

AANS Bulletin

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Editor's Note:

You may notice some changes in this issue of the *AANS Bulletin*. We've altered the design a bit to improve readability. We've added a new ongoing column on managed care. And, we've eliminated the mailing envelope to cut postage and handling costs. More changes are due in coming issues and we hope they make the *Bulletin* a more valuable source of information for members.

President's *message*

AANS Takes the Lead in Defending Against Pedicle Screw Litigation



J. Charles Rich, Jr., MD

In many ways, the past year has been one of ambiguity for the field of neurosurgery. Socioeconomic issues have created both controversy and opportunity for neurosurgeons like never before and research and development are bringing forth medical technologies and treatments that were unimaginable even 15 years ago. As President of the AANS, I am frequently asked, "What is the AANS doing for neurosurgeons to help them cope with the forces now threatening the future of neurosurgery?"

I can assure you that your professional society has become a true leader and advocate for the field of neurosurgery. Over the past year, the AANS has risen to face some of our biggest challenges yet—the proposed changes in practice expense reimbursement by the Health Care Finance Administration (HCFA), the pedicle screw litigation, and increased competition from other specialties—to name just a few. What the future holds for neurosurgery, we cannot be sure, but through the work of such organizations like the AANS, we can certainly try to manage influences over different facets and prepare for whatever changes lie ahead.

Elsewhere in this issue of the *Bulletin*, you'll be reading about our efforts in responding to the practice expense issue and the marketing communications initiative we developed to increase the visibility of neurosurgeons in the public arena. In this, my last President's Message, I wish to focus on the work that the AANS has done in area of the pedicle screw litigation.

Litigation Background

The AANS has long supported the efficacy of pedicle screw fixation in appropriate cases. That support remains strong today. In 1993, we cooperated with the Food and Drug Administration (FDA) and several prominent medical associations in conducting the retrospective Cohort Study. That study, involving more than 300 surgeons and 3,000 patients, was the most comprehensive study of the use of pedicle fixation ever conducted. While its methodology may not have been perfect, its conclusion that pedicle screw systems are efficacious in the reconstruction of certain types of diseased and damaged spines was an important contribution to the literature.

Following the broadcast of the *20/20* television show that severely criticized (in our view, unfairly) pedicle screws and the resulting explosion of litigation, Judge Louis Bechtle in Philadelphia was designated as the multi-district judge who would coordinate all pedicle screw cases filed in the federal courts. Because the results of the FDA-sponsored Cohort Study so undermined the plaintiffs' basic contention that pedicle screws are inherently dangerous and unsafe, the Plaintiffs' Legal Committee (PLC) attempted to attack that study and its participants in an effort to discredit its results.

The AANS's first involvement in that litigation was to take the lead in blocking Judge Bechtle's imminent disclosure of the names of the participant surgeons and perhaps their patients. That data had been submitted by participating surgeons under an assurance of confidentiality by the FDA. It was not until the intervention of the medical associations, led by the AANS, that Judge Bechtle appreciated the sensitivity of the confidentiality of those medical records.

In due course, the AANS and many other additional parties were drawn into the litigation as defendants in complaints alleging a broad-ranging conspiracy to promote the products of the manufacturers. Our attorney was selected as the liaison counsel for all of the medical associations in that litigation and has taken the lead role in coordinating the efforts of not only those associations but

also a wider range of defendants with similar interests. That has resulted in a close coordination of defense efforts and the elimination of duplication of efforts by the law firms representing the associations.

Another important step we took to ensure that the resources of the AANS were appropriately marshaled behind the defense was to appoint a blue-ribbon task force of prominent neurosurgeons, chaired by David Cahill, MD, to prepare an analysis of the scientific and medical issues involved. That report has been completed, and, I understand, has been extremely useful to our attorneys in responding to the issues raised in the litigation.

Motion to Dismiss

Our attorneys, working in conjunction with counsel for the other associations, filed a comprehensive motion to dismiss the "Omni" complaints last year. In August, Judge Bechtle granted that motion to dismiss, but gave the plaintiffs leave to refile with amended complaints. Many (although not all) chose to do so, which led to renewed motions to dismiss filed by counsel for the associations. Those motions were based on deficiencies of the amended complaints in the allegations of the alleged conspiracy and in asserting some causation between the associations' activities and the injuries to each particular plaintiff. In addition, First Amendment protections were asserted with respect to anything taught or discussed at association-sponsored meetings.

The renewed motion to dismiss was argued before Judge Bechtle on February 7, 1997, and he is expected to rule soon. Counsel for the AANS is optimistic that we will be dismissed from the litigation at some stage prior to remand of the cases for trial, whether through this motion or a subsequent one.

The Future for Pedicle Screws

You may have heard that one of the manufacturers, AcroMed, entered into a settlement agreement with the PLC. That settlement is being implemented by the creation of a class of patients who received AcroMed devices. The AANS and the other medical associations were not parties to that agreement and had no voice in its

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Proposed Changes in Practice Expense Reimbursement Threaten Neurosurgery

By Katie O. Orrico, JD
Director AANS/CNS Washington Office

The Health Care Financing Administration (HCFA) is in the process of developing new relative value units for the practice expense component of the resource based relative value scale (RBRVS). The RBRVS is used by Medicare and many other private insurers to determine reimbursement levels. These changes threaten the long-term viability of many specialty practices. Although a number of specialties would face serious reductions in income as a result of the proposed changes, neurosurgery would be especially hard hit. In fact, *neurosurgeons face a 25–35%*

reduction in total income if HCFA implements its current proposal on January 1, 1998, as now planned.

This situation has galvanized much of organized medicine, prodding many groups to initiate counter measures aimed at preventing the implementation of this plan. Neurosurgery is at the forefront of this effort and has taken a very aggressive stance on the issue. The goal of this article is to provide you with background on the practice expense controversy and to detail what your professional organizations are doing about it.

Overview of HCFA Practice Expense Project and Implications for Neurosurgery

Up until 1992, Medicare reimbursed physicians under the usual customary and reasonable (UCR) charge system. There were many critics of this system and in the mid-1980's, Congress decided to explore new ways to reimburse physicians.

Legislative and Regulatory History of the RBRVS

Based on Congressional mandates contained in the Consolidated Omnibus Reconciliation Act of 1985, the Omnibus Reconciliation Act of 1986, and the Omnibus Reconciliation Act of 1987, HCFA began its efforts to develop a physician fee schedule based on a relative value scale. The research was performed by a research team at Harvard University School of Public Health, led by William Hsaio, PhD. The two main objectives were to construct a system that was more equitable (i.e., would increase primary care and general internal medicine's fees with a corresponding decrease in the fees for surgeons and medical proceduralists) and would help constrain Medicare physician expenditures. This was strongly supported by the American Society of Internal Medicine, with additional support by the other primary care societies.

In 1989, Hsaio completed the initial research, "A National Study of Resource Based Relative Value Scale for Physician Services." The Physician Payment Review Commission (PPRC), primary care organizations, and the AMA supported the concept (the American College of Surgeons opposed this effort). As a result, Congress enacted new physician payment rules as part of the Omnibus Reconciliation Act of 1989. Through a series of rulemaking and refinement panels, HCFA transformed

KEY PLAYERS IN THE RESOURCE-BASED PRACTICE EXPENSES DEBATE

The key players in the resource-based practice expenses debate include all three branches of the federal government.

The Congress. The Congress initiated this project (when Democrats controlled both houses of Congress during President Clinton's first term). There are three committees with primary jurisdiction over Medicare payment issues. The Finance Committee in the Senate and the Ways and Means and Commerce Committees in the House. Each committee has a health subcommittee. The Physician Payment Review Commission (PPRC) is a nonpartisan advisory body to the Congress on matters related to health care. The PPRC initiated the research on resource-based practice expenses and continues to be an influential player in this policy debate.

The Executive. The agency with jurisdiction over this issue is the Department of Health and Human Services (HHS). The Secretary of HHS has delegated the authority over matters such as these to the Health Care Financing Administration (HCFA), the agency that administers the Medicare program. HCFA, in turn, has contracted with several researchers to collect the practice expense data. The primary contractor for this project is Abt Associates, a health research firm in Cambridge, Massachusetts. Once HCFA develops the new practice expense relative values it must publish these in the *Federal Register* so the public has an opportunity for review and comment. Prior to publication, the proposal must first be cleared by the Secretary of HHS and by the president, through the Office of Management and Budget (OMB).

The Judiciary. We may use the courts to challenge the accuracy and validity of the new relative values or to challenge the process by which they are implemented. In general, the Medicare statute prohibits the courts from reviewing the substance of regulations promulgated by HCFA, but there may be a procedural challenge under the Administrative Practice Act.

Interest Organizations. Important non-governmental players include organized medicine—both physician and non-physician providers—and various health researchers. Additional groups that may become players include the academic health centers, nurses and the elderly.

the Hsiao research into relative values for most CPT codes. The final fee schedule became effective on January 1, 1992.

Components of the RBRVS

The RBRVS has three components—work, practice expense, and malpractice expense. Each component is multiplied by a geographic adjustment factor or GPCI (geographic practice cost index). The product of each component is then added to one another to arrive at the total relative value for a given service. The total relative value units (RVUs) are then multiplied by a dollar conver-

sion factor to arrive at the fee for the service. Currently there are three different conversion factors: one for surgical services, one for primary care services, and one for all other services.

Thus, the payment formula is calculated as follows:

$$\text{PAYMENT} = \text{CF} \times [\text{RVU}_{\text{work}} \times \text{GPCI}_{\text{work}}] + (\text{RVU}_{\text{practice}} \times \text{GPCI}_{\text{practice}}) + (\text{RVU}_{\text{malpractice}} \times \text{GPCI}_{\text{malpractice}})]$$

Practice Expense Component

The work values of the RBRVS are generally considered to be valid estimates of the physician resources required to

perform a service. Currently, only the work component is “resource-based.” The practice and malpractice expense components, on the other hand, are calculated from historical Medicare allowed charges and from data on practice expense and malpractice expense revenue shares for different specialties. Many argue that the current practice expense methodology produces a bias in payments in favor of surgical and invasive procedures and against evaluation and management services. Since the inception of the RBRVS, numerous groups (including the PPRC, AMA, primary care and general internal medicine organizations) have advocated that the practice expense component should be resource-based.

Since the inception of the RBRVS, several pilot projects to develop resource-based practice expenses have been completed by researchers under the sponsorship of HCFA, the PPRC, and other private organizations. In 1992, the PPRC issued a report outlining their proposed methodology for calculating resource-based practice expenses. This methodology divided practice expenses into *direct* and *indirect* costs for each service. Direct expenses are those costs attributed to a specific CPT code, e.g., clinical labor and equipment. Indirect expenses are those costs common to all procedures, e.g., rent, telephone, some labor. This approach assumes that those specialties that are hospital based, i.e., surgery, have fewer practice expenses than those that are office based, i.e., primary care. In its 1993 Annual Report to Congress, the PPRC formally recommended that Congress revise the practice expense component to be resource-based.

In 1993, Congress first responded with an interim approach in an effort to reduce some of the practice expense RVUs for procedures that were deemed to have excessive reimbursement for their practice costs. The Omnibus Reconciliation Act of 1993 included a provision that reduced the practice expense component to no greater than 128% of the work RVUs (the initial proposal was 110%). Services performed in the office more than 75% of the time were exempted from this reduction. This had

(continued on page 9)

Figure 1

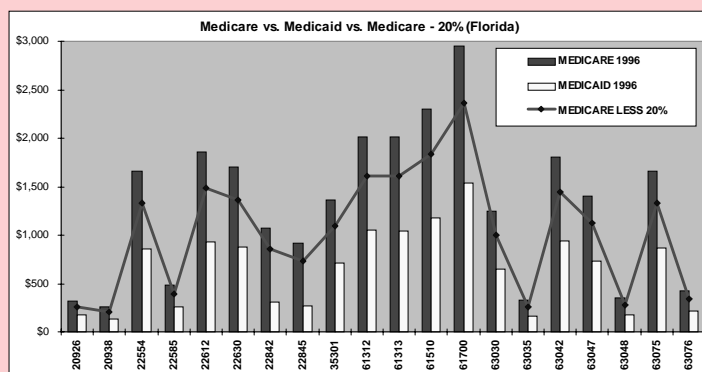


Figure 2

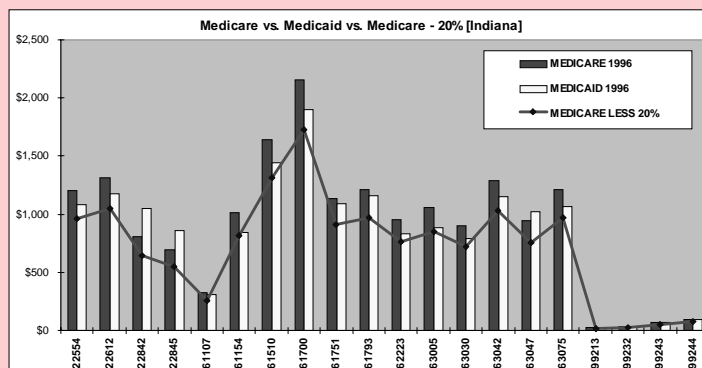
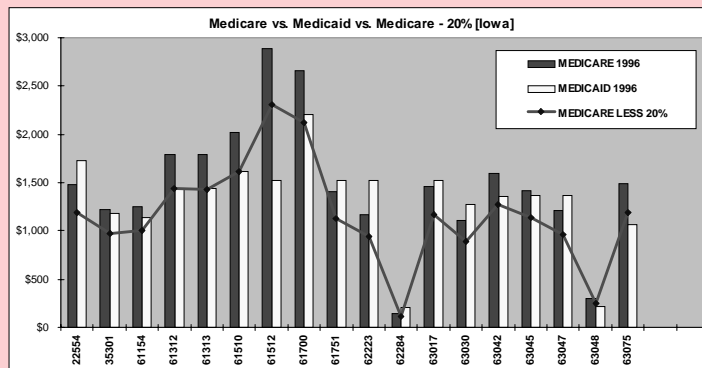


Figure 3



(continued from page 4)

the greatest impact on the surgical procedures (for neurosurgery, the spine procedures took the biggest hit), many of which had practice expense relative values in excess of 140% of the work RVUs.

In October 1994, Congress passed the Social Security Act Amendments. This law directed the Secretary of Health and Human Services to develop a resource-based system for determining practice expense RVUs. In developing the methodology, the Secretary was directed to consider the "staff, equipment, and supplies used in the provision of various medical and surgical services in various settings." If Congress does not intervene, the new system will be implemented on January 1, 1998.

HCFA Research

In November 1994, HCFA issued a request for proposals to develop data on practice expenses and case mix. In the spring of 1995, HCFA awarded the practice expense data collection contract to Abt Associates, Inc. The Abt approach was similar to that originally developed by the PPRC, wherein practice expenses are divided into two categories: direct and indirect. These two "pots" are then added together to produce the total practice expense RVUs. The agency also funded two other projects to produce alternative methods of allocating indirect costs using existing data and a formula-based approach. HCFA awarded these contracts to Daniel Dunn and Eric Latimer of Harvard University and Gregory Pope and Russell Burge of Health Economics Research, Inc.

After a series of meetings and preliminary work, Abt began the actual data

collection process in February 1996 (nearly one year after being awarded the contract). The first part of the data collection process involved efforts to measure the non-physician time and labor that comprise the direct expenses of procedures. Abt. convened Clinical Practice Expert Panels (CPEPs), which collected the direct cost data that could be attributed to specific services and procedures. Follow-up CPEP II meetings were held in June 1996 and were designed to extrapolate to the entire group of CPT procedures from the initial samples in CPEP I.

The second part of the data collection process involved a national mail survey to physicians. In April 1996, Abt sent Phase I of the survey to 1,700 physician practices. The purpose of the survey was to collect data on indirect costs and service mix. In September 1996, because of a poor response rate, HCFA canceled the mail survey. As a substitute, the agency decided to use the research of Dunn and/or Pope to develop the indirect expense component. In January 1997, HCFA released its preliminary impact analysis.

Impact on Neurosurgery

HCFA estimates that overall practice expense changes will cut neurosurgery's total Medicare (and non-Medicare if private insurance carriers adopt the fee schedule as is) income by 25% to 35%, depending on the methodology selected. (*See Table 1 for some examples of common neurosurgical procedures*) These figures are based on 1995 numbers and therefore do not reflect

the recent adjustments made to the fee schedule during the 5-year review of work RBRVS. The impact will be slightly larger, when HCFA includes those downward adjustments. They also do not reflect the proposal to adopt a single conversion factor for all providers, which would produce an additional 10% reduction in all reimbursements for surgery.

Neurosurgeons are not the only specialty adversely affected by HCFA's proposal. The hardest hit is Cardiac Surgery, which faces total reductions from 32% to 44%. Thoracic Surgery, Cardiology, Vascular Surgery, and Gastroenterology will face reductions ranging from 17% to 40%. General Surgery, Orthopedic Surgery, and Plastic Surgery can expect reductions of 8% to 19%. The principal reason for the reductions is that HCFA's methodology assumes that when the surgeon is in the hospital doing surgery, he or she is not incurring any overhead expenses—an obviously faulty assumption.

Given that they have been the most vocal proponents of this new system, it is ironic that under the current proposal general Internal Medicine will at best receive only a 4% increase. Family Practice fares better with increases ranging from 9% to 19%. The big winners, however, are the non-physician providers (as was the case in the 5-year review of work RVUs). Chiropractors will receive increases of 27% to 54%, Optometrists 35% to 40%, and Podiatrists 23% to 41%. These specialties have significant increases because they perform all of their services in an office setting.

Table 1

CPT CODE	DESCRIPTION	TOTAL RVU IMPACT	1997 MEDICARE FEE	1998 MEDICARE FEE
35301	Carotid endarterectomy	-31%	\$1,361	\$ 945
61107	Implant ventricular catheter	-21%	462	365
61510	Remove brain tumor	-39%	2,266	1,388
61700	Carotid aneurysm surgery	-37%	2,957	1,876
62223	Establish brain shunt	-34%	1,320	874
63030	Lumbar discectomy	-33%	1,246	832
63047	Lumbar spinal decompress	-38%	1,497	927
63075	Ant. Cervical discectomy	-30%	1,661	1,162

* Note: These values represent base Medicare Fees without application of geographic adjustments, using the current surgical conversion factor.

Figure 4

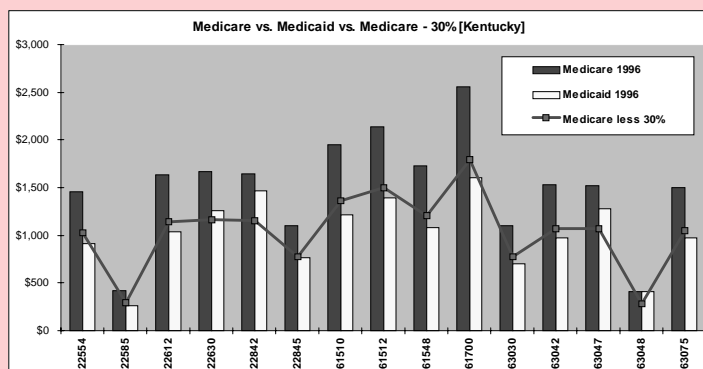
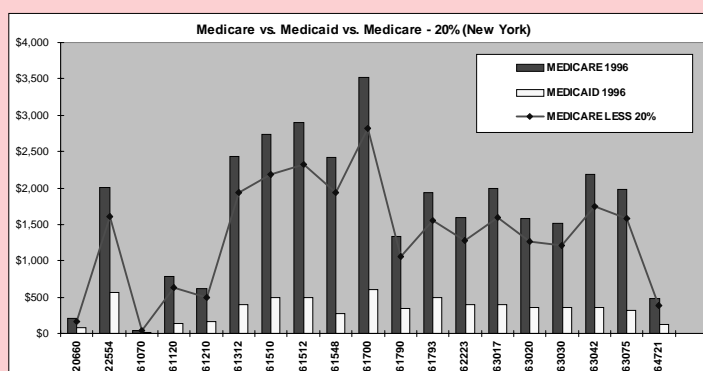


Figure 5



Access to Neurosurgical Care

The AANS and CNS are very concerned these cuts will have a significant impact on access to quality neurosurgical care. Because of low Medicaid reimbursement, many physicians are reluctant to accept Medicaid recipients as patients. The same may be true for Medicare beneficiaries if reimbursement levels reach a point where physicians are no longer able to maintain their practice because they cannot meet their marginal costs for the services provided. This problem is likely to be even more acute in the future given the fact that cost shifting is becoming ever more difficult with a shrinking base of indemnity patients.

A survey of neurosurgical practices in twenty states compared the relationship between Medicare and Medicaid fees given a 20% to 30% decrease in Medicare rates. In thirteen of these states, Medicare reimbursement for common neurosurgical procedures would reach or dip below current Medicaid rates. (See *Figures 1-10* for examples from 10 states.) It is a mixed bag and highly dependent on the Medicaid payment levels. New York, for example, pays virtually nothing

for neurosurgical services provided to Medicaid patients. It is not likely that Medicare rates will ever approach this low level. Nevertheless, the comparison illustrates the potential access problems associated with significant reductions in Medicare reimbursement.

AANS/CNS Effort to Ensure Accuracy

Organized surgery, including neurosurgery, has been an active participant in the debate over resource-based practice expenses. Again, the underlying theory of resource-based practice expenses is that hospital-based specialties (primarily surgeons) have fewer practice expenses because they are not incurring overhead expenses while working out of the office. Since the beginning of this debate, the AANS and CNS have challenged this fundamental premise. We have attempted to interface at every level to ensure that the final outcome represents a reliable, fair, and accurate product. The following briefly outlines our interactions with the various players in the practice expenses debate.

Practice Expense Coalition

The Practice Expense Coalition (PEC) first met in November of 1992 as a result of a PPRC conference on practice expenses (this first meeting arose out of the discussions between AANS/CNS member Dr. Pevehouse and Dr. Rufus Stanley of the American Academy of Orthopedic Surgeons). Initially, the coalition was led by the American College of Surgeons, but over time, the College relinquished its lead role as more non-surgical organizations became interested in participating in a joint effort. Over the years, the coalition has consisted of a loose confederation of over 25 specialty organizations (including all major surgical organizations and other groups such as anesthesiology, pathology, radiology, psychiatry, gastroenterology, cardiology, and dermatology). Its principal purpose has been to ensure that the new system provides a fair and accurate measure of physician practice expenses. We have used the PEC as a vehicle for keeping the federal policy makers focused on this premise.

The PEC has been instrumental in minimizing the negative effects of the practice expense reductions and will continue its efforts until all parties are satisfied that the final HCFA product is methodologically sound and accurate.

Over the past several years, the PEC has accomplished a number of things:

- In 1993, the PEC opposed President Clinton's budget proposal to limit practice expense RVUs to 110% of work RVUs. The PEC successfully lobbied Congress to raise the 110% figure to 128%. The PEC also implemented a strategy to defeat legislation mandating resource-based practice expenses, or at the least ensure that Congress did not spell out in detail the specific methodology that HCFA must use in developing new practice expense RVUs. Language requiring resource-based practice expenses was stripped from the final budget bill.
- In 1994, the PEC had multiple meetings with Congressional staff to refine the language that mandated the adoption of resource-based practice expenses. These meetings resulted in

changes to the proposed language and pushed the implementation date from January 1997 to January 1998.

- In 1996, at the PEC's behest, Reps. Whitfield (R-KY) and Hall (D-TX) introduced a bill extending the implementation date to January 1999. Unfortunately, the bill died when Congress adjourned last fall.

Since 1995, the PEC has also interfaced on an ongoing basis with HCFA and other Clinton Administration officials. These efforts have helped assure that this entire process is conducted in

the "sunshine." The AANS and CNS will continue to be very active participants in the PEC as we fight the implementation of these arbitrary reductions.

Physician Payment Review Commission

The AANS and CNS have followed the activities of the PPRC very closely since the Commission first began significant work on practice expenses in 1992. Our principal means for communicating our ongoing concerns about this project has been in our testimony before the Commission.

- In 1993, we objected to HCFA's continued use of a site-of-service payment differential, arguing that a neurosurgeon's practice expenses may actually increase when he/she performs services in the hospital setting. We reiterated our strong opposition to the reduction of practice expense RVUs to 128% of the work RVU. Finally, we criticized the approach the PPRC took in developing preliminary resource-based practice expense for a small sample of procedures and recommended that the Commission delay making any final recommendations to Congress pending further study.

- In 1994, we reiterated our position that any changes to the practice expense component of the RBRVS should fairly and accurately reflect the costs associated with the practicing neurosurgeon's delivery of quality health care.
- In 1996, we recommended that the entire practice expense project be revised so that the actual costs associated with the delivery of neurosurgical services will be fairly and accurately reflected. We urged the Commission to recommend a one-year delay and a three-year transition period for new practice expense RVUs. We also provided the Commission with data showing that the proposed cuts will reduce neurosurgeons' Medicare fees below current Medicaid rates and noted the potential access to care problems associated with such reductions.

Congress

Much of the AANS and CNS interface with Congress has been in conjunction with our participation in the Practice Expense Coalition and with the American College of Surgeons. We have had a number of contacts with Congress, independent of the PEC and ACS.

- In 1993, we activated our Key Person Network requesting that neurosurgeons contact members of Congress urging them to reject the 110% proposal. Key Persons also wrote members of Congress expressing our

Figure 6

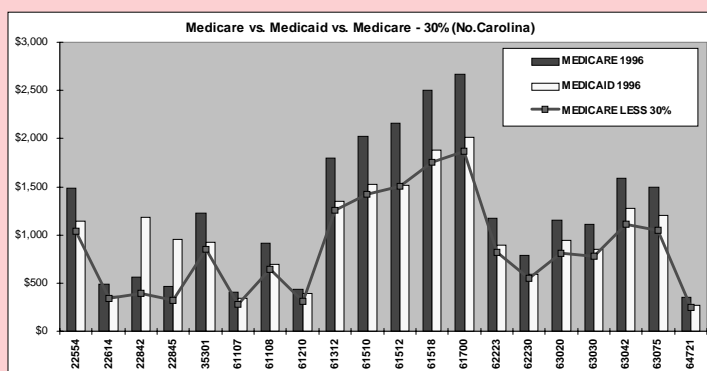


Figure 7

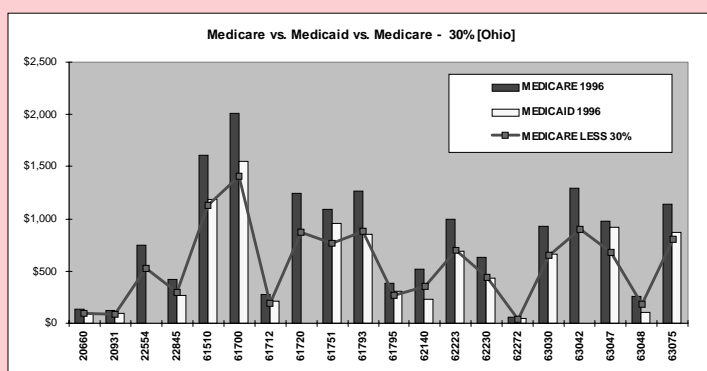


Figure 8

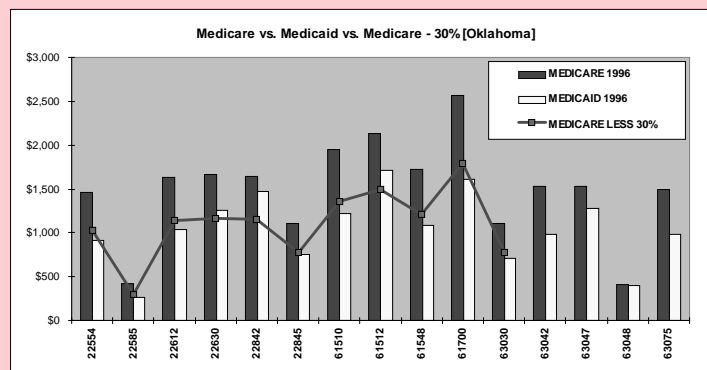


Figure 9

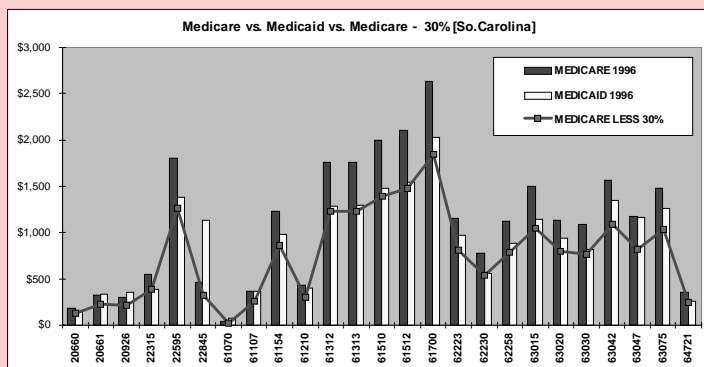
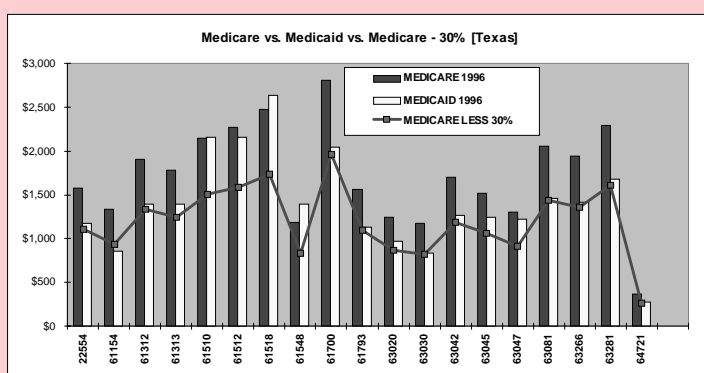


Figure 10



concerns about legislation mandating the development of resource-based practice expense RVUs.

- In 1996, several neurosurgeons met with Rep. Thomas (R-CA), Chairman of the House Ways and Means Health Subcommittee reiterating our view that, as currently configured, the concept of resource-based practice expense is fundamentally flawed. The AANS and CNS issued a "Changing Times" fax broadcast to all neurosurgeons urging them to contact their member of Congress in support of the Whitfield/Hall bill. Finally, at their request, AANS/CNS Washington staff met with House Commerce Committee staff and detailed the status of the HCFA project and associated problems.

Health Care Financing Administration and ABT Associates

The AANS and CNS have interfaced with HCFA on numerous occasions throughout the development of new practice expense RVUs. We have done so

through personal meetings, correspondence, comments to proposed rule-making, and through our participation in the Practice Expense Coalition and with the American College of Surgeons.

- In 1994, we met with HCFA staff regarding the agency's plans for the development of resource-based practice expenses and to determine the advisability of the AANS/CNS undertaking our own practice expenses study. We were advised that it was premature to conduct our own study at that time. Nevertheless, based on a methodology developed by Drs. Pelofsky and Roski (with independent validation by a Harvard accounting professor), we conducted an internal survey of a cross-section of neurosurgical practices to ascertain the impact of practice expense. We then sent the results of this study to HCFA for evaluation.
- In 1995, we submitted comments to Abt regarding the formation of the Clinical Practice Expert Panels (CPEPs). We suggested that neurosurgeons should be represented on several CPEPs other than neurosurgery's own CPEP. This

resulted in the AANS/CNS getting representation on the Orthopedic CPEP. We wrote to Abt suggesting changes to the reference services selected for review. Abt made some of these changes. We nominated Drs. Florin and Lippe to the CPEP Technical Expert Group (TEG). Out of many nominations from many specialty organizations, Dr. Florin was selected and helped develop the process by which the CPEPs would operate. Finally, we nominated several neurosurgeons to participate on the Neurosurgery CPEP. Drs. Pelofsky, Travis, Roski, Cooper, Florin, and Kusske were selected to participate. Two CPEP sessions were conducted—February and June 1996.

- In 1997, we submitted comments to HCFA in response to the preliminary practice expense data. We suggested corrections to some of the data collected by the CPEPs and registered our ongoing complaints about the flawed nature of the project.

American Medical Association

The AANS and CNS have interfaced with the AMA at multiple levels. At numerous meetings held in Washington, DC, since the inception of the project, staff have continued to raise our concerns. In addition, Dr. Florin, through his participation on the AMA Relative Value Update Committee (RUC), has continued to voice our concerns.

Most recently we actively sought changes to official AMA policy through the House of Delegates process. In June 1996 the AANS and CNS successfully led an effort to get the AMA House of Delegates to adopt a policy in support of a one-year delay in implementation and legal action, if necessary. In December 1996 we participated in a successful effort to modify AMA policy, which now requires the AMA to strongly advocate that resource-based practice expense RVUs be based on actual physician practice expense data. In addition, the AMA should only support new RVUs that are methodologically sound and will not have a negative effect on the ability of

physicians to provide high-quality medical services.

American College of Surgeons

As stated above, since the inception of this project, the AANS and CNS have worked closely on a number of levels with the College. The College has also been very active over the past years on all fronts—Congress, PPRC, HCFA, etc. Like the AANS and CNS, throughout the process the College has continued to strongly object to the direction HCFA is taking on this project. We are currently involved with a College study of surgeons' practice expenses. This study is being conducted by Lewin-VHI, Inc., a health research firm, and will hopefully produce a favorable alternative to HCFA's proposal.

Gathering Data

The AANS and CNS recently commissioned The Gary Siegel Organization to collect practice expense data from several neurosurgical practices. The purpose of this project is to provide independently collected data to validate the data generated by the Abt and Lewin projects.

If favorable, we will likely use the results to influence changes to the HCFA data when the proposed rule is issued in May. We may also need to use these data in conjunction with our efforts to show Congress (and possibly the courts) that the HCFA project contains inaccurate data that does not reflect the actual practice expenses of neurosurgeons.

Future Activities to Prevent Implementation

The AANS and CNS will be aggressive in their efforts to prevent the implemen-

tation of the current practice expense project and we are prepared to challenge this proposal at every level of government. It is clear that the effort to redesign the system has failed and most organizations agree that regardless of whether you are a "winner" or "loser" there are serious questions as to the validity of the data, and the current January 1, 1998, implementation date needs to change.

The implications of the HCFA practice expense estimates are profound and reach far beyond the immediate impact on physicians' incomes. Congress therefore needs to direct HCFA to move down another path. No amount of refinement, transition, or delay will solve the problems with this study.

If the AANS and CNS are to be successful, specialty medicine must speak with one voice and strike one deal. Congress will not likely listen to surgery alone, so it is important to build as broad a coalition as possible. Primary care and general internal medicine (and possibly the non-physician providers such as the chiropractors) will be lobbying against us and in favor of the current proposal. They are a formidable force and in the past have been successful at painting this as a surgery only issue. The leadership recognizes this and has agreed to work closely with non-surgical organizations through our participation in the Practice Expense Coalition.

The AANS and CNS have committed significant resources to the PEC effort. At press time our strategy has not been finalized, but we will be considering the following activities:

- Conduct a technical evaluation of the HCFA proposal

- Seek relief from the Office of Management and Budget
- Seek legislative relief from Congress
- Develop an alternative legislative/regulatory proposal for calculating practice expenses
- Review avenues for potential litigation
- Develop and implement a comprehensive grassroots action plan
- Develop and implement a comprehensive AANS/CNS membership communications plan

By the time this issue of the *Bulletin* is published, we will be well on our way to implementing our campaign. The issue will likely be addressed by the Congress in conjunction with the debate over the budget and Medicare reform. If Congress stays on schedule, we may have some resolution by October 1, 1997. (See *Table 2 for HCFA's Implementation Schedule*)

The AANS and CNS leadership will continue to keep our members informed about this issue as we move forward to defeat this unacceptable proposal. We won't be able to do it alone, however. We will need *each and every neurosurgeon to be involved in this campaign!*

For more information, please contact Katie Orrico in the Washington Office at (202) 628-2072.

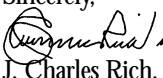
President's Message

continued from page 2

terms. We are, however, indirect beneficiaries in that all litigation against the associations based on AcroMed devices will be dismissed with prejudice.

We believe that it is both unfortunate and inappropriate for medical associations, such as the AANS, to be forced to defend this type of litigation. We will continue to defend not only the integrity of the AANS, but also the efficacy of pedicle screw fixation systems in appropriate cases and the rights of our members to use those systems where, in their judgment, it is in the best interests of their respective patients.

Sincerely,


J. Charles Rich, MD
President

HCFA's Timetable for Implementation

Table 2

April 1, 1997	Begin Internal Clearance Process
May 1, 1997	Publish Proposed Rule in <i>Federal Register</i>
July 1, 1997	60-Day Public Comment Period Ends
August 1997	Conduct Data Refinement Panels
September 1997	Draft Final Rule
October 1997	Begin Internal Clearance Process
November 1, 1997	Publish Final Rule in the <i>Federal Register</i>
January 1, 1998	New Practice Expense RVUs Go Into Effect

MANAGED CARE *update*

Managed Care Process Now Well Entrenched

By John A. Kusske, MD

Managed care has been defined by Edward F.X. Hughes, MD, MPH, professor of Health Services Management at Northwestern University, as "the process of the application of standard business practices to the delivery of health care in the traditions of the American free enterprise system." As Hughes points out, managed care is a process and not a collection of things. Rather, it is change itself. This change is inexorable.

Managed care is a uniquely American invention, and like many other American inventions, Hughes believes it will ultimately grow to dominate the world because there really is no alternative to managed care to rationalize the cost and quality of care. In his view the *sine qua non*, the process of managed care is the presence of management in the health field as it has never before existed.

Management, according to Hughes, is empowered to make decisions regarding the appropriate mix of production factors to achieve the desired health outcomes of a defined population for which the management is now accountable. The essence of managed care is management's choosing from a mix of possible inputs to achieve the highest quality of care for the defined population at the least possible cost.

Era of Corporate Medicine Now Dawning

U.S. health care ended the twentieth century as it began, still primarily a cottage industry, according to a recent Governance Committee publication. Physician practices and hospitals remain largely unorganized, principally charitable or private endeavors. However, the new era of corporate medicine is dawning and the enormous opportunity in health care is only now beginning to catch Wall Street's eye.

As the Governance Committee report reveals, the migration of HMOs from local, nonprofit corporations to national scale and public ownership is already nearly complete—the payer community

has been overwhelmingly transformed in less than a decade. Investor capital is now creating the first truly national physician enterprises, fashioning medical practice on a scale wholly unknown in the past.

The first reports suggest, according to Governance Committee data, that Wall Street driven enterprises are setting new standards of competition in every market sector in which they compete and are outperforming industry norms by every conceivable measure. Competing to the new standard must be within the reach of local, nonprofit systems of physicians and hospitals if they are to survive. The success of investor-owned enterprises is principally a story of discipline and resolve, not scale or Wall Street capital.

HMO Enrollment Soars

The most recent numbers from InterStudy, an HMO research group based in Minneapolis, reveal that HMO enrollment soared 15 percent, to 58.4

million during 1995. Neurosurgeons saw big jumps in revenues from HMOs over the last two years. Across all specialties, according to 1996 data from *Medical Economics*, doctors have gotten the message. The percentage of Midwestern physicians participating in HMOs and PPOs now exceeds that of their western colleagues and eastern and southern doctors aren't far behind.

Medical Economics reports that 83 percent of neurosurgeons surveyed participate in HMOs and 81 percent in PPOs. Interestingly, their data shows that neurosurgeons' median gross income from HMOs reached \$115,860 in 1995. The surveyed neurosurgeons also reported that 30 percent of their active patients were HMO enrollees and 10 percent were PPO members. It was also clear from the study that practice size correlated with managed care participation, with the percentage of HMO/PPO

(continued on page 16)

HMOs' Insidious Intrusion

The following letter to the editor appeared in the February 28, 1997, issue of the Wall Street Journal. It was written by Harvey F. Wachsman, MD, neurosurgeon and attorney, in response to a front-page feature story in that publication which described how HMOs are asking nurses, in a cost-cutting move, to assume some duties previously performed by physicians. His point is that HMOs are finding new ways to cut costs at the patient's expense.

"Nurses taking over the duties of doctors (*Nurses to Take Doctor Duties, Oxford Says, Feb. 7*) is the latest example of a health care provider being squeezed by a profit-minded HMO into a position where it must reduce the quality of patient care in order to save money. That this practice is taking place at Columbia Presbyterian Medical Center is particularly disturbing, because it shows that not even one of the nation's most prestigious institutions is immune from the HMOs' economic pressure.

"Advocates say that nurses will spend more time with patients than doctors do. But it was the HMOs that interfered with physicians' practices and forced them to spend less time with patients in the first place. They say that patients will be able to choose between seeing a doctor or a nurse. But with Columbia Presbyterian leading the way, it can't be long before this becomes such a common practice that patients have no real choice at all.

"First, HMOs restricted doctors' ability to practice as they saw fit, limiting their ability to order tests, admit patients to the hospital, and refer patients to specialists. Apparently, these companies, whose executives are reaping lofty salaries in the face of huge profits, are not content with merely controlling the way physicians practice medicine. They are now trying to take patient care out of their hands completely and turn it over to nurses, who lack the training and expertise doctors possess.

"As a neurosurgeon and attorney, I have already seen numerous cases of people whose lives have been destroyed because of ill-advised HMO policies. Everyone who is concerned about the future of health care in America—doctors, lawyers, patients, potential patients—should draw the line in the sand and let our public officials know that we need new laws to protect the public and our healthcare system against the insidious intrusion of HMOs."

AANS and CNS Launch a New Joint Communications Program Focusing on the Nature and Benefits of Neurosurgery

By Stan Pelofsky, MD

Ad Hoc Committee on Communications

Neurosurgery faces significant challenges to the professional status and livelihood of its members and the specialty. Buffeted as we are by the growing shifts in reimbursement patterns and encroachments by other specialties into our traditional scope of practice, the Joint Council of State Neurological Societies (JCSNS) planted the seed last year for a national effort by neurosurgeons to come forward and be heard. It is vital that we speak up and remind consumers, referring physicians, third-party payers, and even the media about the value and contributions of neurosurgical care to the well being of patients.

In this context, The American Association of Neurological Surgeons (AANS), Congress of Neurological Surgeons (CNS), and the JCSNS created an Ad Hoc Committee on Communications to consider and recommend a communications program that could address the challenges of today's healthcare marketplace. This Committee consisted of myself, Edward R. Laws, Jr., MD, Bruce Kaufman, MD, Mitchel Berger, MD, Susan Nowicki, APR, AANS Director of Communications, and David Tabolt, an outside communications consultant based in Chicago.

Program Elements

We determined that such a program would be most effective if it was designed to build awareness of the specialty of neurosurgery incrementally, over time, rather than all at once on a grand scale. This is in keeping with guiding philosophy of the AANS Long-Range Plan that activities should be *specific, measurable, attainable, relevant, and time-framed* (SMART). The CNS concurs with these defined activities as well.

The Committee decided that each phase of the program should place emphasis on a common condition where neurosurgery should be the provider of choice, but currently does not enjoy an exclusive position. We also felt the

program should educate as well as inform. Finally, and most importantly, we felt strong member involvement was needed in order to ensure its success.

In summary, the overall goals of the program are to:

- Increase awareness of the scope and quality of neurosurgery.
- Engage members in a program of public and professional education about the specialty.
- Promote the timely, appropriate application of neurosurgical solutions to health needs.
- Help neurosurgery enhance and expand its role as a valued provider of health care.

The topic we chose for the first phase of our Getting SMART program is *lumbar spinal stenosis* (LSS). Once our communications process has proven its effectiveness, the Committee, with input from our Sections, will develop other topics to be given similar support.

Guiding Position

In broad terms, the position guiding development of the LSS communications initiative is that tens of thousands of older Americans are suffering severe, unnecessary pain and are being forced to give up active lives prematurely because an increasingly common affliction—lumbar spinal stenosis—is not diagnosed and treated soon enough with successful neurosurgery.

Neurosurgery can restore most of these patients to vital, active lives in a matter of weeks or months, but, unfortunately, managed care and the lack of information on the part of patients and the general public are keeping a growing number of patients from being referred to neurosurgeons for spinal problems. Primary doctors must be made aware of this disease and when it is appropriate to refer patients. Further, patients should ask to

see a neurosurgeon if they have symptoms of lumbar stenosis.

Recruiting Volunteers to Lead the Way

To be effective, the program must be linked to the hundreds of practices that make up our specialty. This will not be easy. Neurosurgeons are busy. Some of you may feel ill-equipped or uncomfortable about promoting neurosurgery and its services. But we are asking members of the AANS and CNS to “raise your hands” to volunteer as local-market Ambassadors for the program.

Each volunteer will be asked to identify (with the help of prepared media listings) the local media outlets to whom information kits should be sent in his/her name.

Any neurosurgeon may voluntarily become an Ambassador for this special initiative. Each Ambassador will receive a kit containing program materials and guides to using them. Materials will include the following:

- A backgrounder and Q&A on lumbar stenosis and treatment options.
- Press releases and guides to working with local print and electronic media.
- Patient and referring-physician brochures that can be customized to their practices.
- Educational slide presentation and teaching syllabus on lumbar stenosis.
- Sample letters to media, referring practitioners, and hospital CME directors.

The aim is not to make our volunteers public relations experts, rather it is to equip them with the tools necessary to tell our story in a comprehensive and coordinated way.

Media Outreach

In addition to the Ambassadors' efforts, the National Office will coordinate a

program to alert national and special-interest publications about the issue of LSS and neurosurgery. Target audiences will include national news publications, as well as other general, senior citizen, women's, health, and healthy living magazines and newsletters, and national and syndicated broadcasting and editorial outlets and health care trade publications.

The program will be supplemented by a special edition of *Neurosurgical Focus* in August 1997.

Incorporate Messages That Advance Neurosurgery

All materials and key media messages focus on both the specific patient benefits of the services offered and why neurosurgery is the "provider of choice." Ambassadors are encouraged to represent the specialty as a whole, and to advocate neurosurgery's capabilities.

Ambassadors will be asked to forward news clips and their success stories to the National Office, who will prepare regular reports to notify members of the program's progress and to provide Ambassadors with tips and ideas for making the program more effective.

Referral Program

A separate package of materials is being developed for referring physicians. These materials can be used as leave-behinds at presentations and in mailings to primary care providers and other referral sources. The package will include:

1. Referral guidelines
2. Background on LSS
3. Frequently asked questions
4. Copies of patient and professional brochures
5. Sample letters to referral sources

Program Ambassadors will be encouraged to disseminate the LSS background information as broadly as possible. Copies of the referral materials also will be available for purchase by members who choose not to participate in the broader Ambassador program.

Gatekeeper Advocacy

In addition to its outreach to referral sources, it is the intent of this program to develop a case for neurosurgery as the "practitioner of choice" for presentation

to HMO and other managed care decision makers. We believe that making these gatekeepers aware that neurosurgeons provide spinal surgery services and are the leading providers of LSS services will be beneficial.

Joining the Program

Members who wish to take full advantage of this public education and professional outreach communications program as Ambassadors will receive 200 copies of the patient LSS brochure, 100 copies of the referring practitioner brochure, slide presentation, personalized press kits mailed to up to five local media outlets, and training.

If you volunteer to be an Ambassador, you will be asked to commit to making at least two public/professional presentations, mailing referral source brochures to at least 50 persons, and to cooperate with media interviews. You will also be asked to contribute \$195 to support the program.

At the same time, all active AANS and CNS members who are not Ambassadors will be eligible to separately purchase sets of 100 patient brochures and 50 referral source brochures for \$100. Reorder sets of public-only brochures will be available for \$50 per hundred.

We will be conducting a volunteer recruitment effort for the next 60 days to establish our network of Ambassadors.

Managed Care Update

Continued from page 14

contracts higher in groups of four or more physicians.

Like hospitals, specialists are on the endangered species list wherever managed care makes inroads, according to recent comments in *Integrated Healthcare Report* (IHR). Only a small percentage of existing specialists in these markets are needed to serve the members. HMOs and primary care contracting groups put these specialists under intense scrutiny. If their utilization and cost profiles are too high, they may be deselected. But the good performers, according to IHR, are increasingly being singled out and grouped up for specialty network participation. Those who aren't included in these networks are bypassed and lose patients. Too often, neurosurgeons in these markets are blindsided because they don't plan for the future.

Then we will distribute our materials to participants and begin our media outreach.

I hope that all of you will consider joining the program as an Ambassador. If you cannot do so, I hope that you will utilize the physician referral materials in your community.

More than at any time in our history, it is important that we educate our patients, colleagues, and policy-makers about the valued role that neurosurgeons play in the health care continuum. And who better to teach that lesson than you.

BECOME AN AMBASSADOR FOR NEUROSURGERY!

If you would like to enroll as an Ambassador for the Lumbar Spinal Stenosis Communications Program, please contact the Communications Department at the AANS National Office for an enrollment form. Call (847)692-9500 and direct your inquiry to Susan Nowicki, APR, Director of Communications. If you are interested only in ordering sets of patient and/or physician referral materials, contact Laura Weiss in the Order Services Department for an order form.

Future Trends

Increasing managed care penetration followed by capitation, or other compensation plans, deselection and ultimately declining physician incomes is a cycle that will continue to play out as long as neurosurgical services are undifferentiated and there is a surplus of neurosurgeons. When the dust settles after the year 2000, there may be fewer neurosurgeons left standing, but those who are will be those who recognize the opportunities and start to reposition themselves today.

In future columns, we will look at recent trends, changes, tips, and different ways managed care influences neurosurgical practice including cost containment, group contracting, physician-hospital organizations, and capitation.

NEUROSURGERY:// ON-CALL™

Continues to Expand Services

NEUROSURGERY://ON-CALL™ continues to grow and improve, providing useful resources for our members. Over the past few months, the Editorial Board and staff have been hard at work developing new features for the Web site. If you haven't already, be sure to visit **N://OC®** at www.neurosurgery.org to check out the following:

Real Audio Slide Presentations

N://OC® takes advantage of streaming audio by utilizing Real Audio technology. The first three online slide show presentations we offer focus on: THINK FIRST, Brain Attack, and Carotid Endarterectomy. In order to view these slide shows, you will need to have the Real Audio player installed on your computer. A free copy is available on the Real Audio Web site, and we provide a direct link to their site from **N://OC®**.

We plan to post selected AANS Annual Meeting presentations as Real Audio slide shows, and will gradually build a library of talks from the AANS and CNS meetings that can be viewed anytime, at your convenience.

Public Pages

We are pleased to introduce a new section dedicated to providing valuable neurosurgical information to patients, referring physicians, and the overall health care community. We encourage you to visit this part of the site also, because it contains material that you might find helpful in providing to your patients. The information can be printed directly off the site and given to your patients, or you can encourage them to access the site themselves. The **Public Pages** section offers the following information:

What Is Neurosurgery?

- Definition of Neurosurgery
- Glossary of Terms
- History of Neurosurgery
- About the AANS and CNS

Patient Resources

- Informational pieces on neurosurgical disorders
- How to find support groups for neurological disorders
- Graphics on the anatomy of the brain and spine
- "Ask A Neurosurgeon"—a question and answer feature that gives patients the chance to query a neurosurgeon about a predesignated topic via e-mail
- "Find A Neurosurgeon"—a directory of AANS and CNS members searchable by name, city/province, and area code. Members may choose to upgrade their free directory listing to provide more details about themselves and their practice (contact Allison Casey at the National Office for more information).

Physician Resources

- Referral guidelines
- Learning modules

Neurosurgery News

- Media kits
- Positions statements
- Press releases

Amazon.com

You can now order neurosurgical related books through Amazon.com, the Internet's largest online bookstore. As part of the Associates Program, **N://OC®** offers a convenient way to browse for books online. In the Marketplace section of the site, you will find listings of books organized by subspecialty. To order, just click on the book title and you will be taken directly to the ordering page of the Amazon.com site.

Resident Corner

A brand new section of the site, **Resident Corner**, focuses on providing resources to current and future neurosurgical residents. In this section, you will find a complete listing of accredited residency programs throughout the United States, including links to their

Web sites. A free copy of OpCoder is also available for downloading. Developed by Joel MacDonald, MD, an **N://OC®** Editorial Board member, OpCoder is designed to accurately catalog operative procedure details and can produce custom reports, including RRC forms and brief operative notes for the medical record.

Outcomes

The Outcomes and Guidelines Committee of the Joint Section on Cerebrovascular Surgery has developed Outcomes Reporting Instruments for carotid artery surgery and intracranial aneurysm surgery. These instruments are formatted in a Java based program available on **N://OC®**.

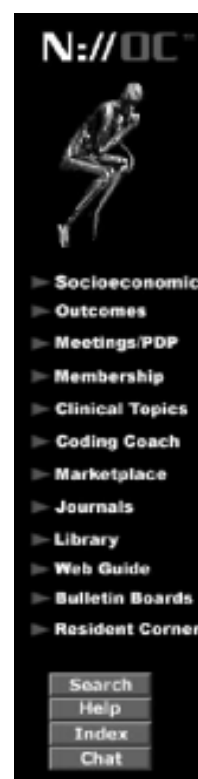
The instruments will be able to be downloaded to individual computers to allow neurosurgeons to keep local databases. In addition, the data can be submitted to the Web site where a combined database will be kept. The program automatically strips patient identifiers from the data submitted, thus insuring patient confidentiality. As reporting instruments for other neurosurgical problems are developed, they can be formatted for use with this Java-based program.

New "Look" for Navigation

In order to improve access to pages within the site, we have implemented a new navigation bar (see illustration). While the Thinker image remains a central figure to **N://OC®**, you can now utilize small menu item images to navigate within the site.

Online Abstract Submission

Abstracts for the 1997 CNS Annual



(continued on page 36)

Joint Section on Pediatric Neurological Surgery Examines CPT Codes for Cranial Endoscopic Surgery

By Harold Rekate, MD
Chairman

The development of specific CPT codes for cranial endoscopic surgery has been an on-going topic for discussion among members of the AANS/CNS Joint Section on Pediatric Neurological Surgery. A 1996 survey of a selected group of surgeons who perform a substantial volume of cranial endoscopic procedures demonstrated variation in billing practices using existing, non-specific CPT codes. The respondents indicated that payers generally were reimbursing them for their work.

Because of the risk that development of new CPT codes for endoscopy might actually lead to lower reimbursement, the Executive Council of the Joint Section on Pediatric Neurological Surgery decided at its 1996 Annual Meeting in Charleston to take no further steps toward approval of new codes. Payers' reimbursement practices are, however, in a state of continual evolution, and the Executive Council wishes to continue to monitor the experiences of the membership. Members are encouraged to contact Joseph Piatt, MD, at (503) 494-8070, fax (503) 494-7161, e-mail piattj@ohsu.edu, to report denials of payment or other difficulties.

Joint Section on Neurotrauma and Critical Care Co-Sponsors Successful Course on Sports Related Concussion and Nervous System Injuries

By Charles H. Tator, MD, PhD
Chairman

Julian Bailes, MD, Chair of the Joint Section's Committee on Sports Medicine, was the Course Director along with Mark Lovell, a Neuropsychology Consultant to the National Football League, and Arthur Day, MD, the former Sports Medicine Committee Chair, for this excellent 200-registrant course. The meeting, organized

by the Division of Neurosurgery from Allegheny University of the Health Sciences, began with presentations on "Spine and Nerve Injuries in Athletes" by several neurosurgeons, including Mark Hadley, MD, Dr. Day, Charles Tator, MD, Dave Kline, MD, Jack Wilberger, MD, and Richard Douglas, MD.

An in-depth symposium followed on the "Neuropsychological Assessment of Athletes" and the last session covered the important area of "Concussion in Athletes," and included concussion classification and concussion guidelines with papers delivered by Joseph Maroon, MD, Robert Cantu, MD, Tom Gennarelli, MD, and Ralph Dacey, MD. There was an important panel discussion on the Professional Athletes Perspective with National Football League players including Lynn Swann, Harry Carson, Merrill Hoge, and Mike Tomczak.

The Sports Medicine Committee is performing the important function of interfacing with the sports medicine community at large, which includes not only injured athletes, but also professional and amateur leagues, athletic trainers, and other medical and non-medical organizations and specialists involved in the treatment of athletes, and the prevention of athletic injuries. All of these groups and individuals benefit from the strong input from individual neurosurgeons and from organized neurosurgery. This is an area in which neurosurgeons and neurosurgery perform a real public service. Congratulations to Dr. Bailes for waving the neurosurgical flag high with this course.

Trauma Section and Joint Section on Spine Launch Pilot Study of Early Decompression of Acute Cervical Cord Injury in 14 Centers

By Charles H. Tator, MD, PhD
Principal Investigator

The Joint Section on Neurotrauma and the Joint Section on Surgery of the Spine and Peripheral Nerves are co-sponsoring a pilot study organized by the National Institutes of Health (NIH) to determine the feasibility of a larger randomized control trial of early decompression. The study will be performed in a small

number of centers, which will log all cases with acute cervical cord injury admitted to their centers and then entering as many eligible patients as possible into the early decompression protocol. McMaster University is the Statistical Coordinating Center and the University of Toronto is the Clinical Coordinating Center for this trial.

The study officially got underway on October 1, 1996, with participating neurosurgeons in 14 centers.

Investigator	Location
Edward Benzel, MD	Albuquerque, NM
Brian Cuddy, MD	Charleston, SC
Donald Cooney, MD	Washington, DC
Michael Fehlings, MD and Mahmood Fazl, MD	Toronto, ONT
Richard Fessler, MD	Gainesville, FL
Barth Green, MD	Miami, FL
Patrick Hitchon, MD	Iowa City, IA
Dennis Maiman, MD	Milwaukee, WI
Larry Marshall, MD	San Diego, CA
Bruce Northrup, MD	Philadelphia, PA
Steven Papadopoulos, MD	Ann Arbor, MI
Volker Sonntag, MD	Phoenix, AR
Frank Wagner, MD	Sacramento, CA
Jack Wilberger, MD	Pittsburgh, PA

These centers were chosen on the basis of their experience in conducting clinical trials in spinal cord injury in NASCIS-3 or the GM-1 trials.

The Pilot Study aims to determine whether decompression can be diagnosed by MRI or CT myelography and then treated by traction alone, surgery alone, or both within the 8-hour trauma-to-treatment time window. This timing is the only confirmed trauma-to-treatment interval in the spinal cord injury field and was established by the NASCIS-2 trial with methylprednisolone. Patients must have cervical cord compression fully documented prior to treatment and then must have decompression accomplished by 8 hours after trauma.

When moving remember to send your change of address to:

**AANS Member Services
22 South Washington Street
Park Ridge, Illinois 60068-4287**

ACS Board of Regents Holds Winter Meeting



Edward R. Laws Jr., MD, FACS
Regent for Neurosurgery
American College of Surgeons

The American College of Surgeons (ACS) Board of Regents met February 7–8, 1997 in Phoenix, Arizona, and covered a good deal of business.

Education

The study on prerequisite objectives for graduate surgical education is nearly

complete and is an excellent survey of the desirable aspects of medical school curriculum needed for individuals going into surgery or the surgical subspecialties. Neurosurgery has made significant contributions to this effort and the results of the study will be circulated as soon as they are available.

It was noted that the most recent longitudinal study of surgical residents covering the year 1993 to 1994 contains erroneous data with regard to graduates of neurosurgical residencies. It suggests that there was a 40 percent increase, but this has occurred simply because they started with the year 1983 as a baseline, and this was the year before significant expansion in both number and length of training programs occurred in neurosurgery. If a baseline of 1985 had been chosen, there would be no change. This underscores the danger in some of the manpower and workforce determinations done by others.

The College has supported neurosurgery's initiative to obtain antitrust relief so that graduate medical education issues could be addressed on the basis of quality of training programs with perhaps some changes in reducing the number of residents trained.

Task Force on Outcomes

The Advisory Councils for the surgical subspecialties have been quite active, with neurosurgery being one of the leaders. They have moved forward with the Task Force on Outcomes Research and the current report has been approved by the Board of Regents. The College has

provided a template that covers the general areas of medical consequences of intervention, patient perception and satisfaction, quality of life, and cost.

The Advisory Councils view these studies as important because they provide long-term functional assessment and will provide for managed care entities and the government, evidence of quality medical care, improvement in the individual surgeon's position in the competitive marketplace, and some means of achieving cost control. Neurosurgery is moving ahead with projects related to cerebrovascular disease, spinal surgery, and brain tumors under this general scheme.

Practice Guidelines and Liability

The report of the Professional Liability Committee raised a number of concerns to whether practice guidelines were in fact a major problem in the liability arena. Because of these concerns, the Agency for Health Care Policy and Research (AHCPR) has halted its development of guidelines.

In the tort reform arena, a study came forth that suggested that \$25 to \$50 billion in excess costs could be saved if there were appropriate liability reform. The College continues to worry about the traveling expert witness problem and has referred physicians at the College to IDEX. At least 12 doctors successfully defended lawsuits with information provided by this agency.

Resource-Based Practice Expense Legislation

The major factors for discussion under physician reimbursement were the fee schedule updates, the MVPS, and, of course, the practice expense issue. It was noted that resource-based practice expenses represent about 42 percent of each surgical fee code. We were already scheduled to lose about 13 percent on the change in the conversion factor, and the various subspecialties stand to lose a good deal more if the resource-based practice expense adjustments become law.

It was felt that a delay in implementation is almost certain, but our position is one of not supporting a delay, but rather pushing for repeal and making sure that the conversion factor changes are somehow acceptable.

AMA Update

There was significant discussion regarding the American Medical Association (AMA) meeting and the presence of surgeons within the AMA structure. The surgical caucus under the leadership of the American College of Surgeons seems to be a more effective voice, however, it is recognized that the AMA continues to be organized along political lines, and of the 447 members of the House of Delegates, only 175 are surgeons. A move to enlarge the Board of Directors to include some more surgeons was not approved.

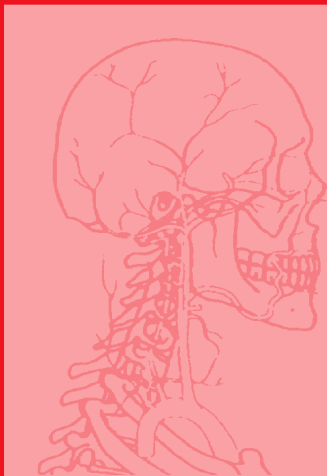
The recent balloting conducted by the AMA to expand federation representation resulted in the College of Surgeons improving its position so it now has two delegates and two alternates; we will go ahead and appoint these additional members. Overall, surgeons gained nine seats and non-surgeons gained 12. The American Society of General Surgery also has a seat. Unfortunately, neurosurgeons did not gain additional representation as not enough votes were received from our neurosurgical colleagues.

It should be noted that the AMA House of Delegates did go on record at its June meeting to support a delay for implementation of the practice expense readjustments and also supported our initiative for relief in matters of GME, and there is some optimism with regard to the ability for surgery to work with the new leadership in the AMA.

Trials and Grants

The ACS has applied to National Cancer Institute for a clinical trials grant that would cover a number of areas of surgery. The request is for \$31 million over five years, and the initial studies would cover lung, breast and colon cancer, along with melanoma and retinoblastoma. A neurosurgical group has been formed and will be available for trials if this grant is approved.

The Committee on Emerging Surgical Technology has applied to the National Institutes of Health and the Veteran's Administration for a prospective trial of laproscopic versus open management of inguinal hernia.



NEW COURSES!

NEUROSURGERY REVIEW BY CASE MANAGEMENT: ORAL BOARD PREPARATION

May 3–5, San Diego, California
November 9–11, Houston, Texas

Chairman: Julius M. Goodman, MD

If you are a neurosurgeon in private, academic, or subspecialty practice who is contemplating taking oral boards in May 1997, or within the next several years, this intense three-day course is for you! Experienced faculty will use the oral board format to cover a broad review of neurosurgery. There will be opportunity to become updated on material infrequently encountered in your practice and to get actual experience answering questions under pressure.

EXTRACRANIAL CAROTID RECONSTRUCTION

May 30–31, Rancho Mirage, California

Chairman: Christopher M. Loftus, MD, FACS
Associate Chairman: Issam A. Awad, MD

Don't miss this innovative program! There is a didactic portion of the course that features a strong emphasis on management issues and clinical decision making. Plus, a unique feature of this course is the opportunity to participate in a day-long, hands-on live animal laboratory. The lab time allows you to refine skills in carotid exposure, arteriotomy technique with primary and/or patch graft repair, shunt insertion, and both loupe-magnified and microsurgical techniques. There is a special session devoted to placement of carotid interposition grafts.

SURGICAL MANAGEMENT OF MOVEMENT DISORDERS

June 27–29, Orlando, Florida

Co-Chairmen: William T. Couldwell, MD, PhD & Robert G. Grossman, MD

Don't miss this advanced course! Surgical treatment of Parkinson's Disease and other movement disorders is regaining popularity. If you want to revisit this treatment, you should take this course. Faculty with experience in these surgical treatments will review the current indications and techniques used to treat patients with Parkinson's Disease and other movement disorders. In interactive discussions, participants and faculty will examine current controversies in surgical technique.

Professional
Development
W I T H



The American Association of Neurological Surgeons

**For more information or to
register for these courses, call
the Professional Development
Department at (847)692-9500.**

SURGERY OF THE CERVICAL SPINE—HANDS-ON

June 27–29, Memphis, Tennessee

Chairmen: Regis W. Haid, MD & Iain H. Kalfas, MD

Mark Your Calendar Now for This Exceptional Opportunity!

If you want to expand your expertise in cervical spine surgery, this course offers a comprehensive review of current concepts for the neurosurgical practitioner.

Based on intensive interactive discussions, laboratory sessions will focus on human cadaver hands-on surgical instruction. You will see and perform a variety of decompression and stabilization techniques, including fixation techniques, utilizing screws, wires, and plates—all under the direction of recognized neurosurgical experts. There also will be discussion and the opportunity for hands-on practice with spinal stereotactic systems.

You are strongly encouraged to bring your challenging patient cases to the course for discussion.

A PROACTIVE APPROACH TO MANAGED CARE: STRATEGIES & SOLUTIONS

June 21–22, Cleveland, Ohio

November 7–8, Palm Beach, Florida

Chairman: John A. Kusske, MD

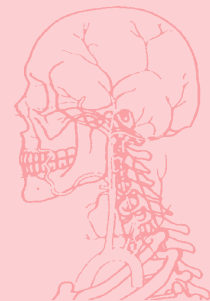
This course is a must-attend for neurosurgeons and their administrators! Do you know how to tell the difference between an essential and a wasted effort in approaching managed care? This course is designed to sharpen your perceptions, challenge your thinking, and motivate you to act decisively and proactively. Building on the foundation of previous managed care courses, this year's program offers less historic background on managed care and more insights into what's really happening.

NEUROSURGICAL CRITICAL CARE FOR NEUROSURGEONS, NEUROSCIENCE NURSES & PHYSICIAN ASSISTANTS

June 5–7, Philadelphia,
Pennsylvania

Chairman: Michael J. Rosner, MD

Significantly increase your ability to manage critically ill patients! This course is uniquely suited for neurosurgeons and their clinical associates and is specially designed to optimize your learning experience. The course emphasizes the team approach to scientific management of critically ill patients by applying quantitative relationships associated with neurosurgical diseases. You will be provided with the most up-to-date information available on cerebral perfusion pressure management, modern fluid management, and cerebral pathophysiology.



REMINDER!!

The Professional Development Program exists to offer neurosurgeons the opportunities for continuing medical education. However, some courses continue to grow in attendance, and we must turn away registrations. Please help us to serve you by registering early so that you can attend the courses you want.

AANS Research Foundation Recognizes 1996 Annual Campaign Donors

The Executive Council of the AANS Research Foundation gratefully acknowledges the following individuals, groups, and corporations for their generous contributions to the Foundation's 1996 Campaign. These donors have set exemplary standards for the entire neuroscientific community by demonstrating the power of philanthropy

to expand scientific knowledge. They deserve the highest recognition.

This list represents gifts of \$100 or more received between January 1, 1996, and February 15, 1997. The number appearing in parentheses following each individual's name indicates the number of years he or she has supported the Research Foundation Annual Campaign.

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(Gifts of \$5,000 and up)

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Scientific Society

The following list consists of university programs, foundations, groups, and organizations that have contributed \$500 or more within the last year. Individual members of these groups are listed within the giving category that corresponds to their individual portion of the total gift.

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Brown University Neurosurgical Foundation, Providence, RI
Cleveland Clinic Foundation, Cleveland, OH
Dartmouth-Hitchcock Medical Center - Neurosurgery, Lebanon, NH
Henry Ford Hospital, Detroit, MI
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Help to ensure a bright future neuroscientific research. Send your 1997 gift today. For your convenience, a Research Foundation gift envelope has been inserted in this copy of the *AANS Bulletin*.

Membership

spring 1997

AANS Membership Exceeds 5,000

The AANS has experienced tremendous membership growth over the past few years. Recently, the total number of AANS members exceeded 5,000, extending its position as the largest neurosurgical organization in North America. More than 1,000 *new* members have joined the AANS during the past three years, doubling the number of applications being reviewed by the Membership Committees.

Just Who Are These New Members?

The AANS recognizes that optimal patient care is comprised of a collaborative approach to medical treatment. Our future neurosurgical leaders need educational guidance from experienced neurosurgeons, and yet, their own voice.

Acknowledging this, the AANS formed the Young Neurosurgeons Committee in 1992. At the same time, the eligibility requirement of the Candidate category of membership was expanded from neurosurgical residents in their last two years of residency to all neurosurgical residents in ACGME and RCS approved training programs. With only 61 Candidate members in 1993, the total number of Candidate members today exceeds 550, giving the AANS more resident members than any other neurosurgical society.

To elaborate on the importance of a collaborative approach to medicine, the AANS opened its arms to certified neuroscience nurses and physician assistants in 1994. The eligibility requirements of the Associate category of membership were modified to include nurses with CCRN (critical care), CNRN (neuroscience), or CNOR (operating room) certification, and certified physician assistants (PA-C). As a result, the Associate category of member-

ship has nearly tripled since 1994. Today, 121 nurses and 46 physician assistants are members of the AANS.

In order for the AANS to truly be the neurosurgical voice of North America, the eligibility requirements of the Active category of membership have been broadened. Last year, Bylaw changes opened the category to neurosurgeons certified by the Mexican Council of Neurological Surgery, A.C. Therefore, we expect to see a significant increase in the number of Active members in the years to come.

The AANS strives to provide its members with a forum for the exchange of issues, ideas, problems, solutions, and developments in the field of neurosurgery while creating an opportunity to build professional relationships. The AANS is on the leading edge of neurosurgery and is working harder than ever to remain in this position. The AANS wants you to be proud of your role in North America's largest society of neurosurgical professionals.

Candidate Members for Spring 1997

M. Samy Abdou
Ayman Fahad Al-Shayji
Clark Hunter Allen
Arun Paul Amar
Marc Shaun Arginteanu
Florence Carsley Barnett
Lynn Margaret Bartl
Jonathan Jay Baskin
Curtis Lee Beauregard
Steven Joseph Beer
Ronald Patrick Benitez
Rajesh K. Bindal
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Kimberly Sue Brown
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Michael James Drewek
Derek Addison Duke
Susan Renee Durham
Deborah R. Elyaderan
Sayed Mohammad Emadian
Andrew D. Firlik
Katrina Schreiber Firlik
Thomas Robert Forget, Jr.
Mark Benjamin Gerber
Holly S. Gilmer-Hill
Ryan Scott Glasser
James David Guest
James Shields Harrod
David Houston Harter
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James R. Hirsh
Philip Joseph Hlavac
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Todd Michael Lasner
Daniel M. Lieberman
Jae Yun Lim
Ted Tai-Sen Lin
William Gunter Loudon
Amir Malik
Lloyd Ian Maliner
Taras Masnik
Douglas C. Mathews
Alon Y. Mogilner
Praveen V. Mummaneni
Ilyas Munshi
Bernardo J. Ordonez
Renatta J. Osterdock
Ian F. Parney
Bryan Rankin Payne
Matthew Frank Philips
Joseph Keith Preston
Patrick Robinson Pritchard
Robert Edward Replogle
Howard Anthony Riina
Robert Dugald Robinson

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Positions

spring 1997

Although the AANS believes these classified advertisements to be from reputable sources, the Association does not investigate offers and assumes no liability concerning them.

Announcements

spring 1997

Names in the News

Michael E. Carey, MD, Professor of Neurosurgery at Louisiana State Medical Center, has been awarded the seventh highest U.S. Army decoration, the Legion of Merit.

The certificate accompanying the Legion of Merit reads, "Colonel Carey's professionalism, exceptional neurosurgery skills, and keen insight were instrumental in the world renowned research on head wounds including follow-up studies on Vietnam veterans, his approach to soldiers' care, dynamic training abilities, and sense of patriotism have been eminently visible throughout his military career. Colonel Carey's

dedication to duty and devotion to soldiers during the past 28 years exemplifies the highest traditions of military service and reflects distinct credit upon him and the United States Army."

A combat neurosurgeon, Dr. Carey served as Chief of Neurosurgery of the 312-91st Evacuation Hospital in Chu Lai, South Vietnam, as well as Chief of Neurosurgery of the 148th Evacuation Hospital in Al Quasimah, Saudi Arabia, during Desert Storm.

Gary C. Dennis, MD, FACS, was recently elected President of the Medical Society of the District of Columbia (MSDS). Dr. Dennis is the Chief of the Division of Neurosurgery at Howard

University College of Medicine. Dr. Dennis has been active in the Society for several years and also serves on the Board of Trustees for the National Medical Association, on the Medical Advisory Board of the Mid Atlantic Heath Care Purchasing Coalition, and is a member of the Practicing Physicians Advisory Council for the Heath Care Financing Administration.

Phillipp M. Lippe, MD, FACS, FACPM, was presented the Byron Cone Pevehouse Distinguished Service Award at the Annual Meeting of the California Association of Neurological Surgeons. Dr. Lippe is a Clinical Professor of Neurological Surgery at Stanford and Chairman of the Department of Clinical Neurosciences at Good Samaritan Hospital in San Jose.

Nicholas T. Zervas, MD, was elected a Fellow of the American Academy of Arts and Sciences.

Dr. Zervas is Chief of Neurological Service at Massachusetts General in Boston.

Calendar of Neurosurgical Events

1997 Annual Meeting of the Congress of Neurological Surgeons

September 27–October 2

New Orleans, Louisiana

New Orleans Convention Center

Contact: Annual Meeting Services Department
(847)692-9500

1997 Annual Meeting of the North American Spine Society

October 22–26

New York Hilton Hotel & Towers

New York City, New York

Contact: Patricia Fuller
(847)698-1630

Associate

Derek C. Harwood-Nash, MD
October, 1996

Lifetime

Charles W. Berklund, MD
November, 1996

Robert J. Clubb, MD
October, 1996

Nicholas Gotten, Sr., MD
October, 1996

Marshall Henry, MD
January, 1997

Richard T. Johnson, MD
September, 1996

Fredrick Latimer, MD
October 19, 1996

Jean Lecuire, MD
1992

John T. Lord, MD
October, 1996

Hector N. MacKinnon, MD
December, 1996

Wylie McKissock, MD
1993

Howard E. Medinets, MD
1996

Jorge A. Picaza, MD
1997

Pierre Wertheimer, MD
1982

W. Lewis Yarborough, MD
July, 1996

In Memoriam

N:/OC®

continued from page 21

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ABNS

N:/OC® is pleased to be hosting the new Web site of the American Board of Neurological Surgery, which is located at <http://www.abns.org>.

Feedback Encouraged

NEUROSURGERY://ON-CALL™ welcomes your comments and suggestions. As the public pages section continues to grow, content suggestions, link ideas, etc., are appreciated.

To contact the Editorial Board with your suggestions, send them e-mail at info@neurosurgery.org or write them at: AANS National Office, 22 South Washington Street, Park Ridge, Illinois 60068-4287.