



# CANS

# NEWSLETTER

California Association of Neurological Surgeons

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## Your JNS library just got bigger—and smaller

*Randall W. Smith, M.D., Editor*

The future is upon us and it is a good thing. The Journal of Neurosurgery has just completed archiving all its journal volumes back to the initial volumes including the actual 1944 first volume. This archiving, which is searchable by keywords, is available to all subscribers to the Journal of Neurosurgery which includes the Journal of Neurosurgery: Spine, the Journal of Neurosurgery: Pediatrics and Neurosurgical FOCUS. To access all the issues, you need to register for the free on-line account at the JNS web site which actually requires you to E-mail the JNS at [subscriptions@thejns.org](mailto:subscriptions@thejns.org) and provide your name, JNS subscription number (on the cover sheet you get in the mail with each month's 3 journals) and the address at which you receive the printed journals. Further, AANS Lifetime members, who are those that have been active members for 30 years or who have retired from operative neurosurgery, can avail themselves of a free subscription to the JNS if they chose to pay an annual fee of \$100 to maintain access to all AANS publications. Any AANS Lifetime member who is paying the \$100 and is not receiving the journals, or who is receiving the journals but wishes to stop doing so, can accomplish this by contacting [jmj@aans.org](mailto:jmj@aans.org). Interestingly, folks who do not subscribe to the JNS journals can freely access some volumes on-line but are limited to the journal volumes over one year old and extending back only 10 years.

What we have here solves the office problem of where to store all the issues of the JNS journals you have received over the years. Unless you can find a home (library, colleague) for the printed journals you have accumulated in your bookcases with the shelves that sag under the journals' weight, they are probably best sent to the recycler. Now you have a smaller physical library in the office but a much, much larger one on-line. Kudos to the AANS and the JNS for making our annual dues an increasingly excellent bargain.

Michael Apuzzo, former long time editor of the CNS journal *Neurosurgery*, recently predicted that the future will bring total on-line publications and that there will be no printed editions. He is probably correct although it will take some innovation to recoup all the income from adverts that will be lost and may well not be replaced with on-line ads which we all love. Also, this writer would find it challenging to take the computer into the bathroom each morning. ❖

## EHR a great idea?—follow the money

*Randall W. Smith, M.D.*

When times are tough and budgets have to be made to cover the really important stuff, some interesting ideas that get a lot of press may take a hit. A case in point is Sutter Health, a multi-institutional health group in the Sacramento area. Sutter has put its Electronic Health Record initiative on hold and has terminated 122 employees in its Information Services Department. Sutter's income for 2008 was \$186 million, down from \$623 million in 2007 and with such an income hit, Sutter's CIO stated "We have a higher responsibility now more than ever to our patients . . . to be good stewards and to keep our services affordable." The implication is that the only way to continue converting the rest of Sutter's institutions to an EHR beyond its first converted location at Burlingame was to raise prices, a particularly tenuous maneuver these days in light of the national angst about health care costs. Apparently the Obama stimulus plan, which included \$11 million for each hospital to convert to EHRs, isn't big enough or available soon enough to save the Sutter Information Services Department. And docs are supposed to jump into this pool? ❖

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## Tidbits from the Editor

### Neurosurgery at top—of PLI premiums

The AMA has completed an analysis of the professional liability insurance (PLI) premium data from the Physician Practice Information Survey and has sent it to CMS for its use in calculating the 5 year update to the PLI RVU's for 2010. CMS has its own vendor to supply these values but the AMA wants CMS to have doc generated data to corroborate the CMS vendor information. Not surprisingly, neurosurgery tops the list with an average of \$81,000 for PLI with orthopedic spine surgery at 61K followed by Ob-Gyn at 57K. The 81K figure is about what we pay in California with our MICRA which suggests there are a whole lot of states out there where it's a whole lot more than 81K. ❖

### Neurosurgical CME—Who's on First?

Any neurosurgeon who has an active California state medical license or is an active member of the AANS or CNS or is in the ABNS Maintenance of Certification (MOC) process must accumulate Continuing Medical Education hours. The state license renewal requirement is 50 hours of any AMA Category 1 activity in the two years preceding your license renewal date. That's the easy part. Then things get dicier.

If you are in the MOC process, you need 150 hours of CME in a three year cycle, 80% of which has to be neurosurgical specific but only 60 hours has to be Category 1, with the courses or meetings that qualify for neurosurgical Category 1 CME listed on the AANS and CNS Web sites. The other 90 CME hours can all be Category II which includes reading journals, teaching, attending M&M conferences and like activities.

If you are a CNS Active member, you need 90 Category 1 CME hours in a three year cycle but they don't specify that any of the hours have to be neurosurgical. You must attend one CNS annual meeting in that three year cycle.

If you are an Active AANS member you need 60 Category 1 CME hours in a three year cycle with 40 of the hours neurosurgical. You must attend one AANS annual meeting in that three year cycle. The AANS allows you to declare any Category 1 CME hours as neurosurgical including attending grand rounds where Category 1 CME hours are awarded.

So what is an every day neurosurgeon to do? Well, in a three year epoch, if you attend the CNS annual meeting in year one and the AANS annual meeting in year two and take a few breakfast or luncheon seminars at those meetings, you should pretty much have 60 Category 1 CME hours in neurosurgery which would satisfy your CA license, AANS membership and MOC requirements. You then need another 30 Category 1 CME credits of any variety in the three years to maintain your CNS membership. It would seem that the CNS could consider reducing its Category 1 CME hour requirements to 60 in a three year period which would bring it in line with the AANS and ABNS. ❖

**THOUGHT OF THE MONTH:** *Money can't buy happiness, but somehow it's more comfortable to cry in a Corvette than in a Kia.* ❖

## Council of State Neurosurgical Societies (CSNS) Highlights of the May 1-2 meeting

**A**ttendance: 43 delegates from state societies (6 from CANS), 23 delegates appointed by the AANS and CNS, 12 resident delegates and 11 guests.

1. **Dr. Peter Carmel**, New Jersey neurosurgeon and member of the Board of Trustees of the AMA, reported that the AMA has decided to reduce its primary advocacy issues to two: Care for the Uninsured and Adequate Compensation for Physicians. He noted that the Medicare pay cut scheduled for this year has been revoked and a small increase allowed with that congressional action coming about because of AMA lobbying. He also felt that AMA lobbying resulted in the three month delay in docs having to have an identity theft policy (red flag rules) and that the AMA will continue to push for excluding docs from having to satisfy the requirement.

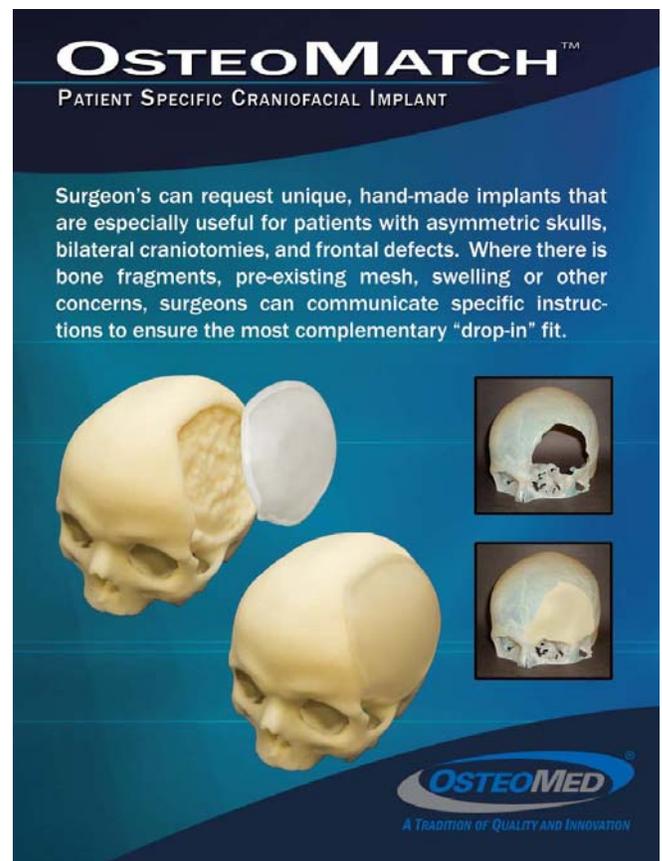
He also noted that the AMA was lead plaintiff in the successful suit against United Healthcare for using the faulty Ingenix database to determine out of network charges. The \$350 million judgment will almost totally go to docs as the AMA legal fees were less than \$2 million (unlike the large legal costs most class action suits generate for lawyers).

Finally, he acknowledged the pivotal role played by Charles Rosen, West Virginia neurosurgeon, in spearheading (at the request of the CSNS) the AMA effort to get industry to accept a universal software viewing program for digital diagnostic studies.

2. The report of the Committee on Socioeconomics of Neurosurgical Research, formed in response to a previous CSNS resolution, was given by Chairwoman **Edie Zusman** from California. She noted that a national database indicates academic neurosurgeons make 30-40% less than their private practice counterparts and that those academicians spend a fair amount of time in clinical practice in order to generate those lesser salaries. She outlined some methods for attracting and keeping academic faculty including equal pay for clinical and research positions, assistance programs for academic faculty to apply for NIH and NINDS grants, encourage academic faculty to spend time applying for grants from philanthropic organizations and for organized neurosurgery to encourage industry to make unrestricted and ethical grants to the Neurosurgical Research and Education Foundation who then awards grants for basic research to neurosurgical academic faculty on subject matter of the researcher's choice. Five such industry/NREF grants were awarded this year on behalf of **Biomet Microfixation, Codman, DePuy Spine, Medtronic and Porex Surgical**.

3. The Coding and Reimbursement Committee report by **John Wilson** included no good news for docs. He noted that CMS has ACD&F on the front burner and plans to bundle 63075 and 22554 into one code which probably will be assigned 45% fewer RVUs over our vigorous objections. It was also noted that the Obama budget included \$300 billion to permanently fix the Medicare Sustainable Growth Rate formula but the Senate cut that to \$40 billion which is not enough to fix the problem beyond a couple of years.

4. The Workforce Committee arranged for a presentation by Osteopathic Neurosurgeons as to their history, training, certification and practice. It was noted that DO and MD medical school curricula was quite similar with DOs getting



additional instruction in manipulation. There are 30 DO medical schools and 40% of graduates go on to ACGME (MD) residencies. Eleven osteopathic neurosurgical residencies turn out 17 new neurosurgeons a year while the 97 allopathic neurosurgical residencies graduate 160+ neurosurgeons annually. The DO neurosurgical residency is of very similar length and breadth as MD programs and each DO program is accredited by the American Osteopathic Association. Graduates of DO neurosurgical residencies take a written and oral exam to become certified by the American Osteopathic Board of Surgery which is not neurosurgery specific as is the ABNS. Recertification is required every 10 years. Most mid-aged and younger osteopathic neurosurgeons do not manipulate but rather send selected patients to osteopaths who do manipulations; they use the technique like physical therapy or chiropractic. It was the opinion of the presenters that older osteopathic neurosurgeons are happy where they are in the national neurosurgery fabric but the younger DO neurosurgeons, many of whom took MD fellowships, are interested in becoming part of national neurosurgery and having a role in the AANS and/or CNS. The AANS is currently considering the issue although a recent AANS by-laws change rewrote the criteria for Associate Members which specifically excluded DOs.

5. AANS President **Jim Bean** addressed the CSNS and gave credit to the late Lyal Leibrock for introducing him to the Council and during his years in the CSNS, culminating in his Chairmanship in 1997-99, he learned the skills necessary for his career at the AANS Board and eventual presidency. He pointed out that his grass roots perspective played a significant role in the recent equalization in the standing of and responsibilities assigned to Regional AANS Board Directors (positions determined by the CSNS quadrants) and the inclusion of CSNS generated socioeconomic articles in the *AANS Neurosurgeon* (formerly the *AANS Bulletin*). He cited the CSNS, through its resolutions, for bringing thoughtful ideas to the AANS/CNS leadership (he modestly failed to mention he was primarily responsible for the adoption of that resolution process in 1995 while CSNS Vice-Chairman).

6. The Lyal Leibrock Lifetime Achievement Award was presented to **Robert Florin, M.D.**, from California for his many years spending very many hours representing neurosurgery in coding and reimbursement activities which resulted in making our neurosurgical practices successful.

7. The Robert Florin, M.D. Young Neurosurgeon Award for best socioeconomic paper was presented to **Brian L. Hoh, M.D.** for his study "*The Effect of Coiling versus Clipping on Length of Stay, Hospital Cost and Reimbursement and Surgeon Reimbursement*". The Byron C. Pevehouse Award for best socioeconomic paper by a resident went to **Jayant Jagannathan, M.D.** for his paper "*Effects of ACGME Work Hour Rules on Neurosurgical Resident Education and Productivity*".

8. From among 41 very good applicants, 12 new resident fellows were selected by their appropriate quadrants to serve as CSNS delegates for the next two CSNS meetings:

#### Northeast Quadrant

Peter Campbell, M.D.	Thomas Jefferson
Maxwell Laurens, M.D.	Yale
Clemens Schirmer, M.D.	Tufts

#### Southeast Quadrant

Wesley Hsu, M.D.	John Hopkins
Matthew Lawson, M.D.	University of Florida
Carrie Muh, M.D.	Emory

#### Northwest Quadrant

Andrew Bauer, M.D.	University of Wisconsin
Joseph Hsiah, M.D.	University of Chicago
Fahd Khan, M.D.	Case Western

#### Southwest Quadrant

Namath Hussain, M.D.	University of Arizona
Paul Kalanithi, M.D.	Stanford
Vincent Wang, M.D.	UCSF

## CSNS Resolutions--Results

**RESOLUTION I**      **Title:** Definitive Direction on the Use of High Dose Methylprednisolone in the Care of Spinal Cord Injured Patients.

**BE IT RESOLVED**, that the CSNS asks the Joint Guidelines Committee to prioritize the update of the spinal cord injury guidelines, and work in conjunction with the Joint Sections on Neurotrauma and Spine.

**BE IT FURTHER RESOLVED**, that the CSNS calls upon the Joint Guidelines Committee to put forth an interim update on the use of methylprednisolone in the treatment of acute spinal cord injury.

**ACTION:** Letter to Guidelines Committee

**RESOLUTION II**      **Title:** Responsibilities of Medical Directors and “PEER” Reviewers For Insurance Companies and Worker Compensation in Adjudication of Prescribed Tests and Procedures for Neurosurgical Patients

**BE IT RESOLVED**; that the CSNS Medical Practice Committee (MPC) develop a white paper for report back to the CSNS body supporting a peer-to-peer utilization review process that addresses the need for specialty specific review, accountability, and transparency.

**ACTION:** Assigned to MPC for report in October

**RESOLUTION III**      **Title:** Protecting Out-of-Network Benefits for our Patients

**BE IT RESOLVED**, that the CSNS Reimbursement Committee in collaboration with NERVES develop a list of resources regarding acceptable methods for determining usual and customary fees.

**BE IT FURTHER RESOLVED**, that the CSNS ask the AANS and CNS through the Washington Committee to support patient access to neurosurgical care by preserving fair compensation for care provided out-of-network.

**ACTION:** Referred to Reimbursement Committee for report in October; Letter to AANS/CNS

**RESOLUTION IV**      **Title:** Trauma Surgeon Management of Traumatic Brain Injuries

**BE IT RESOLVED**, that the CSNS ask AANS and CNS to work with ABNS to issue a joint position statement to the AAST asserting that the training required to fully understand and care for both acute surgical and non-surgical traumatic brain injuries requires several years of dedicated study and practice: and

**BE IT FURTHER RESOLVED**, that the position statement includes the assertion that a neurosurgeon should be involved in the management of acute traumatic brain injuries.

**ACTION:** Not Adopted. Reason: AANS/CNS and ABNS have already done this

**RESOLUTION V**      **Title:** Defining the Role of Simulators in Neurosurgical Training

**BE IT RESOLVED**, that the CSNS investigate whether currently available skills competency training and virtual reality training tools could efficiently contribute to neurosurgery resident training and potentially improve quality of patient care

**ACTION:** Referred to CEC Committee for October Report

**RESOLUTION VI** Title: CSNS Website Tool Box Resource

**BE IT RESOLVED**, that the CSNS encourage the utilization of a password-protected “Tool Box” to allow for an active repository of categorically organized information storing topical financial, legal and economic documents affecting neurosurgical practice; and

**BE IT FURTHER RESOLVED**, that this “Tool Box” be used as a complete reference library including policies, protocols, procedures, rules and regulations, government compliance documents (Medicare, Joint Commission), care maps, standard orders, continuing medical education accreditation compliance resources, informed consent forms, research tools (protocol development, grant application guidelines and opportunities), and other resources related to neurosurgical healthcare delivery which can be modified as needed for individual or institutional use under the direction of a neurosurgeon; and

**BE IT FURTHER RESOLVED**, that the CSNS remind its members on a quarterly basis, through e-mail blasts, requesting submission to this “Tool Box” to encourage and enhance the research capabilities of neurosurgeons seeking expedient information and exemplary resources for their own individual or institutional use.

**ACTION:** Referred to Medical Practices Committee

**RESOLUTION VII** Title: Neurosurgeons and the Physician Payments Sunshine Act

**BE IT RESOLVED**, that the CSNS create an educational module to inform our membership and the public about existing AANS and CNS Guidelines and Policies regarding management of conflict of interest pertaining to neurosurgeons and industry.

**BE IT FURTHER RESOLVED**, that AANS/CNS through the Washington Committee work to make any federal legislation that provides for transparency in the relationship between physicians and industry acceptable to neurosurgeons.

**ACTION:** Referred to Communications and Education Committee for creation of module and letter to AANS/CNS.

**RESOLUTION VIII** Title: National Medical Device Registry

**BE IT RESOLVED**, that the CSNS urges the AANS and CNS, through the Washington Committee, to support the general principle of a national medical device registry based on the concept of a unique device identification (UDI) number.

**ACTION:** Referred to Medical Practice Committee to research and prepare report addressing feasibility (does every pedicle screw need a UDI?) ❖

### Neurosurgical Position

*Any CANS member who is looking for a new associate/partner/PA/NP or who is looking for a position (all California neurosurgery residents are CANS members and get this newsletter) is free to submit a 150 word summary of a position available or of one's qualifications for a one time posting in this newsletter. Submit your text to me by E-mail ([rws-avopro@sbcglobal.net](mailto:rws-avopro@sbcglobal.net)) or fax (858 683-2022). ❖*

Questions or comments can be sent to the editor, Randall W. Smith, M.D., at [rws-avopro@sbcglobal.net](mailto:rws-avopro@sbcglobal.net) or to the CANS office at [janinetash@sbcglobal.net](mailto:janinetash@sbcglobal.net). Past issues of the monthly newsletter are available on the CANS website at [www.cans1.org](http://www.cans1.org).

*The newsletter is a mix of fact, rumor and opinion. The facts are hopefully clearly stated. The rest is open to interpretation. The opinion is mine. R.S. The assistance of Janine Tash and Dr. Bill Caton in the preparation of this newsletter is acknowledged and appreciated. If you do not wish to receive this newsletter in the future, please E-mail or fax Janine Tash [janinetash@sbcglobal.net](mailto:janinetash@sbcglobal.net), (916-457-8202) with the word "unsubscribe" in the subject line.*

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