Chair’s Message

Dr. Joe Cheng, MD

As I finish my first year as Chair of the CSNS, I am sure we would all agree that it has been a year like no other in our careers. We continue to face unprecedented challenges in healthcare with a strain on our neurosurgeons and other members of our healthcare team. And sometimes it is hard to feel that we are truly a part of a team as politics, economics, cultural and ethical fissures arise to isolated us. As was noted by our Covid pandemic, wearing a mask or not was no longer based on scientific and epidemiological evidence, but by philosophical ideas and political viewpoints. No wonder we saw the sharp rise of physician burnout, with a sense of powerlessness as we work to provide care to our patients who were nor either more critically ill from the pandemic or blocked from the needed care due to hospital capacity, while we worry about the financial implications to our practices and the livelihood of our staff who depend on our clinical work.

As we return to in person meetings and work, as Covid hospitalizations minify, I look forward to also returning to our endeavors in organized neurosurgery with our keen focus on improving access and care to our neurosurgeons who they depend on. While we all have become experts on video conferences, Face Timing, and completing work via texts and e-mails, there was also something fundamentally inefficient in working this way along with fostering miscommunications with messages being taken out of context without the body cues and language in our committee and debate process. While it was amusing to say our most common phrase was “you’re on mute”, it also highlights how meanings were lost as we work through challenging healthcare policy discussions. Our volunteer neurosurgeons already sacrifice time away from their family and work, and additional frustrations with communications does not foster that sense of accomplishment as they work on all our behalf.

I do look forward to my second year as Chair of the Council of State Neurosurgical Societies (CSNS) and working with our dedicated volunteer neurosurgeons proving a grass roots voice to the practicing neurosurgeon, focused on facilitating access and care for our patients with neurosurgical disease. The CSNS is an amazing group of dedicated individuals, and I am enthusiastic about what I will see in the coming year from these leaders in organized neurosurgery and medicine. The Council of State Neurosurgical Societies continues to play a critical role in organized neurosurgery advocating for our field and patients!

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Going Back to Our Roots

Dr. Luis M. Tumialán, MD

The Council of State Neurosurgical Societies concluded a successful meeting at the AANS in Philadelphia. With the submission of 16 resolutions and one emergency resolution, our organization was back to its roots debating, advocating and deliberating in person the various issues that affect neurosurgeons around the country. Thirteen of the 17 resolutions were adopted after passing the scrutiny of the reference committee and withstanding another day of testimony. Now the work of the CSNS begins. But alongside that work is the continued realization that the CSNS, which is the most resilient organization I have been privileged to belong to, needs to evolve again. That evolution needs to be framed in the con-
In an effort to respond to the needs of AANS members, the AANS leadership explored a different timeline for the 2022 meeting. The unintended consequence was a narrower time window for the CSNS to complete its core mission, namely resolution testimony, debate and voting along with the committee work. Not only was the time window narrowed, the compacted meeting schedule created an environment where many CSNS members needed to be in two places at once, if not three. Regardless, in usual fashion, the CSNS accomplished all of its tasks while engaging fellows and introducing medical students into the socioeconomics of neurosurgery. For the first time since the beginning of the pandemic, we were back to our core mission in a plenary hall, in person. Under the leadership of Drs. Michael Steinmetz and Joseph Cheng, we had accomplished that feat via Zoom, an unthinkable concept prior to the pandemic. Again our resilient organization adapted to the circumstance. What was clear from this Thursday and Friday, nothing replaces our ability to fulfill that task in person. It was good to be back.

In between now and the fall CNS meeting, the CSNS socioeconomic fellows and members will assemble a position statement regarding the criminalization of medical errors and omission, responding to a recent judgement that found a nurse criminally responsible for a medical error that led to a patient’s death. Fellows and members will also examine the factors that detrimentally impact the ability to create a sustainable reimbursement for the physician workforce of the future, examining in particular the impact of inflation and practice costs. A Diversity Task Force has been created to identify ways to address increase diversity in the CSNS and in all of neurosurgery. The AANS opening session with Michael Bush and Jerome Bettis only validated that resolution even further. And there is so many more resolutions and so much more work at hand. The pandemic may have taken some of our momentum away, but when we went back to our roots with our meeting in Philadelphia, we gained it all back and then some.

Accomplishing all our objectives for this meeting was a very good and badly needed morale builder. But at the same time, we need to pause for a moment and have a thoughtful deliberation for the AANS in Los Angeles in 2023. One thing is certain, the CSNS will modify, adapt and overcome whatever barrier presents itself. The core mission of our work is too important. Our organization is equivalent of the House of Representatives, where the voices closest to a problem can be heard, the problem identified and defined and action taken. The synergy between the Washington Committee, Coding and Reimbursement Committee and all of the Sections has demonstrated the tremendous value that the CSNS bring to Neurosurgery. In the coming weeks, we will all reflect on the manner in which we will approach AANS in 2023 and the path forward will become obvious. But for right now, with all of the meaningful ideas generated in Philadelphia its back to the work of our organization. We are going back to our roots.

Coding & Reimbursement Committee Update

Dr. Akal Sethi & Dr. Anand Veeravagu

The spring Coding and Reimbursement Committee meeting during the CSNS meeting was a pleasant return to normal procedure. With 17 members in attendance there was a lively discussion over several key issues. After discussion of the resolutions for this meeting the group delved into CPT issues. Specifically, a new code for MIS SI fusions has been delayed due to a small percentage of neurosurgeons performing the procedure. We will continue to work with ISASS in developing a new code.

Further discussion ensued over the CPT code change application for a skull mounted generator ie those used in RNS, which is still in process. An interesting point was brought up regarding the value of intensive care performed by the neurosurgeon after an operation for neuro-trauma. The provider should be compensated outside of the operative procedure, but this remains unclear for many. The CRC will work to further identify areas of improvement.

Finally, the CRC will be working on a new position statement regarding SRS being performed the same day as operative resection. This is an evolving trend nationwide and warrants further investigation.
Washington Update

Katie O. Orrico, Esq., AANS/CNS Senior Vice President for Health Policy and Advocacy, provided CSNS meeting attendees with a Washington update. One of organized neurosurgery’s legislative priorities is reforming **prior authorization**. After four years of sustained advocacy, Congress is poised to adopt legislation to streamline prior authorization in the Medicare Advantage (MA) program. The *Improving Seniors’ Timely Access to Care Act* (S. 3018/H.R. 3173) has more than 300 bipartisan co-sponsors and, if adopted, would:

- Establish an electronic prior authorization program with a process for real-time approval for services that are routinely approved;
- Require plans to report to the Centers for Medicare & Medicaid Services on the extent to which MA plans use prior authorization, including the rate of approvals or denials;
- Ensure prior authorization denials are reviewed by qualified medical personnel; and
- Require prior authorization programs to adhere to evidence-based medical guidelines.

She also informed the audience that so-called “Gold Card” legislation would soon be introduced in the House of Representatives. This bill would allow physicians who received prior authorization approvals greater than 80% of the time to bypass prior authorization by MA plans.

The AANS and the CNS, as founding members of the Surgical Care Coalition, were successful in mitigating a 9% **Medicare payment cut** in 2022. This expected cut was due to the following:

- Expiration of a 3.75% payment adjustment to Medicare Physician Fee Schedule conversion factor;
- Expiration of the moratorium on the 2% Medicare payment sequester; and
- Implementation of a 4% statutory Pay-As-You-Go Act cut.

In late December 2021, Congress passed the *Protecting Medicare and American Farmers from Sequester Cuts Act*, which prevented 7.75% of the 9% cut. Ms. Orrico informed the group that, once again, the AANS and the CNS would be contributing to the Surgical Care Coalition’s public communications and advocacy campaign to prevent ongoing Medicare payment cuts. The 2023 campaign will launch in May.

Efforts to implement the *No Surprises Act* (NSA) continue. Passed in December 2020, the NSA prevents surprise medical billing and establishes a process for resolving **out-of-network payment** disputes. Ms. Orrico noted that the independent dispute resolution process rules create a presumption that median in-network rates are appropriate contrary to the NSA statute, which mandates that arbiters consider multiple factors, including the complexity of the patient’s condition, experience of the physician, prior contracted rates as well as median in-network rates. Numerous provider organizations have sued the Biden Administration to reverse this rule. In February, a federal district court in Texas ruled in favor of providers in the *Texas Medical Association v. IHHS* lawsuit, reinforcing that the median in-network rate is only one of several factors to consider resolving a billing dispute between an out-of-network provider and an insurer. Ms. Orrico also noted that the American Medical Association (AMA) and American Hospital Association (AHA) filed a similar lawsuit in federal district court in Washington, DC. The ruling in that case is pending. The AANS and the CNS and Physician Advocacy Institute, along with seven national specialty societies and 16 state medical societies, led an amicus brief effort supporting the AMA/AHA lawsuit.

The AANS and the CNS continue advocating for additional Medicare-funded **graduate medical education** (GME) positions. Medicare funding for GME has been capped at 1996 levels until recently, when Congress authorized spending for another 1,000 residency training slots in the *Consolidated Appropriations Act, 2021*. Legislation is currently pending before the U.S. House and Senate, and with nearly 200 bipartisan co-sponsors, the **Resident Physician Shortage Reduction Act** (S. 834/H.R. 2256) would provide funding for an additional 14,000 Medicare-supported GME positions.

Ms. Orrico issued a call to action for neurosurgeons to join the **AMA** to ensure that neurosurgery maintains its seats in the House of Delegates (HOD). The CNS is at risk of losing its place in the AMA HOD because only 18% of CNS members are also AMA members — and at least 20% must be AMA members. She pointed out that membership in the AMA HOD benefits neurosurgery in the following ways:

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Washington Committee Update
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Allows for representation at the CPT Editorial Panel and AMA/Specialty Society RVS Update Committee (RUC);
Provides neurosurgery with a voice at the HOD, allowing the AANS and the CNS to influence AMA policy favorable to neurosurgery; and
Affords neurosurgery with the ability to appoint neurosurgeons to serve on the Review Committee for Neurological Surgery and other important professional organizations involved in regulating physicians.

CSNS members were encouraged to join or renew their membership in the AMA.

Going Back to School at Age Fifty-Five

Dr. Catherine A Mazzola, MD, FAANS

I am a pediatric neurosurgeon in northern New Jersey; I started my practice (New Jersey Pediatric Neuroscience Institute) in 2009. I became a single parent when I was 19 years old, kept my collegiate academic scholarship, graduated with a GPA of 3.86 and obtained a scholarship to New Jersey Medical School (NJMS). After medical school, I finished my neurosurgery residency at NJMS, and completed a one-year Fellowship in Pediatric Neurological Surgery. As both a single-mother and a female neurosurgeon, I have encountered many challenges. I became involved in organized medicine in 2002, through the Council of State Neurosurgical Societies (CSNS) and the Congress of Neurological Surgeons (CSNS). I have been an advocate for physicians, patients and diverse communities. I have published extensively about many of the medicolegal and socioeconomic aspects of neurological surgery, and I have been involved as Chair of our national American Association of Neurological Surgeons (AANS) Ethics Committee and Medicolegal Committee. I enjoy teaching and have lectured and taught at many universities; I currently teach young neurosurgery residents and medical students at Rutgers University Hospital.

I am mother to five children, and I live in Franklin Lakes, NJ. My youngest daughter, Rosemary, is now in eighth grade. I have been thinking about applying to law school for approximately two years. Over the past decade, as a physician and surgeon, I have witnessed changes in the practice of medicine that have challenged and negatively affected several great doctors. Many physicians were not able to adapt to increasingly complex government mandates, confusing technological advances, and decreasing reimbursement from major insurance companies. Entering into contractual agreements with payors and healthcare networks has become necessary for many practices to survive, yet too often, physicians sign contracts without reading, understanding or negotiating the elements of the contract. Additionally, I have seen many female physicians and other minority group healthcare providers who were taken advantage of in numerous ways. I have been incredibly involved in the politics or organized medicine on local, county, state and national levels. I have been an advocate for physicians within many organizations and have mentored and taught many undergraduate and graduate students, as well as young neurosurgeons. How-

Finally, Ms. Orrico reported that the 2022-23 Washington Committee/AMA fellows had been selected. The fellowship provides neurosurgical residents and fellows an opportunity for a richer, more diverse and actionable experience in health care policy and advocacy. Laura Stone McGuire, MD, a PGY-7 resident at the University of Illinois at Chicago, will serve as the primary fellow and delegate to the AMA’s Resident and Fellow Section (RFS). Michael J. Feldman, MD, a PGY-6 resident at Vanderbilt University, was appointed as an alternate fellow and will serve as an alternate delegate to the AMA’s RFS. Aladine A. Elsamadicy, MD, a PGY-4 resident at Yale University, and Jordan C. Xu, MD, a PGY-5 resident at the University of California, Irvine, were also selected as alternate fellows.

“I am quite excited and am eager to learn more about case law, legal writing, tort and all other aspects of law.”

-Dr. Catherine Mazzola

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ever, I would like to receive a true legal education so that I can better represent physicians and patients in all aspects of medical and healthcare law.

I started studying for the law school admission test (LSAT) in the spring of 2021. I received LSAT study books as gifts from my family and enjoyed reading them through my preparation for the October 2021 LSAT. I completed my applications to Seton Hall Law and Rutgers Law School in January 2022 and I was accepted at both in the spring of 2022. I chose Rutgers Law and I will be starting night school in August of this year. I am quite excited and am eager to learn more about case law, legal writing, tort and all other aspects of law.

I would like to continue to be politically active within our local, state and national medical societies, but with a true legal education and background, I will be a better advocate and teacher. As I am turning 55 in July, I look forward to finishing law school by age 60. At that point, I will “slow down” in my active pediatric neurosurgical practice, stop accepting new patients, and only take one week per month of call. I love being a neurosurgeon and caring for children, but I will be the first to admit, operating from 1 am – 6 am and seeing a full day of clinic that same day really wipes me out! I am looking forward to reading and reviewing cases, while sitting in the shade, on the beach, on Sanibel Island.

2—https://thejns.org/focus/view/journals/neurosurg-focus/49/5/article-pE1.xml

Northeast Quadrant Update

Dr. Dorian Kusyk, MD

Our meeting was brought to order by the current NE Quadrant Chair, Dr. Clemens Schirmer. We reviewed the NE Quadrant CSNS fellow applicants and everyone voiced their approval on the quality of the applications. On the resolution discussion, the group uniformly supported the revisions and recommendations of the Reference Committee. In particular, the group appreciated the complexities that the Emergency Resolution tried to address – there were wide ranging concerns regarding the effects of the case in question on medical malpractice costs and policies, as well as the local variety that was found not only in the legal definitions of medical error, but also the willingness of lawyers to prosecute. Overall, everyone in the group agreed that the AMA and similar organizations need to take a strong stance against the criminalization of medical error.

The group discussed state council updates. Multiple groups expressed the difficulties of maintaining a membership during the pandemic without in person meetings. At the same time however, many individuals predicted that future organized events may revitalize interest. We also discussed some of the nuances of regional groups, in particular the New England Neurosurgical society. After clarifying delegate and membership rules, the group expressed hope that a larger society might further inspire more participation among neurosurgeons in the CSNS.

Finally, we also had a wide ranging discussion on health care monopolies and economics. Many members noted that local systems were consolidating, and that resulting in some monopolies suits being brought forward. Along the same line, many members expressed concern about the increase activity of venture capitalist investors acquiring neurosurgery groups. Overall, this seemed to play out poorly for neurosurgeons, though senior partners seemed to benefit a little more than junior members of purchased groups. Some spoke in favor of putting together a white paper regarding the dangers of accepting a venture capitalist take over, however this issue seemed to stray too closely to financial advice to have a uniform policy written about it.

The meeting was adjourned after completing after discussion AANS cabinet nominations and choosing Reference Committee members for the CNS meeting in the fall. The group’s next meeting will be a zoom state/stakeholder update meeting, which will meet every 6 months, off cycle from AANS/CNS.
Medicolegal Committee Update

Dr. Laura Stone McGuire, MD

The Medicolegal Committee put forth several resolutions at the Spring CSNS meeting and will be moving forward with the following projects. First, case minimum requirements and credentialing practices among hospitals generated much discussion during the plenary session, and following the passage of its resolution, the Medicolegal Committee will pursue a survey for neurosurgeons and hospitals to ascertain this practice and better understand its implications. Also, the Medicolegal Committee worked with Patient Safety Committee to propose a study the current practice and utilization of checklists in the operating room, barriers of safety, logging of time-in and time-out of neurosurgeons. This resolution passed and the survey results will be reported back to the CSNS at a future plenary session.

Resolution Update

Resolution 1: This resolution focused on childcare and pregnancy accommodations within neurosurgery residency programs. It was updated by the reference committee to become more workable, gaining widespread support and passing unanimously. As a result, the CSNS will survey neurosurgeons to see to what degree they would benefit from on-site childcare programs and parental leave.

Resolution 2: This resolution focused on cost awareness of neurosurgical trainees and faculty. There was discussion to clarify the definitions of cost and the actionable items in this resolution. It was ultimately referred back to committee for clarification.

Resolution 3: Initiated by Edie Zusman, this resolution dealt with concussion among victims of domestic violence. There was widespread support on this resolution, and it was passed. The CSNS will ask its parent organizations to draft a statement supporting concussion screening for victims of domestic violence.

Resolution 4: This resolution aims at evaluating practice preparedness among recent neurosurgery residency graduates. This resolution was widely supported and eventually passed unanimously. The CSNS will ask its parent organizations to work with the ABNS & SNS to survey board-eligible neurosurgeons every 5 years to assess preparedness for practice.

Resolution 5: This resolution sought to increase participation of the CNS/CSNS Medical Student Fellow. It ultimately passed after much discussion and, as a result, the summer fellow will be invited to serve on a one-year term to a CSNS committee of their choice. Attendance will not be mandatory, however.

Resolution 6: This resolution aimed to create a “Women in Neurosurgery Medical Student Fellowship” with WINS. There was much discussion regarding the authority of CSNS to follow through with this resolution. It was ultimately rejected.

Resolution 7: This resolution aimed to install medical students on the editorial board of the Journal of Neurosurgery. There was much discussion about this resolution but it was rejected.

Resolution 8: This resolution addressed the cost of conference attendance for medical students. Ultimately the language settled on reducing fees for medical students, but not eliminating them all together. This was passed with overwhelming support.

NTENS Committee Update

Dr. Joseph Domino, MD

The Neurotrauma and Emergency Neurosurgery (NTENS) committee continues to work on issues related to trauma care and coverage, and the interactions of neurosurgeons within the trauma system. The concussion screening in suspected domestic violence resolution which arose in the NTENS committee passed the resolution process and we look forward to following the continued progress. The continued efforts to establish and organize a Neurotrauma Consortium have yielded several initial manuscripts which are under review. We continue to explore a deep dive on the accreditation and verification of trauma centers. We had a robust discussion of new project ideas which include telehealth across state lines, frailty in spine trauma, and barriers to involvement in global neurotrauma organization/care.
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Resolution 9: This resolution aimed at determining case minimums for hospital credentialing across the country. It enjoyed vast support and was passed. As a result, the CSNS will survey hospitals and neurosurgeons to determine case requirements for hospital privileges nationwide.

Resolution 10: This resolution sought to develop a process for fellows and CSNS liaisons assist with socioeconomic content within the various joint section meetings. This resolution was rigorously debated, with concern that it was outside CSNS authority and that it might spread the fellows too thin. It was ultimately passed 24-18.

Resolution 11: This resolution aimed at creating a CSNS diversity task force. One of its two resolves was found to be unworkable and was removed. It ultimately passed with overwhelming support, creating the task force.

Resolution 12: There was much debate about this resolution which aimed to maintain engagement with unselected CSNS fellowship applicants. It was modified by the reference committee and ultimately passed. This will ensure applicants who are not selected remain involved with the CSNS and are encouraged to re-apply.

Resolution 13: This resolution sought to have the CSNS work with the American Heart Association and American Stroke Association to study emergency transport of stroke patients. It was felt this was outside the purview of the CSNS and it was rejected.

Resolution 14: This resolution aimed at studying the operative time out, checklists and how surgeons are logged in and out of the operating room. It had widespread support although there were some concerns regarding ramifications. It ultimately passed and CSNS will be developing a survey to this effect.

Resolution 15: This resolution had vigorous debate, but the underlying message was widely supported: CSNS must advocate for sustainable reimbursement of the physician workforce within Medicare. A substitute resolution was submitted with Ann Stroink ensuring the CSNS has the correct language to work with the AMA on this issue. This was passed with overwhelming support.

Resolution 16: This resolution aimed to assess bedside procedure timeout protocols nationwide. It was passed and, as a result, the CSNS will survey hospital practices on bedside procedure timeouts.

Emergency Resolution: This resolution was submitted in response to the recent trial where a nurse was found guilty of criminal misconduct due to a medical error. It was ultimately passed, ensuring the CSNS will develop surveys on how this will affect malpractice premiums. Furthermore, the CSNS will ask the AANS/CNS to develop a position statement on the criminalization of medical errors.

Patient Safety & Quality Committee Update

Dr. Joseph Domino, MD

The Patient Safety and Quality (PSQ) committee continues to pursue issues relating to patient safety, quality outcome metrics, and physician wellness. Our committee meeting was well attended, and we had excellent discussion surrounding the several resolutions tasked to our group. We discussed future directions and projects for the group which included interest in partnering with the NTENS committee to look at the impact of frailty in spinal trauma as it relates to outcomes similar to prior work which has evaluated this concept in degenerative spine surgery.

Upcoming Meetings

- PA Neurosurgical Society: July 22-23, 2022
- FL Neurosurgical Society: Aug 12-14, 2022
- MI Association of Neurological Surgeons: Aug 26-28, 2022
- OH Neurosurgical Society: Sep 10, 2022
Shaftel et al present an intriguing study on chronic subdural hematomas. They utilize the Nationwide Readmissions Database to examine readmission rates after craniotomy for evacuation of these lesions. There were 49,013 patients in the cohort, 10,643 of which had a readmission (21.7%). Notably, the readmission group was sicker at baseline, reflected by higher severity of illness, higher calculated risk of mortality, greater comorbidities, and longer length of stay. On multivariate regression analysis, the authors found that being admitted to a high-volume center, being discharged home, and having a middle/upper income level (51st-75th percentile) were associated with a lower readmission rate. Notably, the highest income rate also neared statistical significance for being protective against readmission. Multiple comorbidities (CHF, COPD, DM, cancer, renal failure to name a few) were also associated with readmission on regression analysis.

These results paint a picture: patients who are sicker at baseline and who are poor are more likely to be readmitted. All too often, increased comorbidities correlate with increased poverty. The income rates in this dataset are determined by average income for the patient zip code. However, for seniors, this is an imperfect measure, as many seniors move to assisted living facilities in zip codes that are not reflective of their overall socioeconomic status. Regardless, patients coming from a poor zip code were more likely to be readmitted than those that were not. Similarly, a home discharge is reflective of a patient’s social support (in addition to functional status). Again, reiterating the link between poverty and healthcare resource utilization.

In discussing how poverty drives utilization of health care services, Buz Cooper describes this phenomenon on a broader scale. “[Modern medicine] doesn’t work as well for patients who are burdened with multiple chronic illnesses, are socially isolated, and are handicapped economically, educationally, nationally and psychologically.” This quote is apt for the study by Shaftel et al. The readmitted patients appear to be burdened by multiple chronic illnesses, socially isolated and economically handicapped. The readmitted patients aren’t necessarily a failure of the medical system in which they were treated, but their readmission is a reflection of a greater societal illness. This paper is another piece illuminating that problem.