their implications, followed by a discussion of possible solutions, and a look at the related legislative landscape.

Physician Payment Under Medicare: The Overall Formula

Under Medicare, services provided by physicians are paid under Part B, which by law is funded 75 percent by general tax revenues and 25 percent by beneficiary monthly premiums. In contrast, Part A is funded primarily by the Medicare trust fund and payroll deductions and provides hospitalization coverage. Because Part B is funded by general tax revenues, it competes for funding with other federal programs—including defense, education, homeland security, transportation and the like—and is vulnerable in times of reduced federal income caused by recession. In addition, beneficiaries must pay 25 percent of total costs; therefore, an increase in costs translates to an increase in premiums, which is never popular among active senior voters.

Physician reimbursement under Medicare is determined by the resource-based relative value scale. Under the RBRVS system, physician payment is set by the Medicare fee schedule, which assigns a set reimbursement to each physician activity. Each activity is assigned a relative value unit for three components: the work component, the practice expense component and the professional liability insurance component. The process of determining these values is ongoing, and each activity is evaluated at a minimum of every five years to ensure that the RVUs remain accurate.

To determine payment, each of the three RVU components is multiplied by the geographic practice cost index. The products then are added together and multiplied by the monetary conversion factor:

$$[(\text{work RVU} \times \text{GPCI}) + (\text{practice expense RVU} \times \text{GPCI}) + (\text{PLI RVU} \times \text{GPCI})] \times \text{CF} = \text{reimbursement per code.}$$

While RVUs vary by Current Procedural Terminology code and the geographic practice cost index varies by region, there is only one conversion factor for all physician services. The conversion factor is determined by a complex formula and is updated each year. Unlike recent reductions in practice expense RVUs and some work RVUs specific to neurosurgical procedures, the current problem—that all physician reimbursement will take an across-the-board cut from 2006 to 2012—arises from the conversion factor itself.

The Conversion Factor Explained

The conversion factor is designed to update reimbursement for all physician services annually. If the conversion factor increases, reimbursement for all physician services increases; if the conversion factor decreases, reimbursement for all physician services decreases. The conversion factor is determined by three factors: the Medicare economic index, MEI; an expenditure target set by the sustainable growth rate, SGR; and other adjustments that may be required from time to time for budget neutrality.

The MEI, which was developed in 1976, is a measure of inflation in the cost of operating a medical practice. The MEI takes into consideration the change in hourly earnings in the general economy for determining both physician and nonphysician compensation costs; changes in office expenses, medical materials and

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supplies; professional liability insurance; medical equipment expenses; and other similar expenses. Each of these categories is weighted and a positive or negative average change for the year is assigned. Before each MEI is finalized, however, a productivity adjustment is subtracted from the total to account for any increased efficiencies the average medical practice gains over time.

The 2004 MEI was 2.9 percent (with an average inflation rate of 3.8 percent and a productivity adjustment deduction of 0.9 percent), while the 2003 MEI was 3 percent. In essence, using the MEI the Centers for Medicare and Medicaid Services, CMS, has determined that it costs 2.9 percent more to run a physician practice in 2004 than in 2003.

The conversion factor, however, does not rely just on the MEI. The CMS also estimates an expenditure target for physician services in a given year. The expenditure target is determined by the SGR formula. The SGR formula uses the following factors to determine the expenditure target: fees for physician services (utilizing the MEI, the CMS determines how much fees should increase in a given year); the gross domestic product, GDP; increases in the number of beneficiaries for fee-for-service

CMS determines each year how much it will spend on physician Part B services and any overages must be taken out of the next year's payments by reducing reimbursements.

Medicare; and changes in law and regulation. Using these factors, the CMS determines how much should be spent on physician services during a given year.

If actual spending on physician services is greater than the expenditure target, physicians receive a negative update (that is, the conversion factor is decreased, therefore decreasing payment for physician services). If actual spending is less than the expenditure target, physicians receive a positive update. In essence, the CMS determines each year how much it will spend on physician Part B services and any overages must be taken out of the next year's pay-

ments by reducing reimbursements.

The SGR formula has been in place since 1997, when it replaced the Medicare Volume Performance Standard. As with the SGR, the MVPS formula also set an expenditure target. However, instead of just one expenditure target and a related conversion target for all physician services, the MVPS system contained three different conversion factors and expenditure targets, including one for surgical services, one for primary care services and one for nonsurgical services.

While the surgical specialties for many years enjoyed the benefits of meeting or beating their expenditure targets, the primary care and nonsurgical specialties did not. This caused animosity among the specialties, as some enjoyed increases in Medicare payment and others saw cuts. Because of changes made in the calculation of the expenditure target in the mid-1990s, the Physician Payment Review Commission, known as the PPRC, projected that physicians would receive cuts of at least 2 percent indefinitely under the MVPS. The goal of replacing the MVPS with the SGR formula was to prevent long-term cuts in reimbursement, bring stability to the system and prevent the volatility that plagued the MVPS system.

Updates Under the Sustainable Growth Rate Formula

Updates under the SGR formula have been so inconsistent and unreliable that congressional or administrative intervention has been necessary multiple times. In addition, developing an accurate expenditure target based on the SGR formula has proven virtually impossible. In 1998 and 1999, the first two years the formula was used, the CMS underestimated the strength of the U.S. econ-

Medicare and Related Acronyms and Abbreviations

CF Conversion factor	MVPS Medicare volume performance standard
CBO Congressional Budget Office	PPRC Physician Payment Review Commission
CMS Centers for Medicare and Medicaid Services	RBRVS Resource-based relative value scale
CPT Current Procedural Terminology	RVU Relative value unit Three RVU components: Practice expense Professional liability insurance (PLI) Work
GAO General Accounting Office	SGR Sustainable growth rate
GPCI Geographic practice cost index	
MedPac Medicare Payment Advisory Commission	
MEI Medicare economic index	Additional information can be found at www.cms.hhs.gov/acronyms .
MMA Medicare Prescription Drug, Modernization, and Improvement Act of 2003	

omy, and therefore the GDP, as well as the number of enrollees in fee-for-service Medicare. As a result, the expenditure target was 7 percent less than it should have been. In 2001, the CMS had to make adjustments to its fiscal 2000 projections after again underestimating the expenditure target.

By 2002 the faltering economy caused the CMS to lower the expenditure target. To no one's surprise, medical spending did not decrease with the faltering economy and physician spending exceeded the expenditure target. In addition, the CMS revealed that it had forgotten to include some recently approved procedures in its actual spending determinations since 1998. This mistake cost \$4.5 billion and added a 1.6 percent decrease to a previous cut of 3.8 percent (for a total cut of 5.4 percent).

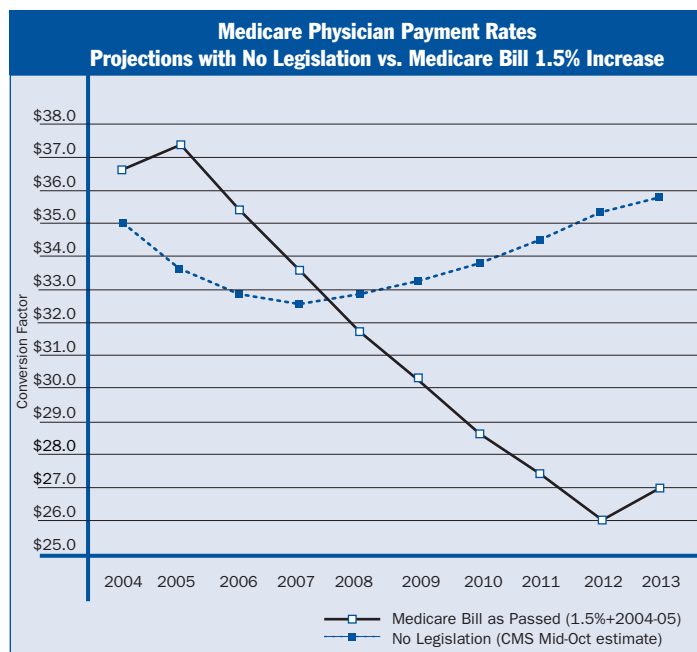
In 2003 the CMS predicted another 4.4 percent cut. However, after intense pressure and delays in the implementation of the 2003 Medicare Physician Fee Schedule, Congress acted that March to allow the CMS to fix the accounting errors it made back in 1998 and 1999 related to the expenditure target and the number of fee-for-service enrollees. The accounting mistakes cost \$54 billion to fix and resulted in a 1.6 percent fee increase for physicians.

In 2004, yet another 4.4 percent cut was predicted. However, a provision in the Medicare Prescription Drug, Modernization, and Improvement Act of 2003, MMA, included a 1.5 percent increase in physician payment for 2004 and 2005 (averting a predicted 3.6 percent cut in 2005). These temporary increases were designed to give Congress and the administration time to review and evaluate the current SGR system. In fact, as currently written, the increases must be paid back to the Medicare program with substantial interest. The General Accounting Office has noted, "Because the MMA did not make corresponding revisions to SGR's spending targets, SGR will reduce fees beginning in 2006 to offset the additional spending caused by MMA's fee increases." Because of this, over a 10-year period physicians would have been better off taking the cut in 2004 and 2005 than taking the temporary increases. Without the increases cuts were estimated until 2006, while with the increases cuts are now estimated until 2012.

In addition to paying back the money used to fund the 1.5 percent increases in 2004 and 2005, the problems that caused the 5.4 percent cut in 2001 and the predicted cuts in 2002, 2003 and 2004 still plague the system. While Congress has acted to prevent negative cuts in the past three fee schedules, the underlying problem with the SGR formula has not been fixed. In essence, they have placed a Band-Aid on an aneurysm and the system is about to burst.

Predicted Physician Fee Cuts

Based on having to pay back the 1.5 percent increases for 2004 and 2005, slow growth in the GDP and, most important, repeatedly spending more than the expenditure target, the General Accounting Office has predicted there will be negative physician updates of 5 percent from 2006 to 2012. The Congressional Budget Office,



however, estimates there will be negative updates of 5 percent, the most likely allowable by law, from 2006 until 2014 (the farthest "out year").

The CBO's estimates also are based on a reduction in spending per beneficiary from 2006 to 2009. If this does not happen, reductions in payment will be greater than estimated. The 2004 Medicare Trustees Report projected the physician update would be approximately negative 5 percent until 2012. The result would be a cumulative reduction in physician fees of more than 31 percent from 2005 to 2012, while physicians' costs of providing services, as determined by the MEI, are projected to rise by 19 percent. Further cuts could come as a result of changes made to the practice expense RVUs, work RVUs or PLI RVUs.

By law, the most that physician reimbursement can be cut in one year is 7 percent, minus the MEI. This usually works out to around 5 percent. If it were not for this law, physician cuts in 2006 would be in the 25 percent range. The reason the cuts are for such an extended period of time is because the amount owed is rolling over to the next year.

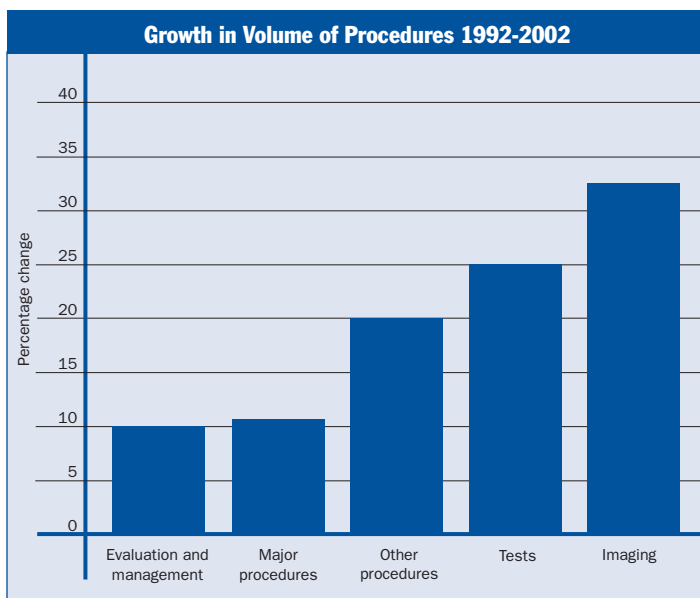
Why Cuts Are Predicted: Problems With the SGR

Problems with the SGR formula have been well-documented by independent agencies and groups since before the formula became effective. The reason for the past and future decreases is threefold:

1. the expenditure target is lower because growth in the GDP has slowed;
2. actual expenditures have outpaced the expenditure target

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significantly for a number of years in a row; and

3. real per-beneficiary spending on physician services is projected to grow faster than allowed by the SGR.

It is important to understand, however, that the root cause of all the concerns and problems is an explosion in volume. The amount and intensity of services has increased significantly since 2000, with diagnostic imaging and cardiac services leading the way with an almost 35 percent increase in volume. If the overall expenditures are capped and the number of services provided has increased, the only option is to reduce the cost paid per service.

That is exactly what a reduction in the conversion factor does—by reducing the conversion factor by 5 percent, physician reimbursement receives a 5 percent across-the-board reduction and more services can be provided for the same overall price. It is this unexpected increase in volume that the system was not designed to handle. While the following discusses specific problems with the SGR formula that are leading to the predicted cuts from 2006 to 2012, keep in mind that the volume increase has exacerbated all of these issues. The problem is not that the Medicare program is actually being cut; in fact, the expenditure target will rise from \$62 billion in 2004 to more than \$120 billion in 2014. The problem is that volume increases have—and will—continue to drive actual costs beyond those numbers.

Specific problems with the SGR include use of the GDP to set the expenditure target; the cumulative nature of the formula; the inclusion of outpatient drugs and other “incident-to” services in the actual costs; and inability to recognize and account for changes in beneficiary demographics.

How the SGR Uses the GDP

The SGR formula uses the GDP to set the expenditure target. When the GDP increases, the expenditure target increases; when the GDP decreases, the expenditure target decreases. There has never been any evidence, however, that the healthcare needs of Medicare beneficiaries proportionally increase in a strong economy or decrease in a weak economy. As the MEI has indicated, the costs of providing services to beneficiaries also are not related to the GDP. In times when the economy is strong, physicians may receive an update that is greater than costs and the Medicare system will therefore spend more than is necessary. In contrast, when the economy is in recession, reimbursement will be cut unfairly.

The MVPS system did not use the GDP as an indicator for how much physician services should grow during a given year. Instead, the system relied on historical trends in volume and intensity growth to set new targets. While use of the GDP has been a strong point of contention in recent years, the MMA changed the SGR so that, instead of using a single year’s GDP to set the expenditure target, a 10-year rolling average is now used. This should stabilize the system somewhat and make the formula less susceptible to sudden changes in the economy.

Cumulative Nature of the Expenditure Target

Under the SGR formula, the expenditure target for one year is not compared with actual spending for that year to determine the level of spending. Instead, the cumulative expenditure target is compared with cumulative spending. Exceeding the expenditure target one year affects not only next year’s update, but also all future updates. For example, when setting the 2006 update to the conversion factor, the CMS will review the expenditure target from April 1, 1996, through Dec. 31, 2005, and compare it with the actual expenditure target for that time period. Once the expenditure target has been exceeded, it will affect all future updates. To get back under the expenditure target and receive a positive update, physician spending not only would have to come in under the expenditure target in future years, but also make up for any overages in past years.

The SGR’s cumulative nature is the primary reason for the currently predicted multiple years of negative updates—once the program gets off track, it is nearly impossible to make up that money. Unlike 2003, when Congress added \$54 billion to the expenditure target to fix accounting errors, when legislation prevented cuts in 2004 and 2005, no money was added to the expenditure target. Instead, the positive updates just added to the actual costs for those years. Because the SGR is cumulative, in 2006 those expenditures now need to be made up.

Immediate Recoupment of Excess Spending

The SGR formula also requires that all excess spending be immediately recouped, up to the amount allowable by law. The formula

requires that actual expenditures be brought back into line with targets each year and does not allow cuts to be spread out over several years. The PPRC also predicted this would make the SGR system more volatile than the previous MVPS system. This volatility is fueled by both the SGR's immediate recoupment of any excesses as well as the cumulative nature. The PPRC concluded:

Another limitation of the proposed approach is that it adjusts the conversion factor annually to recoup all excess or surplus spending that occurred in the prior year. This approach makes the system's conversion factor update more volatile because it not only reflects year-to-year fluctuations in volume and intensity of growth, but also recovers the entire excess or surplus in a single year.

In essence, if actual expenditures are greater than the expenditure target, physicians are punished twice: once in the following year when the excesses are immediately recouped, and then each year thereafter when the cumulative target is compared to the cumulative actual expenditures.

Outpatient Drugs and Other “Incident-To” Services

The SGR expenditure target encompasses both spending for services on the physician fee schedule and services incident to a physician visit. These “incident-to” services include some prescription drugs, the prices of which physicians cannot control, that are covered under Medicare Part B. Including incident-to services within the expenditure target and actual expenditures can artificially inflate costs. The CBO has concluded:

Although the SGR expenditure targets are adjusted for changes in the prices of a market basket of prescription drugs, shifts in the quantity and in the mix of drugs administered—toward the use of more recently introduced and more expensive drugs—tend to result in spending that grows faster than the inflation adjustment.... CBO projects, however, that spending for incident-to services will grow faster, on a per-beneficiary basis, than the adjustments for inflation and the GDP-based allowance for volume and technology. Therefore, spending for incident-to services will grow more rapidly than the SGR expenditure targets, and payments for those services will consume an increasing share of the target, rising from \$12 billion in 2004 (20 percent of the \$62 billion expenditure target) to \$28 billion in 2014 (23 percent of the \$121 billion target). In turn, the effective expenditure target for services on the physician fee schedule will decline from 80 percent of the SGR target in 2004 to 77 percent in 2014, CBO estimates. That decline in the share of the SGR expenditure target for physicians' services will be almost half a percentage point lower, on average, than the growth in the SGR target as a whole.

Individual physicians are punished by reimbursement cuts if the actual charges for the year exceed the expenditure target.

In essence, if a physician provides chemotherapy for a cancer patient in the physician's office, the cost, including the cost of the drugs used, is included in the actual physician expenditures for the year. However, if the physician sends the patient to the hospital for chemotherapy treatment, where overall costs are higher, the cost is not “counted against the physician.” By including incident-to services in the expenditure target, the Medicare

program is penalizing physicians for bringing more procedures, treatments and therapies into the office and encouraging them to send patients to hospitals or other, more expensive, facilities.

Unevenly Applied Changes in Law and Regulation

Under the SGR formula, changes in law and regulation, including coverage decisions, should be reflected in changes to the expenditure target. However, there is little detail and explanation on how these changes are first estimated and then tracked and adjusted in the future by the CMS. Each year Congress adds benefits to the Medicare program, including the expansion of services to include new procedures and technologies, screening benefits and diagnostic tests. It is unclear, however, how the CMS accounts for these new benefits when developing the expenditure target.

For example, the MMA added a “welcome to Medicare” screening benefit for all new enrollees. However, no additional funds were added to the expenditure target to cover the costs of the physical itself or the procedures, including laboratory work, colonoscopies, mammograms and so forth, that are likely to be ordered. Changes in law and regulation, including coverage decisions and the addition of preventative tests, can add to volume that is not necessarily reflected in the expenditure target.

Impossibility of Setting the Expenditure Target

Another problem with the SGR formula is the nearly impossible task of setting the expenditure target and calculating actual expenditures. As explained earlier, each year since the inception of the SGR formula the CMS has had to retrospectively make adjustments to either the expenditure target or the actual expenditures because of miscalculations, accounting errors or other problems. While this is understandable given the complexity of Medicare physician payment, physicians are being held accountable for a standard that cannot accurately be set until after the fact. In addition, as the Medicare Payment Advisory Commis-

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sion has noted, individual physicians are punished by reimbursement cuts if the actual charges for the year exceed the expenditure target, but they have no way of controlling overall spending.

Another problem with the SGR formula is that in order to accurately estimate an expenditure target, the number of Medicare beneficiaries enrolled in fee-for-service Medicare must be accurately determined. Obviously, if more beneficiaries are being treated than estimated, volume will increase and vice versa.

Both the CBO and the CMS also assume in their recent estimates that a significant portion of the Medicare population will enroll in HMOs over the next 10 years, further reducing the expenditure target. If this does not happen, actual expenditures will obviously be more than the expenditure target because there are more enrollees in fee-for-service Medicare than original estimated. This happened in the late 1990s and led to Congress needing to allocate \$54 billion to fix these "accounting errors."

Changes in the Medical Marketplace

Lastly, the SGR formula does not take into account changes in the medical marketplace, especially changes in the age, health and demographics of Medicare beneficiaries. According to information recently released by the CMS, for example:

1. More than 25 percent of Medicare beneficiaries are either over the age of 85 or are under the age of 65 (and are, therefore, likely disabled).
2. The proportion of women increases as the Medicare population grows older, and women tend to use more healthcare services.
3. Nearly 65 percent of Medicare beneficiaries have annual incomes below \$25,000 and more than 56 percent have incomes below \$15,000; more than 70 percent of Medicare expenditures are on behalf of these individuals.
4. More than half of Medicare beneficiaries suffer from hypertension and/or arthritis; almost 20 percent have diabetes; and 15 percent have pulmonary disease—all conditions that require significant medical management.
5. More than one-third of Medicare beneficiaries need assistance with activities of daily living.
6. Medicare beneficiaries in poor health or with functional limitations are more likely to receive Medicaid assistance, have no supplemental insurance and be enrolled in fee-for-service Medicare.

While the demographics of Medicare beneficiaries continue to change, the SGR formula simply looks at the number of beneficiaries without considering the characteristics of those beneficiaries.

Other changes in the medical marketplace that can affect volume and intensity of services include new, more aggressive methods of treating common medical problems, including car-

Two enormous obstacles stand between physicians and a stable future reimbursement environment: time and money.

diovascular disease, musculoskeletal disease and cancer; direct-to-consumer advertising; the medical liability crisis and its effects on defensive medicine, especially diagnostic services; and more educated healthcare consumers who expect and demand more services.

If Not the SGR, Then What?

There is a growing consensus among Washington policymakers that the SGR formula is ineffective, volatile and beyond repair. However, for physicians looking to prevent cuts under the SGR or enact a new update system, the timing could not be worse. Two enormous obstacles stand between physicians and a stable future reimbursement environment: time and money.

While cuts are not scheduled to begin until 2006, the 2006 Medicare Physician Fee Schedule will need to be ready and published by August 2005, cutting the lead time roughly in half. Asking Congress to draft, debate and pass a major overhaul to the physician payment system in only six months is a tall order, especially in an election year, when inaugurations and the related orientations delay the start of the new session. Furthermore, the president in 2005 must turn in a budget by Feb. 1. In addition, Congress, the CMS and the related agencies have before them the task of implementing the new prescription drug benefit in 2005, a mammoth undertaking in itself that will no doubt devour large amounts of resources in 2005. Time may prove to be a formidable obstacle for those looking to prevent physician reimbursement cuts for 2006.

Perhaps even more of a challenge than time is the money to finance a potential solution. In August, the White House Office of Management and Budget released its budget projections for 2005, which include a federal budget deficit of \$445 billion. By 2012, the federal deficit is expected to grow to \$2.2 trillion. The report also stated that Medicare would spend an additional \$67 billion over its already dismal forecast for 2005 through 2009. The prescription drug benefit, originally given a price tag of \$400 billion, has already exceeded its original estimate, even though the major tinkering that is likely to come with implementation has yet to be determined, and is currently running at about \$540 billion. The report concluded with the statement that "Medicare and Medicaid spending must be brought under control to help rein in overall federal spending." Washington experts already are predicting that regardless of who wins the presidency, when the president's budget is submitted on Feb. 1, it probably will include cuts to the Medicare and Medicaid programs. Any cuts likely will affect all providers, including hospi-



tals, skilled nursing facilities and so forth, leading to a flurry of lobbying activity as they all head to Capitol Hill to make the case as to why their funding should not be cut.

Finally, early drafts of a much-anticipated report by the General Accounting Office state that Congress will need to come up with between \$150 and \$200 billion to prevent the cuts. Because the problem has been delayed for four years and the debt has been allowed to stack up, any “fixes”—from taking drugs out of the formula to discontinuing the cumulative nature to scraping the SGR all together—have this type of price tag. This is an enormous amount of money at any time, but perhaps an insurmountable amount during a deficit.

In addition, it is important to remember that beneficiaries must by law pay 25 percent of the total cost. If Congress adds money to the pot, beneficiaries must add money to the pot through increased premiums and deductibles. In September the Department of Health and Human Services announced Medicare beneficiaries will see a 17 percent increase in monthly premiums and a 10 percent increase in the yearly deductible in 2005. It is hard to imagine any politician supporting additional increases beyond those already required.

It is in this environment that physicians will work to fix or

replace the SGR and obtain the necessary funding. Surprisingly, not only is there little consensus on what to do, but few options have been put forth. Even if Congress came up with the billions necessary, there is no guarantee that volume would not continue to grow at unprecedented levels, requiring billions more to prevent cuts yet again.

The Medicare Payment Advisory Commission is working on a volume-control approach it has labeled “private purchasing strategies,” which would take the cost-control measures used by HMOs and incorporate them into the Medicare system. This would include pre-authorization for test and procedures, credentialing restrictions and other strategies commonly used by managed care companies. Another idea currently being investigated by the CMS involves implementing pay-for-performance programs that would pay incentives to physicians who follow set standards and protocols for treating specific illnesses. It is not clear how this would save the program money in the long run. In addition, the American College of Radiology has started a campaign arguing that the dramatic increase in imaging procedures is caused by self-referrals by physicians using Stark II law exceptions to own in-office imaging equipment.

Bright Spots in a Grim Landscape

While from a neurosurgeon’s perspective the future of Medicare payments looks grim at best, there are several bright spots. First, problems with the SGR already are well-documented and recognized. The U.S. House of Representatives Energy and Commerce Committee held hearings last spring on this issue, which resulted in letters from both the House and Senate being sent to the CMS requesting additional information and action. Second, unlike medical liability reform, this is not a partisan issue at this time. Both Democrats and Republicans have publicly stated that they will work to prevent cuts in physician reimbursement. Third, there is no real “opposition” to this issue, except from those who also are jockeying for additional funding. This problem is and will continue to be all about finding the money. ■

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For Further Information

Title XVIII—Health Insurance for the Aged and Disabled
www.ssa.gov/OP_Home/ssact/title18/1800.htm

Medicare Prescription Drug Improvement and Modernization Act of 2003
www.cms.hhs.gov/medicarereform

Medicare RBRVS 2003: The Physician’s Guide
www.neurosurgery.org/marketpl

Current Procedural Terminology
www.neurosurgery.org/marketpl

The Medicare Monolith

A Neurosurgeon Wonders What Can Fix Spiraling Problems

Medicare is a monolith in American healthcare. Although it accounts for only 20 percent of all healthcare spending and 16 percent of all federal spending, its influence can be felt on all healthcare payment and policies in the United States.

Few of us were in active practice in the 1960s when Medicare began covering treatment of the elderly, let alone during the years preceding its passage when organized medicine opposed any government-run medical care program. But technological advance in healthcare—unavailable to the most needy and vulnerable, especially the elderly, due to cost beyond their means—and its promise of a longer life with better health gave rise to grinding social conflict that demanded resolution. In 1965, with Democratic majorities in Congress and Lyndon Johnson in the White House, Medicare—Title XVIII of the Social Security Act—was born.

The Medicare program was a compromise between universal healthcare supporters and opponents, settling on healthcare not for all, but for those defined as neediest. It made the promised benefits of modern healthcare more widely accessible, but at the same time began a spiral of regulation now growing exponentially, while expanding cost threatens Medicare program solvency.

The Medicare fee schedule, its expenditure target, and its perverse sustainable growth rate formula are pieces of federal cost control policy that attempts the impossible: unrestricted access to unlimited care of growing complexity for growing numbers of people by restricting costs and constraining payments under tax-funding limits. The SGR formula ties physician expenditure targets and fee schedule conversion factor updates to growth in the economy, as measured by the percent of growth in gross

domestic product each year.

The Medicare method for fitting mission to means is to tie spending to available tax revenues. With service volume and expense growing faster than funds, the simple solution is price reduction using the SGR formula. This translates to fee cuts for physicians. The rationale for the physician expenditure target is to create an incentive for physicians to reduce treatment costs for individual patients and thus save money in the overall budget. But it hasn't worked. Physicians don't make treatment decisions

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based on what's good for the federal budget; they make them based on what's good for the patient.

The pressure for cost control in Medicare will worsen. The Congressional Budget Office warns that the 32-year trend in Medicare spending growth has amounted to GDP growth plus 2.8 percent per year. Medicare spending, \$3 billion in 1967, ballooned to \$272 billion in 2003. At this rate Medicare spending will grow from 2.5 percent of GDP in 2002 to 9.2 percent of GDP in 2075. Combined with Medicaid and Social Security, total federal entitlement payments in 2075 would be 18 percent of GDP, which is equivalent to all federal tax revenues generated today under current tax policy.

In addition to these projected costs, the new Medicare Drug Benefit (Medicare Part D) passed in November 2003 will add an

estimated 28 percent to the future Medicare payment obligation (\$8 trillion in future benefit payment exposure versus \$20 trillion for Part A and Part B.) The drug benefit was passed without any new tax funding to pay for it. If tax cuts passed in 2002 do not "sunset," the General Accounting Office estimates that by 2040, interest paid on federal debt will equal all federal tax revenue, and Medicare, Social Security, and other spending will exceed tax revenues by 250 percent. This prospect, which obviously would bankrupt the government, is completely unsustainable.

Medicare and the Medicare fee schedule are casualties of federal tax policy, and particularly of tax shortfalls and budget deficits. The cuts projected over the next seven years for the Medicare fee schedule conversion factor represent only the beginning of the downward pressure on all Medicare payments, unless costs unexpectedly fall or new money is poured into the program from somewhere. Even new tax sources don't solve the future cost problem because the annual growth rate in Medicare costs and health services in general exceeds the growth in national income and eventually will outstrip tax revenues. It is growth in medical services and the demand for services that ultimately drives the cost. Until a means of reducing the demand is accepted, the cost dilemma will grow, and for physicians price (reimbursement) cuts will continue.

With this background in mind, this issue of the *AANS Bulletin* focuses on Medicare and the effects of new Medicare legislation. Although from a neurosurgeon's perspective the future appears discouraging, we must continue to search out and lobby for solutions that fit national healthcare needs and budget realities. ■

TIMELINE: Neurosurgery Through History

Cushing, AMA: Keep Government Out of Healthcare

Organized neurosurgery, along with the rest of American medicine, continues to lobby, cajole, and plead its case with the government in order to increase payments by Medicare. Surprising? Probably not. But for those who opposed the adoption of Medicare 40 years ago, these efforts may vindicate their dire predictions.

The creation of some sort of national health insurance was advocated in the early part of the 20th century as an outgrowth of labor and social reform movements. Much of organized medicine at the time, were more or less in favor of the idea. However, state medical societies were against the idea, reflecting the opposition of rank-and-file physicians.

The Depression and President Roosevelt's "New Deal" lent momentum to the

national insurance movement, but FDR himself was noncommittal. A key adviser on his Medical Advisory Committee was neurosurgeon Harvey Cushing, whose daughter was to marry the President's son soon after. FDR invited Cushing to a private lunch at the White House the day before the committee was to meet for the first time. Cushing was against any major health insurance program, fearing the effects of this governmental control on physicians' practices and on the quality of American medicine as a whole. In the end no national health insurance was passed under the Roosevelt administration.

The debate on this issue continued through the mid 1960s. The increase in the number of elderly Americans, together with incremental steps that were taken, led ultimately to the creation of Medicare on April 9, 1965. The American Medical Association

warned against the huge bureaucracy that would result and the effect on physician-patient relationships. At first doctors' fees were not part of the plan but then were included as "Part B" of Medicare. The ensuing 40 years have seen ever-expanding federal regulation of physician payments and an increasingly arcane system of coding, documentation, reimbursement, and penalties. And the Medicare program sets the tone for essentially all of the huge American third-party healthcare payment system.

So perhaps the concerns of the AMA and of Harvey Cushing were not unfounded. When asking the government to pay for your services, *caveat doctor*. ■

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Declining Medicare Reimbursements

How Practice Administrators Can Take Action

Medicare physician reimbursements continue to decline while practice expenses increase dramatically. This pressing problem has prompted neurosurgery's practice administrators to ask what they can do to support organizational efforts that address this and other daunting Medicare issues.

Medicare physician fee schedules are updated annually based on a statutory formula designed to control the rate of growth in spending for physician services. The Centers for Medicare and Medicaid Services adjusts the update annually depending on expenditures compared to a target rate called the sustainable growth rate. The SGR is calculated based on increases in the number of beneficiaries, projected growth of the economy, medical inflation and changes in the law.

Reimbursements would have been reduced nearly 10 percent in the past three years if the Medicare Prescription Drug Improvement and Modernization Act of 2003 had not replaced the proposed 4.5 percent decrease under the SGR update with a 1.5 percent increase in 2004. Looking ahead, physicians will receive negative updates (decreases) of approximately 5 percent each year from 2006 through 2012. In other words, physicians will receive less reimbursement in 2012 than they did in 2002 for the same procedures.

Decreased Medicare reimbursements often mean decreased insurance reimbursements. Commercial insurance fee schedules are increasingly tied to Medicare fee schedules. For example, one carrier may reimburse at 140 percent of the Medicare rate, while another may have contracted at 165 percent. As Medicare's rate decreases, so do commercial insurance payments.

In addition, organizations that provide

re-pricing services to client companies may negotiate additional discounts for self-funded employer plans based on Medicare reimbursements. For example, a surgical code originally negotiated at \$1,000 may be discounted by \$150 because the Medicare allowable charge is only \$850.

The first step you should take is to know what Medicare changes are occurring and how those changes will affect your business.

Of paramount importance to neurological physicians is the rising cost of medical liability insurance. In some states, carriers no longer offer professional liability insurance or the price of coverage has become cost prohibitive. Many physicians are moving their practices to neighboring states with comparatively affordable premiums and favorable business climates.

Keep your patients informed on how this will affect them. Some practices have used newsletters and pamphlets to explain to patients how decreasing Medicare payments and medical liability issues are affecting the physician's ability to deliver care. In addition, some offices have created an open letter to patients encouraging them to contact their congressional representatives.

Take the time to visit your state and federal representatives yourself. Speak to them face to face about how Medicare and medical liability reform issues affect care and the ability to continue doing business. Follow up with a letter thanking them for their time and reiterating your major topics of discussion.

Get to know your regional Medicare medical director. Correspond and speak with this individual when needed.

Also, when contracts are up for renewal, read and negotiate each section. Know whether the organization with which you are negotiating is also a re-pricer of claims. Do not assume that negotiation is impossi-

ble, even if you have had contracts with given area payers for more than a decade. You may be surprised what you can do, especially if your specialists are needed to maintain a complete panel.

Network with other practice administrators. Join professional organizations such as NERVES, the Neurosurgery Executives' Resource, Values and Education Society; the American Medical Group Association; the Medical Group Managers Association; and other associations that actively promote your profession. Perhaps consider participating as an officer or delegate. Sharing ideas, experiences and resources will enrich you, the organization, your business and your profession.

Attend local, state and national healthcare conferences. These activities provide continuing education, networking opportunities, ideas and resources for every practice.

Become involved in the business community. Look for opportunities to educate others about your unique specialty and the challenges it faces. Because Medicare reform affects a large section of most communities, openly address the issue as it relates to your patients and practice.

Look for opportunities to participate in focus groups or healthcare forums as well, to educate others on Medicare reimbursement or medical liability reform.

Practice administrators have the unique opportunity to interface with other healthcare businesses, multidisciplinary professionals, legislators, the community and patients. Your sphere of influence is greater than you think. ■

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Medicare Methodology Lags Behind PLI Cost

Formula for Professional Liability Insurance RVUs Examined

Like the practice expense component of Medicare's resource-based relative value scale, the professional liability insurance portion of relative value units became based upon the resource cost to the physician in 2000. With significant nationwide attention on the exponentially rising costs of liability insurance in states lacking liability reform, one would anticipate a substantial rise in the PLI RVUs for high risk specialties such as neurosurgery. However, a closer examination reveals a methodology that fails to properly capture the rapidly growing cost.

According to statute, the Centers for Medicare and Medicaid Services must reexamine and update PLI RVUs no less than every five years. Therefore, the CMS hired a contractor to examine PLI data and provide recommendations for updating the 2005 Medicare Physician Fee Schedule with new PLI RVUs at the individual code level.

The CMS has based PLI RVUs on three-year averages of PLI premium data obtained from major national carriers that held representative market share. Because the data was provided voluntarily by insurers, there was a discrepancy between the data set and the year of the survey. For example, neurosurgery's current PLI RVUs are based on a three-year average of premiums collected between 1996 and 1998. But for many states, the rapid rise in PLI costs did not begin until 2000. Rather than using the subsequent three-year interval (which would still fail to reflect the current premium environment), for the currently proposed update, the contractor used 2001 and 2002 data and extrapolated 2003 data.

Data from this time interval include premiums charged by insurers that no longer write PLI policies for physicians. These data also do not include tail coverage, which represents a substantial and growing cost to physicians. Moreover, it is

important to realize that averaging the nonlinear growth of PLI costs continues to underestimate the financial impact of these real and significant costs.

The CMS recognized physicians' increasing PLI costs and adjusted the weighting of the PLI component from 3.2 percent to 3.8 percent of total RVUs. Although 0.6 percent is a substantial increase, the CMS has failed to acknowledge the larger proportion of practice costs that PLI represents in many specialties. In neurosurgery, PLI RVUs represent approximately 10 percent of total RVUs for a particular service. Current CMS methodology, by which the high risk provider will be underpaid and the low risk provider will be overpaid, uses averaging of the insurance risk factors of all specialties providing a particular service, including assistants at surgery. A review of the provider profiles for neurosurgery procedures identifies many non-neurosurgeons as well as non-neurosurgeons providing some of these services to Medicare patients.

Consequently, the American Medical Association's Relative Value Update Committee, known as the RUC, requested that the CMS remove the assistants at surgery from the weight-averaged calculation of risk. Moreover, the RUC supported a recommendation put forth by the American College of Surgeons that would use a dominant-specialty method rather than a weight-averaged method.

Using the current methodology, the CMS contractor determined that neurosurgery PLI RVUs would actually decline in 2005. In fact, neurosurgery is estimated to have the fourth largest reduction in PLI RVUs among the medical and surgical specialties. However, using a dominant-specialty method would result in increases, thereby better reflecting the true experience

of practicing neurosurgeons.

But even if using a dominant-specialty method, the CMS proposes that the anticipated increase in PLI RVUs should be adjusted for budget neutrality through a reduction of the work and practice expense RVUs. Although this would preserve the conversion factor and result in relatively small changes in the work and practice expense components, it actually would eliminate the impact of rising PLI cost by "paying" for it out of current work and practice expense pools. The RUC has advocated strongly that the statutory requirement of a budget neutrality adjustment be made in the conversion factor. This not only would preserve the integrity of the critically measured work and practice expense components, but also directly would acknowledge these increasing costs by a reduction in the conversion factor, thereby further stimulating Congress to critically examine the Medicare physician payment methodology.

The RUC is continuing to work with the CMS to make recommendations that will result in better acknowledgement of growing PLI costs. In addition, the recently established PLI work group, part of the RUC, is exploring alternative methods that better reflect PLI premiums. In fact, since PLI costs are not substantially related to the type and volume of procedures performed within a specialty, the relative value system may actually be an inappropriate method for attributing these costs to specific physician services. ■

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applications that allow information to be placed in a contextual framework.

One of the major responsibilities of the AANS is to organize and provide a framework for these educational experiences that promotes the independent judgment and professionalism of our members and, most importantly, provides objective and balanced information. The AANS has the responsibility to require that its members participate in the continuing education processes, and thus, have in place requirements for membership which will complement those of the ABNS in their Maintenance of Certification efforts. There is in place a process to track CME activity for each neurosurgeon and also to review and approve neurosurgical CME. The AANS has the ability to sponsor and jointly sponsor category I CME, a process carried out under the auspices of the Accreditation Council for Continuing Medical Education.

An important service to society and for the quality of neurosurgical education is specialty-specific CME. We must guarantee to the public that neurosurgeons are receiving appropriate neurosurgical CME. The responsibility for educational content must be firmly in the hands of neurosurgery and not under the direction of some quasi-governmental agency or those with conflicting interests. Neurosurgery's educational leadership must ensure that the policies put in place by the ABNS' Maintenance of Certification and the AANS and CNS are fully married in order to prevent confusion and maintain and support the standards which society expects of us.

There are some challenges to contemporary CME. A great deal has been said about the role of industry and its influence upon CME programs. Industry spends in

excess of \$11 billion or between \$8,000 and \$13,000 per physician each year on education and marketing, and the difference between the two is not always clear.³ Industry, an abundant source of medical advances, plays a crucial role in disseminating up-to-date medical information. Although industry information fills an important need, it is often biased.⁴ It is not difficult to see why this may be so.

A company's primary obligation is to obtain maximum benefit for its shareholders. Medical professional societies such as ours have the altruistic duty to advocate and act in the best interest of the patient and society and are expected to serve as independent and trustworthy sources of objective and balanced healthcare information and education for members and the public. While seeking to achieve these goals, professional associations frequently seek external funding to defray costs and risk arrangements that can result in dual commitments or conflicts of interest, and they therefore must follow specific guidelines when dealing with industry sponsorship to ensure that unbiased information is presented in a scientific program.

The AANS has established policies that require complete control of program planning, content and delivery by the organization in its programs. Our interactions with industry have been harmonious and supportive and present little in the way of a problem. However, society has deemed it appropriate that this relationship be further clarified in order to ensure that the material presented by medical associations, such as ours, is unbiased and accurate. The AANS has charged a task force to review guidelines and interactions with commercial and corporate sponsors in an effort to further the continuation of appropriate relationships. These guide-

lines will ensure that industry's presence does not detract from the annual meeting's focus on professionalism and other organizational goals.

With a professional organization such as ours, the appropriate role of sponsors and industrial contributors has been easy to maintain. However, this becomes *much less clear* when dealing with commercial support for smaller organizations and individual physicians. In such situations companies have been known to help organize and advertise educational events, prepare teaching slides and curriculum materials, compile lists of possible speakers as well as indirectly pay speakers. Attendees are often rewarded with free meals and other amenities.

Anthropologists have looked at the cultural significance of gifts. They recognize that the central importance of gift exchange is a means of initiating and sustaining relationships. In our society we are not taught to accept gifts without accepting certain obligations and only the very callous would do so. This makes things far less clear for the individual physician accepting gifts, such as hospitality and travel expenses. The obligations established are minimized when gifts are institutional rather than personal as no personal relationship and no obligation to respond in any way are established between the individual physician and the company. Nevertheless, some might argue that issues of justice and influence by promotion still remain and that institutions can also be corrupted. However, for an institution, full disclosure, avoidance of extravagance and the primary goal of improving patient care by physician education make these activities ethically acceptable and laudable.

The neurosurgeon's primary concern must be with the quality of the CME that is offered, and not just with the accumulation

of credits of any conceivable merit. Although current guidelines for organizational CME appear appropriate and effective, there are other dangers to unbiased content.

I suspect there is a more insidious threat to neurosurgical CME that resides within our own house. Conflict of interest is an obstacle to the honest exchange of information that has been heightened by the increasing involvement of neurosurgeons with commercial ventures. Teachers, who also function as CEOs of their own companies, or stock or option holders of others, or paid consultants, are asked to carry a difficult burden in providing unbiased evidence regarding their products and inventions. The disclosure of a conflict of interest, by itself, does not guarantee that the information provided will be without prejudice, and there must come a point when the requirement for unbiased educational content should restrict certain individuals from participating in specific educational venues.

One should also be wary of personal marketing. We have all been at CME venues where colleagues have claimed remarkable successes through the use of technology or vastly superior surgical skills that only they can provide. While in some cases this may be true, the desire to enhance one's practice can also lead to the delivery of biased and compromised information.

Do we have a huge problem? I suspect not. For neurosurgery, guidelines are in place and clearly additional ones can be effectively constructed as needed to make sure that the CME delivered to neurosurgeons can be represented to society as unbiased, free of outside influence, and in the best interest of our patients. These concerns are shared by many of you, I know, as well as by the medical community and society at

The AANS organizes and provides a framework for educational experiences that ... provide objective and balanced information.

large. On Sept. 28, the ACCME and its seven member organizations, among them the ABMS and Council of Medical Specialty Societies, released new guidelines that address many of the issues raised above. In the Standards for Commercial Support: Standards to Ensure the Independence of CME Activities, six standards are defined and a document of frequently asked questions helps put them in context.

These issues should be looked at with the appropriate perspective. I would assure you that the problems of CME represent a much less significant threat to the practice of medicine than the pressure exerted by those who wish to directly influence how we practice for their financial gain. The influence of HMOs, physician joint ventures, proprietary hospitals and federal constraints on best practice along with the effect of medical liability issues, when measured against threats to CME, are the proverbial giant to the gnat.

I have been involved with the organizational aspects and the delivery of neurosurgical CME for over 25 years. I recall the first CME meeting I attended on behalf of neurosurgery. It was in 1978 and attended by no more than 150 individuals; I also recall the second which had closer to 400, and the last, just a few years ago, which was attended by thousands. I have observed CME become a giant bureaucratic industry with arcane rules. What has been learned? The majority of knowledge that I have gained beyond my residency, my reading and my role as a program director has been learned at neurosurgical meetings. It has been gleaned from colleagues and friends who have provided new ideas that I have been willing to try

because of my trust in and respect for them. The ability to interact with my peers has been the cornerstone of my CME. When one considers the missed benefit to early neurosurgical patients which resulted from the lack of communication and conviction about Dandy's ventriculography, society can be grateful that our small part of the medical profession has evolved differently.

Irrespective of the progress that will be made in communication of information through electronic and other formats, the ability of neurosurgeons to communicate with each other about their mutual problems, and as Sachs said, "its benefit in preventing us from becoming too self-satisfied or self-important," will remain the most effective CME of all. ■

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This article is adapted from Ratcheson, RA. "Neurosurgical Continuing Medical Education." *Clinical Neurosurgery*. 2004;51: 36-38.

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Your Money's "No Good"

AANS Benefits Now Free to Residents and Fellows

For those of you currently in the midst of residency or fellowship training, it may come as a surprise that the American Association of Neurological Surgeons has recently adopted a number of changes that will benefit you. These changes are specifically designed to promote a seamless (and hopefully painless) transition from training through board certification to the life of a practicing neurosurgeon.

The AANS already has provided free AANS membership for residents and fellows (no annual dues); the *Bulletin*; free attendance at selected resident-oriented practical clinics at the annual meetings; access to the online journal *Neurosurgical Focus* and the Online Career Center; and more. But effective in January 2005, Resident and Fellow members also will receive free registration for AANS annual meetings beginning with the April 2005 meeting in New Orleans. They also will receive free subscriptions to all AANS scientific journals: the *Journal of Neurosurgery*, *Journal of Neurosurgery: Spine*, and the *Journal of Neurosurgery: Pediatrics*. Courses geared toward practice management or preparation for oral board certification will be made available at reduced rates.

These changes arise from the AANS' desire to foster a lifelong partnership between neurosurgeons and the national organization. A review of candidates who successfully completed the American Board of Neurological Surgery's oral examination identified a significant number of young neurosurgeons who had been resident members at one time but allowed their memberships to lapse.

I myself had been a Resident/Fellow member for seven years, however, one year I had to register for an annual meeting as a nonmember. I was no longer considered a Fellow, but had not yet passed my oral

If it means that I now chip in an extra hundred dollars so that one of the residents can go to his first annual meeting, so be it.

boards, and therefore could not be considered an Active member. I wore my non-member badge proudly at the meeting that year in defiance of the establishment, and may have even gone to a breakfast seminar without a tie on. What a rebel I was!

The AANS Long Range Planning Committee, under the leadership of Fremont P. Wirth, MD, president-elect of the AANS, included the problem of "losing" residents and fellows between the conclusion of their programs and ABNS certification in the 2004 AANS Strategic Plan. Item 2.4 of this document, which essentially balances resources and needs in a



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hierarchy based upon importance, initiated a broad review of the benefits available to young neurosurgeons.

Quite simply, the realization that membership dues, registration fees and subscription dues were limiting the dissemination of critical clinical, ethical, and medicolegal information to early career neurosurgeons seemed contrary to the very mission of the AANS.

Your own perception of the impact of the new and valuable benefits for residents and fellows will ultimately depend upon which side of the training line you find yourself. If you are still in training, this may

seem like a godsend delivered to make that book fund last a little longer or allow you to go to the spring meeting when it otherwise might not have been possible. In discussing this with a resident from the University of California system, he commented that it will be great to be able to start building his own *Journal of Neurosurgery* library, instead of photocopying articles of interest from the residents' single issue.

On the other hand, the cost to provide such free services and subscriptions to residents must be spread among the AANS membership. Although the cost is not astronomical, will it mean raising dues for current active members just a little higher? One of my former partners simply dropped his AANS membership, finding the cost-benefit ratio to be prohibitive.

For what it is worth, I am close enough to the training line to have an opinion on the subject. When I was still a fellow, my director would tell me that my money was "no good" whenever I attempted to pay for both of our lunches or two iced teas. He told me that I could chip in when the fellowship was over. The idea has stuck with me. If it means that I now chip in an extra hundred dollars so that one of the residents can go to his first annual meeting or keep a copy of the current *Journal of Neurosurgery* on his desk, so be it. I wholeheartedly agree with Dr. Wirth in telling the residents that their money is "no good" as far as I am concerned. By participating in the AANS now they may be asked sometime in the future to do the same for the next generation of neurosurgeons. ■

More information on AANS membership benefits for residents and fellows is available at www.AANS.org/residents/membership.asp.

New Tools of the Trade

Leadership, Business Management Courses Now Essential

Aneurysm coils, pedicle screws, and ventriculoscopes are not the only new tools neurosurgeons are learning to use. While the economic stress on neurosurgical practice is an obvious motivation, neurosurgeons today are demanding, and getting, the opportunity for education in such diverse subjects as leadership, politics, business planning, practice management, marketing, and career planning. Neurosurgeons increasingly are taking time out of their practices to earn master's degrees in business administration just to run their practices and help with hospital and insurance negotiations.

So along with watching "Masters Operate in 3-D," neurosurgeons are filling the classrooms to master these new tools of the trade. With such a high demand, organized neurosurgery has responded with a rapid growth of special courses and seminars at national meetings and throughout the year. The scope of opportunities currently available to neurosurgeons deserves highlighting.

Coding courses were among the first to emerge, influenced by the rapid changes in national and insurance company regulations in the 1970s and 1980s. Byron C. Pevehouse, MD, conducted presentations on coding at breakfast seminars during annual meetings of the American Association of Neurological Surgeons before 1990, when he organized the first pre-meeting AANS coding course covering International Classification of Diseases and Current Procedural Terminology. That 500 people showed up when only 100 were expected to attend attests to the intense interest in and need for such courses. Since then, these courses have become a staple of neurosurgical education, with more than 40 courses devoted exclusively to coding and reimbursement.

Both the AANS and the Congress of Neurological Surgeons now offer courses in neurosurgical coding.

In 2000, Women in Neurosurgery sponsored a leadership seminar during the AANS Annual Meeting. The seminar included talks on career promotion, time management, and conflict resolution. Edie E. Zusman, MD, codirector of the seminar, said "The response to this educational offering was tremendous. The program was sold out, the evaluations were excellent, and nearly all the participants wanted more time and more programs like this one." Based on this success, two subsequent leadership skills seminars have been held. Most recently, the Advanced Leadership Skills session was held during the 2004 Annual AANS Meeting.

Another venue for developing leadership skills is the Leibrock Leadership Development Conference. The program, developed initially by the Council of State Neurosurgical Societies and the AANS/CNS Washington Committee, responded to the desire to build a core of neurosurgeons who could become involved in political issues that affect healthcare delivery. This year, the conference was held July 18-20. James R. Bean, MD, a participant and speaker, noted that "The interactive sessions on recent Medicare law, media messaging, medical liability, new EMTALA regulations, and the current political situation in the run-up to the presidential election were priceless [and] worth every bit of the time spent."

At the training level, the Accreditation Council for Graduate Medical Education now expects residents to gain an understanding of all aspects of healthcare delivery, extending well beyond mastering surgical and diagnostic skills. Recent educational requirements during residency training include ethics, communication, professionalism, leadership, and administrative skills.

The complexity of resident education and evaluation even has led to the establishment of advanced degrees in surgical education.

Residents also have recognized the difficulty of choosing jobs and career paths. Beginning in 2001, the AANS held its first course devoted exclusively to guiding early-career neurosurgeons in taking these critical steps. Beyond Residency: The Real World, focuses on preparing residents for their future practice opportunities by addressing issues such as: choosing a practice setting; negotiating contracts for joining a practice; preventing medical liability claims; recognizing applicable regulatory requirements; coding effectively; and analyzing and maximizing reimbursement.

An AANS course offered for the first time this fall was designed to meet many of the same needs for seasoned neurosurgeons. Representing academic practice and private practice, respectively, Samuel Hassenbusch, MD, and Stan Pelofsky, MD, led an experienced team in the presentation of the Neurosurgeon as CEO: The Business of Neurosurgery. The course focused on strategies for building revenue streams, increasing business, enhancing performance, and improving the bottom line. That the course filled completely several weeks in advance speaks to the fact that economic and practice management issues currently weigh heavily on the minds of many neurosurgeons.

The experience of many suggests that taking the time to master these new tools of our trade may pay off handsomely in job satisfaction. Organized neurosurgery should continue to provide innovative educational programs, embedded within our annual meetings, with expert instruction modified specially for neurosurgical practice. ■

Deborah L. Benzil, MD, is associate professor in the Department of Neurosurgery at the New York College of Medicine, Valhalla, N.Y.

112 Join AANS

New AANS Members March-August 2004

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Education and Innovation

Make for New Orleans and the 2005 AANS Annual Meeting April 16-21

The American Association of Neurological Surgeons is already tuning up for a festive and informative annual meeting in the jazz and Mardi Gras capital city, New Orleans.

AANS President Robert A. Ratcherson, MD, has selected the meeting theme, Education and Innovation in Neurosurgery, which will set the tone for the entire event.

The Annual Meeting Committee, chaired by Richard G. Fessler, MD, has been hard at work crafting an enjoyable event that will play up all the advantages this culturally rich, gracious Southern city has to offer. Mardi Gras World, the City Park Botanical Gardens and the D-Day Museum are among the “Crescent City” sites meeting attendees will have the opportunity to enjoy. A jewel in the neurosurgical event calendar, this 73rd annual meeting is sure to live up to the lofty standards AANS members have come to expect.

Chair James T. Rutka, MD, and the Scientific Program Committee have taken the lead in planning a top-notch slate of science in tune with topics AANS members have said they are interested in learning about.

Many program decisions are influenced by the previous meeting's detailed evaluations. Attendees who completed and returned



Ronney Caruso New Orleans CVB

evaluations for the 2004 AANS Annual Meeting not only gave themselves a say in this year's annual meeting, but also became eligible to win five prizes, drawn daily, that ranged from AANS gift certificates in various denominations to complimentary air fare to the 2005 AANS Annual Meeting and dues renewal for one year of AANS membership.

Thirty members reaped material rewards for their participation in the 2004 evaluation program. Of the 30, Jerry Hubbard, MD, and Marion McMichael, RN, will enjoy one year of complimentary AANS membership; Mark Kubala, MD, and his guest can fly free, and Marc Friedberg, MD, will receive a free five-night hotel stay, both in conjunction with the AANS Annual Meeting in New Orleans; and Mahadev Souri, MD, and Daniel Donovan, MD, each will receive complimentary registration for the New Orleans meeting.

While the Cushing orator and special lecturers are being finalized, the committee has selected several new topics that members have said they want to explore.

New Breakfast Seminars

- Evidence-Based Medicine and Outcome Studies—The Design of a Clinical Study
- Congenital Craniofacial Deformities
- Changing Career Paradigms in Cerebrovascular Neurosurgery
- European Versus U.S. Residency Training of Complex Cranio-Orbital Tumor Lesions
- European Versus U.S. Residency Training of Pineal Region Tumors

New Practical Clinics

- Interventional Neurovascular Disease: Complication and Avoidance
- Preparation for Medical Legal Testimony
- Noninvasive Preoperative and Intraoperative Brain Mapping and Treatment of Epilepsy

Also new for Resident and Fellow AANS members in North America: complimentary registration at the 2005 Annual Meeting. Additional information on new benefits for Resident and Fellow members is available in Residents' Forum, page 22.

Annual meeting details are posted online at www.AANS.org as information becomes available. ■

Planning for the 2005 AANS Annual Meeting

AANS Members Get First Crack at New Orleans

Nov. 1 General meeting registration and housing reservations open for AANS members only; registration and housing open to everyone two weeks later.

Mid-January Tickets for practical clinics, breakfast seminars and other optional events become available exclusively to AANS members for two weeks. In late January tickets become available to everyone.

March 18 Early registration and housing deadline for everyone.

Details are at www.AANS.org.

Neuros Head for the Hill

LLDC's a Primer for Impacting the Political Process

In this important election year, more than 55 neurosurgeons from across the country participated in an event especially designed to teach neurosurgeons how to influence the political process.

The Leibrock Leadership Development Conference, presented by the Council of State Neurosurgical Societies July 18-20 in Washington, D.C., readied neurosurgeons for the final day's journey to Capitol Hill. The message neurosurgeons delivered to their senators and representatives or their health aides: The medical liability crisis must be effectively addressed by federal legislation because it is creating a hostile environment in which physicians must practice and it is negatively affecting patients' access to care. Their individual messages were bolstered by compelling data from recent surveys, which suggest:

- 66 percent of neurosurgeons are limiting their services because of rising liability insurance premiums or risk of a lawsuit.
- 37 percent of neurosurgeons have altered their emergency or trauma call coverage because of liability concerns.
- More than 50 percent of neurosurgeons have altered their treatment protocols—because of liability concerns.

The conference opened with a half-day coding and reimbursement course, run by Sam Hassenbusch, MD, and Greg Przybylski, MD, which featured an overview of the processes that lead to the development of new Current Procedural Terminology codes and assigns them values. Other speakers and topics included Jim Bean, MD, on the new interpretive guidelines for the Emergency Medical Treatment and Labor Act; Stan Pelofsky, MD, on physician ownership of specialty hospitals; and Michael DeMane, chief executive officer of Medtronic Sofamor Danek and Jeffrey Segal, president

of the Medical Justice Services, on medical liability from. The day concluded with Stanley Fronczak, MD, and Robert Gillen, JD, presenting a course on legal strategies for handling assets.

The next day's program tackled medical liability reform. Dr. Bean and Katie Orrico, JD, reviewed progress of the Protect Patient



*Frederick Boop, MD,
is chair of the
Council of State
Neurosurgical
Societies.*

Now campaign for federal medical liability reform, followed by Peter Carmel, MD, a member of the American Medical Association's Board of Trustees, who discussed the AMA's approach to liability reform. Then Chuck Todd and Vaughn Ververs of "The Hotline" provided an insightful review of all the major political campaigns around the country, including how the contenders vote, how campaigns are funded, and how the campaigns are expected to play out. This was followed by a report from Charles S. Trump, House minority leader for West Virginia, who related that the medical liability crisis had caused physicians to flee the state, necessitating statewide reform.

That afternoon, Patrick McCabe of GYMR Public Relations spoke about how to effectively take the medical liability crisis story to the media. He was very informative about which strategies might garner support versus those that might cause a backlash. Stephen Northrop, the health policy adviser for Sen. Michael Enzi who serves on the U.S. Senate's Health, Education, Labor and Pensions

Committee, spoke of alternative legislative proposals for medical liability reform.

Rep. Mark Kirk of Illinois discussed how to get the liability reform message home to the constituents. He spoke of a tragic case in the Chicago area in which a schoolboy ran into a wall while playing and suffered an epidural hematoma. The boy was taken to the local emergency room, which no longer had neurosurgical coverage for intracranial emergencies. Apparently the child herniated while waiting for helicopter transport to another facility and now has significant impairments. Illinois, a major crisis state, now has no neurosurgeons practicing south of Springfield in the state. Of those in the Chicago area, the vast majority have now given up their intracranial privileges, leaving many of the local hospitals short staffed for trauma coverage.

Michael C. Burgess, an obstetrician who left medical practice to become a representative for Texas, spoke about what it will take in the upcoming presidential election to pass federal medical liability reform legislation.

Just before heading to the Hill on Tuesday, participants held a breakfast conference with Sen. Ben Nelson of Nebraska to discuss strategies for building a bipartisan consensus on federal reform legislation.

In all, the Leibrock Leadership Development Conference was a success. Attendance by members of the Executive Committee of the Congress of Neurological Surgeons strengthened the audience, and the support of exhibitors greatly added to the meeting's positive outcome. Kudos go to Dr. Leibrock, Gary Bloomgarten, MD, Pat Jacobs, MD, and Fernando Diaz, MD, members of the conference development committee and the AANS/CNS Washington Office staff for putting together an all-star symposium. ■

CSNS information is available at www.AANS.org/legislative/council/organizational.asp.

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AANS/CNS Sections Committees Associations Societies

In Memoriam

Nadason Arumugasamy, MD
Christopher Y. Cai, MD
Harvey Chenault, MD
Francisco R. Escobedo, MD
Leslie E. Geiger, MD
Sam Hanzel, MD
Robert A. Hayne, MD
Robert B. Livingston, MD
O. Charles Mitchell, MD
Robin L. Mitchell, MD
Dogan M. Perese, MD
William S. Pollard, MD
J. Lawrence Pool, MD
Brigadier Ramamurthi, MD
Franklin Robinson, MD
John R. Russell, MD
Robert Winton Schick, MD
Mario J. Sculco, MD
Harold Stevens, MD
Palle Taarnhoj, MD
Francis J. Williams, MD

NREF Launches Annual Celebrate a Life Campaign

The Neurosurgery Research and Education Foundation launched its annual Celebrate a Life campaign in August with the mailing of new campaign brochures to all non-academic AANS members. "The Celebrate a Life program provides a unique opportunity to honor someone's life and at the same time enable a young scientist to create new knowledge that will benefit many of us," said Julian T. "Buz" Hoff, MD, NREF chair. "AANS members in private practice, group practice and hospital settings are encouraged to share NREF's Celebrate a Life memorial and tribute giving program information not only with their patients, but also with their patients' family and friends." In its first year the program raised more than \$23,000 in support of neurosurgical research and education through donations from AANS members, hospitals, practices and the general public. Additional copies of the Celebrate a Life brochure are available by contacting the Development department at (847) 378-0500. Donations can be made online at www.AANS.org/research.

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AANS/CNS Stereotactic, Tumor Sections Address SRS Coding (Contributed by Michael Schulder, MD)
Changes in coding for stereotactic radiosurgery have been proposed that would, in essence, redefine

SRS as a form of radiation therapy. The effect on reimbursement would be such that neurosurgical expertise, time, and effort will not be adequately compensated. The AANS/CNS Section on Stereotactic and Functional Neurosurgery joined forces with the AANS/CNS Section on Tumors to address this problem. A committee led by Andrew Sloan, MD, is preparing an official statement on SRS that will be sent to the American Medical Association and the Centers for Medicare and Medicaid Services in an effort to preserve the input of neurosurgeons as leaders in the development and clinical applications of SRS. Background on this issue is that many neurosurgeons have advanced the field of SRS over the past 50 years so that it has become a routine method of minimally invasive stereotactic neurosurgery. However, the development of new technologies has begun to blur the lines, in some cases, between stereotactic radiosurgery and radiation therapy. It is now possible to deliver SRS outside of the cranium or even the spine, to patients and targets that do not come under neurosurgical purview. Stereotactic fractionation also has called into question the exact definition of SRS. This fact, together with technological convergence, has raised the concern that the neurosurgical role in SRS will be greatly reduced.

Dr. Weiss to Assume NREF Chair

After eight years of outstanding service, Julian T. "Buz" Hoff, MD, announced that he is stepping down as chair of the Neurosurgery Research and Education Foundation of the American Association of Neurological Surgeons.

"I accept Dr. Hoff's resignation with great reluctance," said AANS President Robert A. Ratcheson, MD. "The AANS and NREF are grateful to Buz, an exemplary physician, educator and researcher, for all that he has done on behalf of neurosurgical research. With rare grace and skill, he has brought healing to patients, knowledge to students and leadership and expertise to research and to his profession."

Under Dr. Hoff's leadership, the grants program has matured, and the number of grants awarded annually from 1998 to 2004 has nearly doubled to nine. In addition, the annual

fundraising campaigns, including Cushing Scholars, memorial, past awardees, online and general public giving, have grown consistently under his direction. The Silent Auction has also achieved annual financial success during its six years in existence.

Dr. Ratcheson appointed Martin H. Weiss, MD, as the NREF chair effective Oct. 16. Dr. Weiss has been a leader of numerous neurosurgical and medical organizations, among them the AANS, for which he served on the Board of Directors from 1988 to 1991, as secretary from 1994 to 1997, and as president for the 1999-2000 term. He serves as associate editor of *Neurosurgical Focus*, and has been a member of the Editorial Board of the *Journal of Neurosurgery* since 1987.

Dr. Weiss served as chair of the Department of Neurological Surgery at the University of Southern California for more than 25 years and recently relinquished that position to spend more time in the laboratory and classroom.

Lacking Legal Ease

Expert Witness Rules, Liability Crisis

Editor: I was pleased to read “Rules for Neurosurgical Medical/Legal Expert Opinion Services,” in the Spring 2004 issue of the *Bulletin*. The rules were well written, however there is an important element that has been overlooked. More often than not, when a case reaches the discovery phase, any number of years may have gone by, even though it was filed within the statute of limitations time frame. In fact, the average time frame for discovery and trial litigation is between five and seven years.

Neurosurgery is a medical specialty where major advances happen within the scope of cognitive knowledge yielded by basic and clinical research, surgical technique innovations, neuroimaging advances, as well as other vital technological advances. These advances can be dramatic, generate profound impact on how we treat, even revolutionize treatments and can come about with the rapidity of six, eight and 12 months. Therefore, the standard of neurosurgical care is constantly evolving and may be quite different come trial time from what it was during the historical time in which the challenged care was given.

Therefore, I would humbly suggest that the rules should read like this:

■ The neurosurgical expert witness shall represent and testify as to the practice behavior of a prudent neurological surgeon giving different viewpoints if such there are and *which existed and were entertained during the historical period of time in which the practice behavior took place in consonance with the core neurosurgical knowledge, technological advances and ancillary resources available then.*

■ The neurosurgical expert witness shall recognize and correctly represent the *prevalent and accepted level of neurosurgical care or accepted care guidelines in the national neu-*



rosurgical community during the historical period of time in which the care of the case at hand was delivered and shall with reasonable accuracy state whether a particular action

was clearly within, clearly outside of, or close to the margins of the prevalent and accepted level of neurosurgical care or accepted guidelines during that historical time period.

I believe that we should use more cogent and less compromising terms such as “national neurosurgical prevalent level of care” or “acceptable treatment guidelines,” specifically when it reflects more accurately the reality of neurosurgical care and always keeps in mind that you specify what the level of care or treatment guidelines were during the period of time in question, since it may have varied by the time the expert is deposed or interrogated in trial.

— Modesto Fontanez, MD, JD, Toledo, Ohio

The AANS Expert Witness Testimony guidelines are available at www.AANS.org/about/membership/ExpWitness03Dec04.pdf. Find the referenced article at www.AANS.org, article ID 21843.

Editor: Your comments [on neurosurgery’s medical liability reform campaign in the Spring 2004 issue of the *Bulletin*] were quite interesting, however they still didn’t address some of the issues confronting us.

First, there is a lack of unity, which exists not only amongst us and other high-profile specialties, but also amongst our medical colleagues who only have to pay \$5,000 a year for their liability insurance premiums.

Another issue is that big awards are not necessarily the main problem. Of the insur-

ance premiums we pay, approximately 60 percent goes to our own defense lawyers. The obvious reason is that 90 percent of medical liability lawsuits are frivolous, but it sometimes takes two to three years to defend the suit until its disposal. Further, every year there are approximately 4,000 new law school graduates getting into the market, and the way they can make money is to create lawsuits.

Finally, attorneys tell me that if the U.S. Congress eventually passes tort reform and places a cap on pain and suffering, every state still has to ratify that. I was under the impression that the federal law superseded any local law.

In our own state of New Jersey there were approximately 95 neurosurgeons 10 years ago, and there are now 75. One of the insurance companies almost went broke and the other, Princeton, stopped reissuing any contracts other than \$1 million and \$3 million coverage. I personally had a big fight with them because in 33 years I haven’t had any settlement or judgment against me. Eventually they agreed to give me \$2 million and \$4 million coverage. If it weren’t for the hospital subsidy covering the emergency room, it would have been very difficult for me to stay in practice.

I believe we have excellent representation in Washington, D.C. Full-page newspaper advertisements, the interactive Web-site and satellite conferences are extremely important and very effective, and I also believe that placing brochures in our offices for the patients to read is extremely important and we should continue to do this. Each of the 230,000 medical specialists nationwide should contribute \$1,000 to fight the medical liability crisis. However, I don’t think that we have been aggressive enough. I think we should combat this issue on a nationwide basis with a strike. Maybe then legislators will do something about this problem.

— David A. Yazdan, MD, FACS, Brick, N.J.

The Spring 2004 and past issues of the *Bulletin* are available at www.AANS.org/bulletin. Find the referenced column using article ID 21841.

A Patient's Perspective

Memoir Seeks to Fill a Void



I Had Brain Surgery, What's Your Excuse? An Illustrated Memoir by Suzy Becker, Workman Publishing, New York, N.Y., 2004; 256 pp., \$19.95.

Suzy Becker was an author and artist with a best-selling book (“All I Need to Know I Learned from My Cat”) before she developed an intracranial problem and had surgery. Having gone through such a life-changing experience,

it seems logical that she would write about it.

Sometimes doctors are viewed as less than ideally empathetic, and some show little appreciation for what their patients experience. Now comes a book describing and illustrating in great detail the experiences of neurological dysfunction and of complicated brain surgery.

Becker suffered nocturnal seizures and eventually had a magnetic resonance scan showing a small left parietal lesion that needed to be removed surgically. She does a splendid job of describing

the tests and anxiety that preceded surgery. Post-operatively she was markedly dysphasic and required prolonged rehabilitation.

The author describes many ups and downs during her illness, and she has the skill to make the reader laugh and cry along with her. This book alternates poignancy with humor. Best of all are the illustrations, which cover every page of the volume.

Becker wrote this book because she could not find anything to read from a patient's perspective. She writes, “I wanted to read something by someone with a *real* tumor ... I couldn't find anything, and the harder I looked, the more I knew I needed to hear what awake brain surgery was like from someone who had had it. Not a resident or a surgeon. I wanted someone who really knew what this experience was like to tell me I was going to make it through this part okay.”

Patients now have such a book. But this book serves another need as well: It is a helpful book for neurosurgeons, too. We need to know about what our patients are experiencing. ■

We need to know about what our patients are experiencing.

Gary Vander Ark, MD, is the director of the neurosurgery residency program at the University of Colorado. He is the 2001 recipient of the AANS Humanitarian Award.



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EVENTS

Calendar of Neurosurgical Events

2004 Annual Meeting of the Congress of Neurological Surgeons

Oct. 16-21, 2004
San Francisco, Calif.
(847) 240-2500
www.neurosurgcon.org

2004 AANS/CNS Section on Tumors Sixth Satellite Symposium⁺

Oct. 21-22, 2004
San Francisco, CA
(847) 378-0500
www.neurosurgery.org/sections/section.aspx?Section=TU

2004 Annual Meeting of the Society of Neurosurgical Anesthesia and Critical Care

Oct. 22, 2004
Las Vegas, Nev.
(804) 673-9037
www.snacc.org

2004 Annual Meeting of the American Society of Anesthesiologists

Oct. 23-27, 2004
Las Vegas, Nev.
(847) 825-5586
www.asahq.org

Society for Neuroscience

Oct. 23-27, 2004
San Diego, Calif.
(202) 462-6688
www.sfn.org

5-Day Gamma Knife Radiosurgery Training Course

Oct. 25-29, 2004
Cleveland, Ohio
(800) 223-2273, ext. 47591
www.clevelandclinic.org/neuroscience

Research Updates in Neurobiology for Neurosurgeons

Oct. 30-Nov. 6, 2004
Woods Hole, Mass.
www.societyofneurobiology.org

4th International 2004 Skull Base Congress

Oct. 31-Nov. 4, 2004
Darling Harbour, Sydney, Australia
www.tourhosts.com.au/skullbase2004

American Association of Electrodiagnostic Medicine Annual Meeting

Nov. 3-7, 2004
Savannah, Ga.
(507) 288-0100
www.aaem.net

American Board of Neurological Surgery Meeting

Nov. 9-16, 2004
Houston, Texas
(713) 441-6015
www.abns.org

Association of Military Surgeons of the U.S. Annual Meeting

Nov. 14-19, 2004
Denver, Colo.
www.amsus.org

Advanced Techniques & Technology in Brain & Spine Surgery: An Intensive Review & Hands-On Practical Course

Dec. 3-5, 2004
New York, N.Y.
(212) 241-9638
www.mssm.edu/neurosurgery

2004 AANS/CNS Section on Pediatric Neurological Surgery Annual Meeting⁺

Dec. 8-11, 2004
San Francisco, Calif.
(888) 566-2267
www.neurosurgery.org/sections

Brain 2004: A Multidisciplinary Meeting for Nervous System Diseases in the Asia Pacific Region

Dec. 10-11, 2004
Shatin, Hong Kong
www.acp.cuhk.edu.hk/brain04

CANS 2005 Annual Meeting

Jan. 21-23, 2005
San Jose, Calif.
(916) 457-2267
www.cans1.org

Neuro-Oncology 2005 Current Concepts

Jan. 28-31, 2005
Orlando, Fla.
(800) 223-2273 ext. 53449
www.clevelandclinic.org

Richard Lende Winter Neurosurgery Conference⁺

Jan. 28-Feb. 1, 2005
Snowbird, Utah
(801) 581-6554

2005 Joint Annual Meeting of the AANS/CNS Cerebrovascular Section and the American Society of Interventional & Therapeutic Neuroradiology⁺

Feb. 1-4, 2005
(847) 378-0500
New Orleans, La.
www.neurosurgery.org/sections/section.aspx?Section=CV

⁺These meetings are jointly sponsored by the American Association of Neurological Surgeons. A frequently updated Meetings Calendar and continuing medical education information are available at www.AANS.org/education.

Upcoming AANS Courses

For information or to register call (888) 566-AANS or visit www.AANS.org/education.

■ Managing Coding & Reimbursement Challenges in Neurosurgery

Nov. 12-13, 2004 San Diego, Calif.
Jan. 28-29, 2005 Miami, Fla.
Feb. 18-19, 2005 Phoenix, Ariz.
March 18-19, 2005 Dallas, Texas (Advanced)
May 20-21, 2005 San Francisco, Calif.
Aug. 27-28, 2005 Chicago, Ill.
Sept. 16-17, 2005 Nashville, Tenn. (Advanced)
Dec. 2-3, 2005 Washington, D.C.

■ Neurosurgery Review by Case Management: Oral Board Preparation

Nov. 7-9, 2004 Houston, Texas
May 22-24, 2005 St. Louis, Mo.
Nov. 6-8, 2005 Houston, Texas

■ Innovation in Spiral Fixation: An Advanced Course

Feb. 26-27, 2005 Memphis, Tenn.

■ Minimally Invasive Spinal Techniques

Dec. 4-5, 2004 Memphis, Tenn.

■ Anatomy & Terminology

Jan. 27, 2005 Miami, Fla.
Aug. 26, 2005 Chicago, Ill.