



## President's Message: Why Do a Small Case When a Big Case Will Do?

*Kenneth Ott, M.D., F.A.C.S.*

A few weeks ago, CANS' Sacramento office was contacted by a reporter from Bloomberg News Service regarding our payments from insurance companies for spinal surgery. We could not meet their time limits for publication but it started me thinking...

At the same time my group in San Diego, the Neurosurgical Medical Clinic, Inc., decided to conclude our contract with Anthem Blue Cross. I hope I am not breaking federal law by complaining to my fellow neurosurgeons about insurance payments. It seems clear to me that BC intends to lower surgeon payments until most of us quit. That will establish the threshold for their remuneration. Then they will probably increase the fees 10 to 20% to bring many back into the fold at a barely tolerable rate. BC has billions in reserves and beggars hospitals and physicians. But then again... that's just my theory.

So I asked our billing office to research payments from various insurance companies and Medicare to our group over the past decade. Totally unscientific and I hope not against federal law! We looked up two billing codes: 63047, a single level lumbar laminectomy, and 22612, a inter-transverse fusion of a spinal segment.

The analysis is complicated and fraught with anti-trust peril. Let me then paint with a broad brush. In 1999, a major insurance carrier, Cigna, paid a reasonable fee for a single level lumbar laminectomy (63047)...let's call it 100% and normalize all other payments for the next decade to this standard. In the same year (1999) the "Blues" paid about 57% of this amount and Medicare paid 35%. Over the next decade, in our experience, it was a race to the bottom. Last year Cigna paid 35% of their original 1999 fee, the Blues paid 40% (vs. 57%) and Medicare paid 27% (vs. 35%).

In terms of the lumbar inter-transverse fusions rates, the reduction of compensation rates were much less drastic. For example, Aetna's rates were 84% of the Cigna laminectomy rate in 1999 and 76% in 2009, the BC rates were about 90% in 1999 vs. 75% in 2009. Medicare 59% vs. 56%.

In short, the insurance companies moved to the low fees of the federal government over the past decade for commercial insurance payments for our corporation. Cigna commercial rates are now at the level of Medicare 10 years ago. Let's not consider increased expenses for our offices and inflation over the decade. Now, under the leadership of Anthem Blue Cross, the movement is toward MediCal rates.

So what has been our response as neurosurgeons in California? Some have argued that surgeons have performed many more surgeries to make up for the lost revenues. This is a limited response... there are only so many lumbar stenoses out there. Another trend suggested by the controversial retrospective review of spinal stenosis surgery by R.A. Deyo and others<sup>1</sup> is the inflation of surgical coding and the expansion of surgical complexity.

A resident colleague of mine years ago coined the aphorism "why do a small case when a big case will do?" Now-a-days a simple cervical discectomy easily becomes coded as a cervical corpectomy...who's to say at what point drilling out the disc space with a diamond tipped drill passes from 63075 to 63081? More interesting is the trend in performing more dramatic, drastic procedures when more simple procedures will suffice.

### January 14-16, 2011 CANS Annual Meeting San Francisco

#### Bring your office staff on Sunday for EHR (Electronic Health Records):

- Its implementation
- Funding
- Pros and cons

(see page 3 for more meeting details)

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One opening shot across our surgical bow was the recent retrospective review of surgery for spinal stenoses cited above. This review was gleaned retrospectively from Medicare data and published in JAMA a few months ago. In brief, over the study period the number of operations for spinal stenosis did not increase, yet the fusion rate increased 15%. In this retrospective study there occurred more complications, deaths and costs. Difficult to attribute to the increased complications to the actual fusion procedures themselves from the retrospective data... but the feds are listening.

We are all challenged by compensation deflation. Many meet this challenge by taking more call, some by stretching the billing code envelope (and reviewer credulity). Hopefully fewer will carry out unnecessary surgery.

How should we all meet this continuing challenge? At the macro-level we should support our national political representatives who value the service of neurosurgeons. I am talking Republican and Democratic politicians and not AANS and CNS politicians! Let's face it, the macro level is very expensive and inefficient. OK, probably valueless.

Secondly we should support our subspecialty organizations in their efforts to change billing compensation. This is a very important effort we all can make. Witness the recent experience outlined in Neurosurgery with compensation efforts for payments for neurosurgeons performing radiosurgery. Kudos to John Adler, Doug Kondziolka and others for representing neurosurgery in radiosurgery compensation. Each interest group, such as pediatric, spine, trauma, tumor, etc. has its own issues which cannot be addressed by our national organizations. Take up the initiative as special groups.

Finally, all neurosurgery is local. We have a monopoly on neurosurgical care of ER and trauma patients. We remain a crucial ingredient in trauma programs throughout our cities, counties and state. Our recent survey of California neurosurgeons shows a need to inform our members of their value is participating in this important service and the fact that we are undervalued by most emergency room and trauma facilities in California.

Let's replace my fellow resident's aphorism with "local is better," or "less is more". The former is mine; the latter is Mies van der Rohe's.

1. *JAMA* 2010, 303 (13):13009 1259-1265 ❖

### Going Digital—or not

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

No reader of this newsletter can be unaware of the Electronic Health Record (EHR) brouhaha in this country particularly as such records relate to the Federal program to assist docs in installing such a capability and using them "meaningfully." The Federal help amounts to 44K between 2011-2015 for docs who comply and treat enough Medicare patients. It is 63K if one treats enough Medi-Cal patients but few if any neurosurgeons would qualify for that. There are 15 Core items and 5 Menu items one must perform to qualify. Failure to get on board will result in a small decrease in Medicare payments beginning in 2015. No one believes the 44K will actually cover an EHR conversion.

Although all the returns are not in, it is probable that having a real EHR system in the office will reduce errors, make your life easier once installed and comprehended and save some money though not necessarily any of your money.

Now, nearly 80% of docs practice in a group of 6 or fewer physicians who can be expected to not be sitting on a lot of cash. Kaiser in California has completely converted to EHRs at a cost in the ten figure range and though they should qualify for the Fed subsidy, it is unlikely to cover even half of their costs. Their system should work well with a captive doc cadre and clinics and hospitals only used by them. Docs in small groups don't have that kind of capital and they frequently use multiple hospitals, each of which will have their own idea of EHRs. Even if your main hospital assists you in installing an EHR system, it surely won't be compatible with the systems your other hospitals use and if your IPA helps you out, the system probably won't work with all the doctor offices with which you deal and who are not in the IPA. All in all, it sounds like a major pain in the behind.

So, what should your small group do beyond letting your main hospital set up, ay no cost to you, a system so you can access hospital stuff like lab results and diagnostic studies? You might consider doing nothing. For those members of your small group who are in their 50s or beyond, by the time the Feds get nasty about not having an EHR, you will be retiring--all the richer for not having shelled out a bunch of cash the benefits of which you will not see. For small groups with docs in their 30s and 40s, save your money and whenever it suits you, sell the group to an IPA or a foundation making the installation of a true EHR their problem and cost which they should accept because they want to lock your group in their fold. Either way, your next 10 years should be at least bottom line happier.

Alternatively, particularly if you think your independent small group practice will continue to survive and be a viable practice option over the next few decades, play ball with the Feds, go through all the hoops and dollars to become a true electronic practice. We all wish you well. You will be bucking a trend that has enveloped the personal computer, supermarket, airline, hardware and egg production industries—consolidation.

The Feds think we doctor cats can be herded if they create enough bush beaters. We shall see.

(Editor's note: There will be a half day program regarding EHR at the CANS annual meeting in January of 2011 where, along with a number of other EHR topics, the pros and cons of playing with the Feds will be presented.) ❖

## Make plans now to attend the CANS 2011 ANNUAL MEETING

Ritz-Carlton Hotel, San Francisco January 14-16, 2011

### *“The Future of Your Neurosurgical Practice after Health Care Reform”*



Reservations can be made by phone (800-241-3333) or via the link below:

<https://www.ritzcarlton.com/en/Properties/SanFrancisco/Reservations/Default.htm?gc=cnsensa&nr=1&ng=1>.

The contracted hotel room rate of \$225 is available from Thursday January 13 through Monday January 17, 2011.

### Attention: EXHIBITORS

**F**or those of you who participated in the CANS January meeting in Anaheim, thank you for contributing towards its success. CANS has over 400 members in academic, private practice and residency. These neurosurgeons and our business colleagues who support our efforts with innovative equipment, insurance products, office software and the vast panoply of other supporting products face a great challenge in the coming era of the new federal health care legislation.

We will meet this challenge, and we hope you can help us. Next year we will convene at the Ritz-Carlton Hotel in San Francisco on January 14<sup>th</sup> to 16<sup>th</sup>. The theme of the meeting is *“The Future of Your Neurosurgical Practice after Health Care Reform.”* Together we can inform our members of future socioeconomic issues related to these new laws and provide an opportunity to interest neurosurgeons in your health care products.

You will have an opportunity to interact with California neurosurgeons during the evening reception on Friday, January 14<sup>th</sup>, during the meeting sessions on Saturday and perhaps Sunday morning if this fits your needs. We also invite you to the Saturday evening banquet to enjoy dinner with our members.

Click here for exhibitor invitation and agreement forms: <http://cans1.org/AnlMtg2011/AnlMtg2011intro.htm>

## Editorial: California Legislative Review

*John Bonner, M.D., Associate Editor*

The time for fiscal committees to consider business has passed, so all fiscal bills that were not considered are dead for this session. These include CMA-sponsored bills such as AB 2470 (DeLaTorre) protecting our patients from unlawful rescission of health insurance, AB 1602 (J.Perez) and SB 900 (Alquist/Steinberg) establishing two legislative vehicles for Health Insurance Exchange in California that would limit taxation on insurers and require more legislative oversight. This is required by Federal law, but opposed by the insurance industry without amendment. Bigger government always seems to be a turn off. Smaller health plans appear to end up with a disadvantage.

Insurance rate hike proposals continue to be controversial, especially after the Blue Cross Anthem meltdown, with a bill by Senator Mark Leno requiring insurers to justify rate increases (complicating the market place process) and another by Assemblyman Dave Jones giving state regulators control over potential rate hikes. The Governor has proposed actuaries to review any such rate hikes. The CMA is rightly concerned that such rigid rate control would result in a squeeze on physician and hospital reimbursement rates. Evidently the federal health care reform mandated that 80% of insurance revenue be spent on patient care, which could mitigate any such fee squeeze.

The integrity of the corporate bar of medicine remains at risk with AB 648 (Chesbro) being reconsidered while SB 726 (Ashburn) remains eligible for passage. (Hopefully AB 2093 [M.Perez] providing adequate vaccine reimbursement, which was passed last week, will be signed into law).

SB 227 (Alquist) was signed by the Governor, taking effect immediately, setting up the Federal Temporary High Risk Pool (FTHRP) program to draw down federal health reform for high risk pool individuals. Those with preexisting conditions may purchase coverage. This bill was a companion measure to AB 1887 (Villines).

Other potentially destructive, or possibly helpful, legislation remains to be acted on -- too numerous to be reviewed in detail. Several CMA-supported bills are alive and well; but the legislative session is supposed to end on August 31, 2010. If bills are not acted on by then, they die.

**Obama Care** appears not to be doing well, with even a CNN poll indicating 56% of Americans oppose it, only 40% supporting, which is no different than polls at the time the legislation was passed. The Saturday/Sunday, August 21-22, 2010 Wall Street Journal illustrates that the new national health plan, despite congressional and administrative efforts, has not become more popular since it passed. In fact it has lost ground, and efforts to convince the population that it will reduce costs and deficits appear to have been abandoned. Evidence of the unpopularity of the new national health care program may be seen in the unexpectedly small number signing up for the new health insurance under the federalized program for uninsured people with health problems. Even former President Bill Clinton conceded that Obama Care was unpopular, but advised his party members to "put the corn where the hogs can get to it," which I consider a deprecating reference to we the public, suggesting that if the explanation of the plan was simplified, explained more clearly and simply, we the voters (evidently the hogs) would come around. Clinton appears also under the delusion that the Republicans took the House in 1994 as a punishment for Hillary Care not being passed by the Democrats. It would appear to me that the new health care program could possibly be rescinded or watered down by the next Congress, depending on the results of the next election. This does not mean that health care does not need to be improved or revised. I especially believe that the quality of mental health care needs to be improved. ❖

**Quotation for the month:** From an August 12<sup>th</sup> commentary in the NEJM by Danielle Ofri, a primary care doc at NYU in which she laments the individual doc "quality scorecard."

"Doctors who actually practice medicine — as opposed to those who develop many of these benchmarks — know that these statistics cannot possibly capture the totality of what it means to take good care of your patients. They merely measure what is easy to measure." ❖

## Brain Waves

*Deborah Henry, M.D., Associate Editor*

“You should tell them you need a bigger office,” a patient recently said to me after a consultation in my office at the clinic. The shared office space has all the essentials: a computer, printer, fabricated desk, place to put my lunch I always bring, antiquated X-ray view box, two Office Depot chairs, and a trash can. I can squeeze a wheelchair in the room if I don’t close the door. It is perfectly functional. But the thought of those with a bigger office ran through my mind.

I have sat in two large offices of lawyers in my time. One must have been at least a thousand square feet and over-looked the entire downtown Los Angeles. The other lawyer office was a glassed-in corner view of the Pacific Ocean in Long Beach. Of course I’ve sat in a few small lawyer offices too that seemed like mine in private practice – books, journals and papers vying for space on an over-worked desk.

My first office in Temple, Texas looked like a study carrel at the library. Bookshelves and desk were a single unit. There was barely room for a loveseat. I could take a quick nap in the evening waiting for a case with my legs strung over the side.

My private practice office had dark wood paneling. My first desk there I still have. I think it belonged to Ted Kurze and is a solid something-or-other wood with Army green leather inlays on the top. It had a matching chair that I long ago gave to Goodwill. Couldn’t take that green color.

Kaiser gives you the standard white desk, sort of a product from the Clone Wars. This office too was quite functional, but was often shared with others when you weren’t around. It reminds me of how little we clean our telephones and computers.

My non-clinical office at Loma Linda may be the biggest office I have ever had. It has a nice Office Depot desk and standard issued chairs, built in bookshelves and a view of the San Bernardino Mountains when the day is clear.

I type this article from my office at home late on Sunday night. I have always needed a home office in order to organize my thoughts. In the daylight, it overlooks the water on the backside of Balboa Peninsula. In the dark, there is little to see except for house lights and the gleaming pink lights of the Royal Thai restaurant. Interesting, no matter what office I am in, I rarely take the time to look out the window. It must be that the most important thing about an office is what gets done within the walls. ❖

## TIDBITS from the Editors

### Peer Review Privacy Comes Under Attack in Los Angeles

Los Angeles County supervisors are battling to obtain peer review records of doctors from Olive View-UCLA Medical Center hospital according to the *Los Angeles Times* (Saturday, August 28, 2010, AA1-2). The supervisors state they needed the information on the neonatal unit in order to evaluate patient safety and justify settling malpractice claims against the county. The peer reviews from the neonatal service in the preceding year were made available to the supervisors who concluded that adequate peer review was taking place. Subsequently, supervisors Michael Antonovich and Gloria Molina requested to see all peer review cases from the hospital over the past two years.

According to the *Los Angeles Times*, the county faced fewer lawsuits in recent years, but has paid out 12 million dollars- compared to 8 million in 2007. Two large settlements, one of 5.9 million in 2008 and another of 4.5 million in 2007 involved alleged delayed delivery of infants who sustained brain damage. Supervisor Molina states that these peer records need to be reviewed by the Department of Health Services in the interest of patient safety and to substantiate the malpractice settlements. If additional peer review records are released, it conceivably may set a precedent for release of peer review records at other hospitals thus eroding the sanctity of the peer review process. ❖

## Letter from Mrs. Pevehouse

Following the death of our esteemed colleague Byron Cone Pevehouse, CANS President Ken Ott wrote to Mrs. Pevehouse and she responded. Both missives are reproduced below.

Dear Mrs. Pevehouse,

It was with great sadness that we learned of Cone Pevehouse's passing this past week. Let me express my deepest sympathies to you and your family. Although I only met him a few times, I was struck with his humility and considerable leadership skills. He had a great many close friends who continue to contribute to the CANS board and fondly recall his many contributions to neurosurgery in general and California neurosurgery in particular. We continue to have great respect for him.

In recognition of Dr. Pevehouse's achievements we instituted the Byron Cone Pevehouse Award of the California Association of Neurological Surgeons which is presented to a neurosurgeon who has greatly influenced our science, art and craft in California. This is a fitting and enduring memorial to Byron Cone Pevehouse.

Please accept the condolences of the board and members of CANS.

Yours truly, Kenneth Ott, MD, FACS, President

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Dear Dr. Ott:

Thank you for your kind words in expressing your sympathy on Cone's passing.

It is indeed a terrible loss to all of us. I know Cone was pleased, yet humbled, that CANS instituted an award in his name.

Thank you for sending the CANS newsletter with the splendid commentary by Dr. Smith. I am sending copies to his children.

Thank you again for your kind words.

Sincerely, Lucy Pevehouse

## UnitedHealth Group settlement info from CMA.

Don't miss the chance to claim your share of the \$350 million UnitedHealth Group settlement. The settlement is the result of a class action lawsuit, initially filed in 2000 by the American Medical Association and other health care provider and patient groups, alleging that United conspired to defraud consumers by manipulating out-of-network reimbursement rates, shortchanging physicians and patients by hundreds of millions of dollars over the past 15 years.

The deadline to submit claims for payment from the settlement fund is October 5, 2010. Physicians are eligible to file for damages if they provided covered out-of-network services or supplies between March 15, 1994, and November 18, 2009, to patients covered by UnitedHealth or its subsidiaries, including PacifiCare. Physicians may recoup underpayments for out-of-network services provided to PacifiCare subscribers at any time during the claim period, even before PacifiCare became a subsidiary of United.

Physicians will be paid according to their total "recognized loss" between 1994 and 2009, which is calculated by determining the difference between a physician's billed amount and the "allowed amount" that United actually paid for covered out-of-network services. If the total amount of submitted claims exceeds the settlement fund, physicians will receive a pro rata share based on their total recognized loss.

United has submitted data to the claims administrator showing all the payments it made (i.e., the allowed amounts) for covered out-of-network services from January 1, 2002, to May 28, 2010. Physicians can request a copy of their own claims data from the claims administrator. It may take several weeks to receive the report, so the sooner you request your copy, the better.

A hearing to determine final approval of the settlement is scheduled for September 13, 2010, in U.S. District Court in New York.

For more information about the settlement and what physicians need to do to claim their share, visit the California Medical Association's [settlement resource center](#). There physicians can find CMA's United Healthcare/Ingenix Settlement Guide, claim forms, and a number of other helpful resources. ❖

## ACO and Foundation info from CMA

### *Accountable Care Organizations (ACOs)*

Congress authorized ACOs, which are intended to create incentives for physicians who work together to coordinate care, improve quality and reduce unnecessary costs at the local level for a specific population of Medicare patients. Bear in mind that the final rules of how ACOs will operate depends on regulations that have yet to be written at both the federal and state levels. The ACO concept couples payment and delivery system reform. ACOs are paid through a shared savings payment approach. ACOs allow physicians to be jointly rewarded for the efficiencies they achieve in both the Medicare Physician Part B and the Hospital Part A programs. Physicians in ACOs will continue to bill Medicare under the traditional fee-for-service program. If an ACO reports on quality measures and achieves savings by meeting a cost benchmark, Medicare will share a portion of the cost savings with the ACO. ACOs must have a legal and administrative structure to distribute the savings to physicians.

ACOs do not have to involve a hospital and may be physician-led and comprised of physicians only. CMA fought very hard to maintain such physician autonomy in the legislation. ACOs can be primary care or multi-specialty medical groups, or they can be IPAs or other networks of individual physician practices, all with or without integration with hospitals. The ACO must, among other things, establish a mechanism for shared governance, and agree to be accountable for cost, quality and the overall care of the Medicare patients assigned to it. ACOs must participate in the program for at least three years, and must have an adequate network of primary care and specialist physicians to serve at least 5,000 Medicare patients. While Congress only contemplated a fee-for-service model, some medical groups are asking Medicare to expand the program to allow capitation.

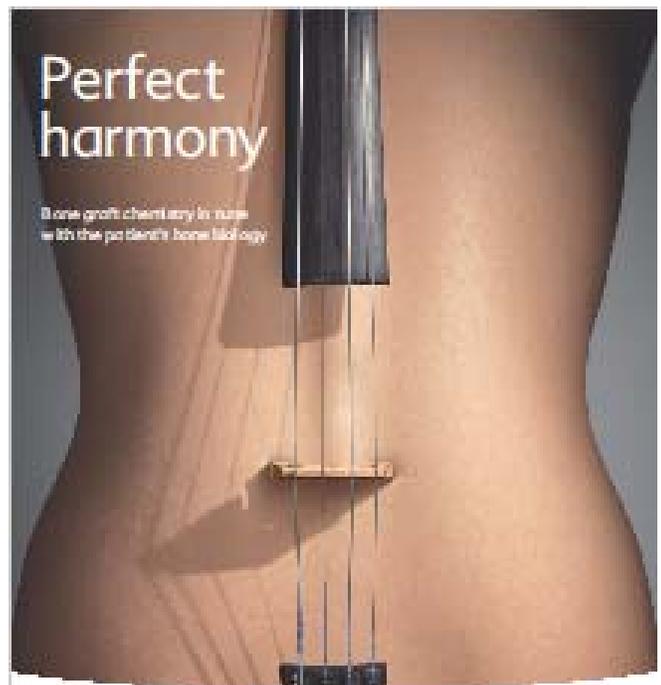
The creation and operation of an ACO could require substantial clinical, technical and financial resources. While creating an ACO or joining one may sound like a daunting task, the ACO concept is not new in California. Many California physicians have been at the forefront of designing physician-led, patient-centered medical group/IPA delivery models, which effectively function as ACOs already. CMA will rely on this experience and expertise, to ensure that as members, you have the necessary tools and information to make the right decisions about your practice.

ACOs could also provide a path to anti-trust relief for physicians in the private sector. Some physicians are forming ACOs to eventually negotiate and contract with private payers.

The Federal Trade Commission (FTC) has allowed medical groups that meet certain standards for clinical integration, to collectively negotiate with private payers. FTC Chairman, Jon Leibowitz, recently stated that he does not see much enforcement risk with respect to ACOs in the Medicare program, and he believes there is room for ACOs to use joint contracting with respect to private payers, as long as they comply with the FTC's well-established financial or clinical integration guidelines. ACOs could be financially integrated by virtue of distributing a shared savings, and clinically integrated through systems such as electronic health records, collaborative referrals and quality reporting. Of course, the FTC will be monitoring ACO market power in the private sector.

### *1206(l) Medical Foundation Model*

In an effort to capture the potential cost savings of ACOs, provide capital to physician practices, and/or compete with physician groups, some hospital systems and their associations are seeking to create hospital-led 1206(l) Medical Foundations. Contrary to the current trend, foundations can be, and often are, physician-led and not necessarily affiliated with a hospital. Indeed, Health and Safety Code Section 1206(l), which codifies the foundation law, was adopted to



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benefit two non-profit, multi-specialty physician-controlled medical clinics and the communities that they serve. The 1206(1) law exempts a clinic from the clinic licensing law if it is operated by a non-profit corporation that "conducts medical research and health education and provides health care to its patients through a group of 40 or more physicians and surgeons, who are independent contractors representing not less than 10-board-certified specialties, and not less than two-thirds of whom practice on a full-time basis at the clinic."

While the exemption was enacted to provide benefits to the communities that they serve, the Medical Foundation model is sometimes used as a hospital-physician alignment strategy in order to, among other things, address declining reimbursements and increased financial pressures, and improve quality of care. Unfortunately, today some hospitals are seeking to inappropriately apply the foundation model to gain control over physician practices, since they have failed to change state law to employ physicians and are facing increased financial pressures. ❖

## Another of the thousand cuts

A month doesn't seem to go by without another mandatory requirement coming into play to make our practice of neurosurgery just a little more irritative. This month we highlight new documents necessary for your current and future employees regarding your Work Comp insurance. Taken from a WorkCompCentral article:

*California employers need to freshen up their stocks of new-hire pamphlets and workers' compensation notices and posters by Oct. 8, when new state regulations take effect. The rules require employers to provide an updated version of the workers' compensation new-hire pamphlet to all employees hired on or after that date, post revised workers' compensation employee posters, provide an updated version of the DWC-1/Notice of Potential Eligibility to injured workers and post new medical provider network (MPN) notices, according to a bulletin issued by the California Workers' Compensation Institute. The revised requirements in California Code of Regulations Section 9767.12 require that MPN notices be posted in both English and Spanish in a conspicuous location.*

*The CWCI also says "Because the details on this 'complete written MPN employee notification' are MPN-specific, claims administrators are scrambling to make sure these notices are ready for employers to post by the Oct. 8 effective date," CWCI said. "In addition, however, the recently adopted regulations require MPN information to be added to the workers' compensation new-hire pamphlets, the general workers' compensation posting notices, and to the DWC-1/NOPE, so all of these materials are also being revised to reflect the new rules that take effect in less than two months."*

*Failure to provide the required information can result in loss of medical control for employers that use an MPN, bring civil penalties of up to \$7,000 for each violation of the posting requirement, and toll the statute of limitations on claims, CWCI said.*

*Contacting the Work Comp insurance carrier your practice uses may be enough to get all the handouts you need. If not, then CWCI is in the process of revising the mandatory posters, notices and pamphlets and will make them available for sale through its online store before the Oct. 8 effective date. Employers that need the materials may go to <http://www.cwci.org> to place pre-orders. (They can't prepare a MPN list for you; that has to come from your carrier.)* ❖

### **Meetings of Interest for the next 12 months:**

#### **CANS: Board Meeting, October 2, Los Angeles, CA**

North American Spine Society: Annual Meeting, October 5-9, Orlando, FL

Western Neurosurgical Society: Annual Meeting, October 8-11, Santa Fe, NM

CSNS Meeting, October 15-16, San Francisco, CA

Congress of Neurological Surgeons: Annual Meeting, October 16-21, San Francisco, CA

Cervical Spine Research Society: Annual Meeting, December 2-4, Charlotte, NC

#### **CANS: Annual Meeting, January 14-16, 2011, San Francisco, CA**

Southern Neurosurgical Society: Annual Meeting, February 23-27, 2011, Orlando, FL

Neurosurgical Society of America: Annual Meeting, March 27-30, 2011, Island of Hawaii, HI

CSNS Meeting, April 8-9, 2011, Denver, CO

AANS: Annual Meeting, April 9-13, 2011, Denver, CO

New England Neurosurgical Society: Annual Meeting, June 11-12, 2011, Chatham, MA

Rocky Mountain NS Society: Annual Meeting, June 18-22, 2011, Taos, New Mexico

### 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). ❖

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 newsletter issues are available on the CANS website at [www.cans1.org](http://www.cans1.org).

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*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. Ken Ott 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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