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THE AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS

AANS BULLETIN
The quarterly publication of The American Association of Neurological Surgeons
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Focus on the Future

Member Support for the Research Foundation can Help Assure Growth of the Specialty.

At the Board of Director's meeting held in April, I commended my predecessors on the outstanding work they have done to set in place strong socioeconomic and political advocacy programs, such as the AANS/CNS Washington Committee and the Council of State Neurosurgical Societies. These groups are functioning at levels beyond our modest expectations, and for that we should be proud.

With our successes in these two arenas well underway, I plan to focus the energies of the Association on several other program elements during the year ahead. Accordingly, I have selected five specific areas for attention that are critical to the future growth of organized neurosurgery and our role in the delivery of quality patient care.

Programmatic Goals

My first two programmatic goals are truly "no brainers." First, we need to remain committed to maintaining the Annual Meeting as the world's leading resource for the dissemination of cutting-edge research and socioeconomic information. Second, we need to take every step necessary to ensure that our scientific publication, the *Journal of Neurosurgery*, along with its online counterpart, *Neurosurgical Focus*, remain the standard by which all other neurosurgical publications are judged.

My remaining goals relate to: (3) expansion of the resources and activity of the Research Foundation; (4) enhancement of the role of our Sections in the deliberations and actions of the AANS; and (5) expansion and enhancement of the role of our Young Neurosurgeons Committee in the activities of the Association.

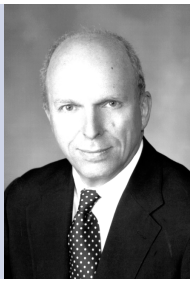
Research Foundation of the AANS

Of these goals, I wish to focus the remainder of this message on the Research Foundation. I choose to do so because I believe that it has the potential to reap tremendous benefits for the field of neurosurgery, as well as individual practitioners.

Investment in R&D is the only mechanism to assure the long-term growth and survival of a focused discipline. This fundamental truism is particularly important to us in neurosurgery, as we are poised on the threshold of some of the most exciting molecular and technical advances ever open to our practices and patients. Basic neuroscience research has recently focused upon efforts of translational import that will lead to clinical applications literally undreamed by all of us even in the recent past.

Some areas of fertile research that will impact the future of our practices include tumor molecular biology, vascular physiology, spinal biomechanics, cortical architectonics, and more. Each of these areas of research is poised to provide new opportunities for expansion of the neurosurgical armamentarium that will constitute our practices in the future.

Martin H. Weiss, MD, is President of the AANS and Professor and Chairman of the Department of Neurological Surgery at the University of Southern California's School of Medicine.



Think of the excitement and satisfaction that we will derive in being able to define, and then eradicate, the genetic changes underlying the evolution of glioblastoma. Or, consider the benefits of reversing the malignant effects of cerebral vasospasm or the degenerative brain diseases that afflict our aging population. Each of these achievements, along with many others, are within the reach of the next generation of clinicians. However, this scenario for success requires that we invest in our own future.

One of the Foundation's proudest achievements has been its ability to provide start-up funding for both residents and junior faculty pursuing an academic career. It has already built an outstanding track record in helping to launch a distinguished group of young neurosurgical investigators. These investigators, among whom include many of today's neurosurgical leaders, have compiled an enviable record with respect to continued research that has earned support from national extramural funding agencies such as the National Institutes of Health. Our responsibility is to assure the continued growth of this effort, which yields benefits to each of us and our patients.

In its formative years, the Research Foundation focused on support of basic neuroscience research to unravel the mysteries of diseases of the nervous system. With this process soundly in place, the leadership of the Foundation is now looking to develop clinical research that could translate some of the meaningful information already derived to the clinical setting. This is a major new effort that deserves our strong support.

Your Help is Needed

At present, only about 4 percent of AANS members actively support the Foundation. We can do better. I'm embarrassed to tell you that, in comparison, more than 50 percent of practicing orthopaedic surgeons support the Research Foundation of the American Academy of Orthopaedic Surgeons! Is that the reason that orthopedics has enjoyed such a lead in the development of spinal biomechanics laboratories that has postured them in the arena of spinal surgery? We have the manpower; we certainly have the brainpower! I'd hate to think we are losing out for lack of support for our own Foundation.

We must invest in our future if neurosurgery is to thrive. Please consider a generous gift to the Foundation this year. I hope that you will join me in wearing a Research Foundation major contributor pin on your lapel.

For more information on the Research Foundation, please see page 28.

NEWSLINE

News Members Trends Legislation

FROM THE HILL

- **"Quality Health Care Coalition Act" Gains Momentum in House.** HR 1304, the "Quality Health Care Coalition Act," is gaining momentum in the House of Representatives. The bill now has nearly 145 co-sponsors, with a majority of House Judiciary Committee Members co-sponsoring the measure. This bipartisan legislation will allow physicians to jointly negotiate the terms and conditions of their contracts (including fees) with health plans, without violating antitrust laws and without joining a labor union. Currently, individual practitioners must "take or leave" the prices set by insurance companies. HR 1304, however, will enable groups of physicians to negotiate with insurance companies. A delegation of physicians, including neurosurgeons Troy M. Tippett, MD, and George H. Koenig, MD, recently met with Henry Hyde (R-IL), Chairman of the House Judiciary Committee, to discuss the prospects of HR 1304. At that meeting, Chairman Hyde acknowledged the problems physicians currently face with health plans and expressed his commitment to finding a solution to this problem. The AANS and CNS, along with the American Medical Association (AMA) and others, are currently working to introduce a companion bill in the U.S. Senate.

- **AANS/CNS Oppose Chiropractor Legislation.** The AANS, CNS, AMA, American College of Surgeons, American Association of Orthopaedic Surgeons, and others, recently sent a letter to all members of the House Ways and Means and Commerce Committees opposing HR 1046, the "Chiropractic Patients' Freedom of Choice Act." Introduced on March 9, 1999, by Representative Wes Watkins (R-OK), this bill would expand the scope of services that chiropractors could perform under Medicare. In the opposition letter, the groups noted that chiropractors are trained to perform the manual manipulation of the spine to correct a subluxation and this treatment modality should only be performed within the first month of symptom onset. "Beyond this, according to published scientific evidence, any other diagnostic and therapeutic services for back pain performed by chiropractors is ineffective and would result in the expenditure of unnecessary resources adding to the already significant costs associated with treating back problems." The bill currently has 30 co-sponsors, but is not expected to pass this year.

- **Congress Debates Legislation to Halt GME Cuts.** Several bills aimed at providing teaching hospitals with critical financial assistance have been introduced in Congress. In particular, S1023 and HR 1785, the "Graduate Medical Education Payment Restoration Act of 1999" and HR 2266, the "Medicare Hospital Emergency Assistance Legislation" would halt the implementation of further GME cuts that were enacted in the Balanced Budget Act of 1997. The AANS and CNS, along with the Association of American Medical Colleges and others, are supporting these measures. Additional legislation eliminating Medicare GME support for residents also may soon be introduced. This proposal would create a new GME trust fund that would be subject to the annual discretionary appropriations process, putting at risk stable financial support for residency programs. The AANS and CNS oppose this approach and will actively work to defeat any such legislation.

NEWSLINE

News Members Trends Legislation

NEURO NEWS

- **AMA Votes to Form a Collective Bargaining Unit.** The American Medical Association (AMA) House of Delegates voted on June 23, 1999, to form a collective bargaining unit to counteract the powers of managed care organizations and give physicians a voice when negotiating with health care contractors. The labor organization would support the creation of local bargaining units as an option for physicians who are employed by managed care companies or who are self-employed and under contract with such companies. In a statement following the House of Delegates vote, Randolph D. Smoak, Jr., MD, Chair of the AMA Board of Trustees, said, "By forming an affiliated labor organization, eligible physicians will be able to fight for quality patient care, while remaining faithful to the AMA's historic and unwavering commitment to ethics and professionalism. The move will enable eligible physicians to advocate more effectively on behalf of their patients."

- **President Clinton Releases Medicare Reform Proposal.** On June 29, 1999, President Clinton unveiled his plan "to modernize and strengthen Medicare for the 21st century," including a new Medicare prescription drug benefit. While the details were not available at press time, the plan does not appear to include any new physician payment cuts. Overall, the President proposes funding his Medicare reforms through $64.5 billion in savings over 10 years using measures intended to foster "competition and efficiency" (such as competitive bidding), as well as using funds from the projected budget surplus. Several key members of Congress are expected to introduce their own plans in the upcoming months. Given the political nature of this debate and the complex issues involved in reforming the program, it is unlikely that any final action will be taken until after the 2000 elections.

- **Medical Societies Launch Campaign for Universal Health Coverage.** Some of the nation's largest medical associations, including the American Medical Association and the American College of Surgeons, are launching a campaign to make universal health care coverage the central focus of the 2000 U.S. presidential election. The campaign will draw together the associations' resources, as well as the grassroots membership of more than 600,000 doctors to press political candidates to put heath care for the uninsured at the forefront of public debate.

AANS Supports Universal Emergency Care Systems

Recently, the availability of timely and appropriate sophisticated emergency medical treatment has become a public health concern. The AANS has recognized this problem and issued a position statement in support of emergency neurosurgical services.

AANS Position Statement on the Management of Emergency Neurosurgical Services

Healthcare facilities that provide emergency medical services have a responsibility to maintain an organized system for providing, or insuring referral for, emergency neurosurgical care.

A neurosurgeon who has accepted the responsibility of being "on-call" at a given time to assist a healthcare facility in meeting these demands is obligated to respond promptly when called to provide emergency neurosurgical care, regardless of the patient's race, ethnic background, religious affiliation or ability to pay. In the event the on-call neurosurgeon cannot personally deliver care because of an irresolvable, professional conflict, the healthcare facility trauma system should have a protocol for obtaining other neurosurgical services.

Increasing Income: Seven Steps to Controlling Your Practice Expenses

By Barbara Peck

Calculating net income is really a simple formula: revenues minus expenses. For years, neurosurgeons from all types of practices have focused primarily on the revenue side of the equation — do more procedures, see more patients, charge higher fees, perform electrodiagnostic studies, put in a CT scanner — just bring in more revenue. However, with Medicare and managed care companies setting and reducing fees, both private and academic practices also are being forced to reduce expenses in order to increase, or even maintain, net income.

Practices in the process of deciding on new equipment, procedures, partners and staff also need expense information to accurately predict profit potential. Unfortunately, analyzing practice expenses is not easy, and there is no magic formula that is right for every practice. However, there are some simple steps a practice can take to evaluate, and begin to change, practice expenses.

Step One: Faithfully Review Your Practice Expenses

Enclosed with your monthly, or quarterly, financial statements should be an expense sheet. This sheet should be organized in a way that is understandable and makes sense for your practice. If you don't understand where the numbers are coming from, it is well-worth an hour of your accountant's time to walk you through it.

The amount of detail and the way expenses are broken down vary from practice to practice. For example, a small-size practice might have one category of "office space" that includes all overhead costs. Another practice may wish to break this down into more detail, including line items for rent, cleaning services, electricity, etc. Accountants often break expenses down into direct, or variable, and indirect, or fixed. Direct costs can be linked to a specific service and include: salaries, supplies and clinical space. Indirect costs are general, non-allocatable costs that include: legal fees, accounting functions, insurance, rent, loan interest and administrative office space.

Step Two: Establish a Practice Philosophy and Expense Priorities

Once a practice's expenses are in order, there is often a tendency to compare one practice with a "benchmark" or another practice. However, where a practice spends its money should be a reflection of its overall philosophy and reflect how the practice is organized.

"In our practice, rent costs may be higher than someone else's," said James R. Bean, MD, managing partner of Neurosurgical Associates in Lexington, Kentucky. "But, our location also is across the street from one of our top referring hospitals, convenient for our patients and in proximity to a large number of referring physicians' offices. If we moved five to10 miles farther out, we might save some money on rent, but we would see fewer patients every day because of increased travel times, and our referral numbers could drop. Our philosophy is to make it as easy as possible for our referring physicians to send patients and for our surgeons to save travel time so we can see as many patients a day as possible."

Some factors to consider when analyzing practice expenses are:

Office location: Why is the office located where it is? What are the advantages and disadvantages? Are satellite clinics used? Is office space optimally utilized?

Referral sources: Where do referrals come from and why? How does the office location and marketing expenses reflect this?

Outpatient services: Are diagnostic and imaging studies sent outside or done in-house? Can some be done by the practice to enhance revenues?

Clinical staff: What is done in the office that requires an RN or physician's assistant? Why? Can administrative staff perform the same task for less expense?

Administrative tasks: Is payroll done off or on-site? Why? How often are accounting services being utilized? What is the feasibility of bringing these tasks in-house to reduce consulting or expenses or, what is the feasibility of sending these tasks out and opening up office staff for other duties? Is billing and collection done in-house or outsourced, is it efficient, and are accounts receivable excessive?

There are no right or wrong answers to these questions. Rather, there should be well thought-out reasoning behind each decision.

Step Three: Take A Closer Look at Practice Expenses

After it is established how costs should be allocated, it's time to evaluate what's actually happening. There are two decisions to be made in this step: 1) what system for measuring expenses should the practice use; and 2) should this process be done in-house, or by an outside consulting firm?

"It helps to know the practice expense for each office service, patient, or procedure, rather than just the total for all services, as listed on the revenue and expense statement," said Robert E. Florin, MD, Chair of the AANS Physician Reimbursement Committee. "Knowing the cost to the practice of each patient seen or procedure performed allows the practice manager to decide how much profit, or loss, each service produces from the different payers."

There are two systems for measuring practice expenses. One method estimates costs according to relative value units (RVUs). The total annual expenses of a practice, minus physician salary and benefits, are added up, as well as the total annual number of RVUs figured by CPT codes billed. Total expenses are divided by total RVUs for an average cost per RVU. This number is then multiplied by the number of RVUs for a given procedure to come up with a cost for that procedure:

Total expenses for 1998:	$1,500,000
Total RVUs billed in 1998:	70,000
RVU per lumbar discectomy:	27
Number of lumbar discetomies performed in 1998:	350
RVUs billed in 1998 for this CPT code:	9,450
Cost per RVU:	$21
Cost per lumbar discetomy:	$567
Reimbursement per discetomy:	$850
Income per discectomy:	$283

One disadvantage of RVU accounting is that all tasks under a CPT code are considered equal. For example, whether a new office visit with history takes 12 minutes or 45 minutes, it is considered the same expense and whether a patient has one follow-up visit after a cervical disectomy or three, it's all considered the same amount of expense.

"The cost per RVU approach cannot tell which services actually cost the practice more than others," Dr. Bean said. "Therefore, it can't be used to decide if some procedures are winners and some are losers for the practice. They are all assumed to have the same average expense, when actually they probably don't. What it does do is allow a quick decision regarding the adequacy of a contractual fee schedule, by showing the difference in the fee and the average cost for each CPT code."

The second method for measuring practice expenses is activity-based cost accounting (ABC). ABC uses detailed information to determine all the costs, resources and time associated with a given service or process. Costs are figured by staff time involved, occupancy expense, administrative expense and clinical expense. Often, similar CPT codes are grouped together to define most of the "activities" the practice performs.

"The 80 or so individual activities in a neurosurgical practice can be grouped into 13-14 processes," Dr. Bean said. "The aim of the exercise is to identify these common functions, such as scheduling, patient reception, transcription or billing, and determine how much each of these costs the practice. This is better than determining cost per RVU because it doesn't average costs across all codes; it finds the actual cost for each group of related codes. It also details which costs are higher for one process as compared to another (i.e: a new patient visit versus a surgical procedure or return visit). It further shows which activity might be excessively costly in the process and where the process can be redesigned to cost less."

The starting points for ABC are to: 1) determine overall expenses; 2) list the activities performed in the practice; 3) figure a cost per hour for each activity; 4) group related activities to establish the processes in a practice; and 5) evaluate the time needed to complete each process. Following is a basic breakdown of how this analysis might look.

Occupancy Expense (all indirect expenses in this case):

Rent:	$40,000
Utilities:	$2,000
Cleaning:	$3,000
Other (taxes, phone, property insurance):	$30,000
Total:	$75,000 per year

Expense: $75,000/office hours (52 x 40) = $36.06 per hour

Clinical Expense (direct expenses to clinical activities):

Medical Equipment: $5,000 year/estimated hours in use (52 x 28) = $3.43 per hour

Clinical Supplies: $6,720/hours (52 x 28) = $4.62 per hour

Nurse: $35,000 year + $8,400 benefits = $43,400 x .70 (to deduct the 30 percent of time not spent in clinical activities) = $30,380 year/ hrs worked (52 x 28) = $20.86 per hour

Total Clinical Expense: $28.91 per hour

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Administrative (indirect expenses):

Manager: $50,000 year + $12,000 benefits =$62,000 year/ hours worked (52 x 40) = $29.81 per hour
Supplies: $7,280 year/office hours (52 x 40) = $3.50 per hour
Total Administrative—Indirect Expenses: $33.31 per hour

Administrative (direct expenses):

Receptionist: $20,000 year + $4,800 benefits = $24,800/hours worked (52 x 40) = $11.92 per hour
Billing Clerk: $25,000 year + $6,000 benefits = $31,000/hours worked (52 x 40) = $14.90 per hour
Nurses (non-clinical time): $43,700 x .30 = $13,110 (52 x 12) = $21 per hour
Total Administrative (direct expenses): $47.82 per hour
Total: $146.10 per hour

ABC can break down costs into general, or specific, categories, depending on the level of detail the practice would like. The more detail, the more accurate the information, but also the more time-consuming and costly it is to develop the system.

More sophisticated ABC systems are usually developed by healthcare consulting firms like Gary Siegal and Associates or Grant Thornton.

Step Four: Look for Areas to Reduce Expenses

A quick glance and some modest research can lead to a significant reduction in practice expenses right off the top. Areas to watch include:

Utilities: Competition between phone companies has led to price wars in the long-distance arena. Switching long-distance carriers and finding a rate plan that parallels long-distance calling patterns can cut bills. Electricity and air conditioning bills also can be reduced by cutting back on night and weekend use.

Professional fees: Accountant and attorney fees can be a large portion of a practice's expenses. What information are these professionals supplying, and can it be gathered in-house for half the price? "Our accountant fees have been reduced by almost half by hiring a practice manager with an accounting background," Dr. Bean said."There's often a fine line between when it is better to outsource a task or bring it in-house and neurosurgeons need to be aware of what that line is for their practice. This is usually something that can be figured out after an in-depth practice expense study has been done."

Supplies: Group purchasing with other practices can qualify a practice for quantity discounts. Reducing inventory on-hand also can open up cash flow.

Banking: Finance charges and other fees can sometimes be reduced with some negotiations in today's competitive market.

Personnel overtime: Time-and-a-half for hourly employees and overtime should be avoided as a permanent solution to staffing issues. Outsourcing excess work may save money spent on overtime pay.

Printing: Letterhead, envelopes, business cards and forms should all receive three competitive price quotes each year to insure the best price. Also, printers can provide strategies to reduce the printing costs, if asked.

Insurance: There's more to insurance than malpractice. Have your agent evaluate your general liability, worker's compensation and other plans for possible savings.

Step Five: Analyze the Process of Doing Business

There are only so many "hard expenses" that can be reduced without affecting the quality of the services a practice provides. The next step in reducing overall practice expenses is to analyze how efficient the processes are in a business. How are tasks performed? Who performs each task? Is the RN doing basic filing tasks that a high school student could do? Does an out-dated computer system slow down billing clerks? Is work being redone because of quality issues?

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Cost For a New Office Visit Using ABC

	Schedule Appointment	Check-In	History, Exam	Check-Out	Med Records	Coding/Reimbursement	
	3 min. cost	5 min. cost	30 min. cost	5 min. cost	20 min. cost	10 min. cost	
Indirect Expenses							
Occupancy ($36.06/hour)	$1.80	$2.88	$18.03	$2.88	$11.90	$6.13	
Administrative ($33.31/hour)	$1.67	$2.66	$16.66	$2.66	$10.99	$5.66	
Direct Expenses							
Clinical Expenses ($28.91/hour)	$1.45	$2.31					
Receptionist ($11.92/hour)	$0.60			$0.95	$2.03*		
Billing Clerk ($14.90/hour)						$2.53	
Nurse ($21/hour non-clinical)					$3.57*		
Totals:	**$5.52**	**$7.85**	**$34.69**	**$6.49**	**$28.49**	**$14.32**	**$97.36**

** The medical records task was split between the nurse (non-clinical rate) and the receptionist.*

AANS Works to Provide Members with Practice Expense Data

Robert E. Florin, MD

The narrowing margin between reimbursement for patient services and practice costs is affecting most neurosurgeons. The changes begun in January, 1999, by the Health Care Financing Administration (HCFA) for practice expense Relative Value Units (RVUs) have reduced our payments in the range of 3-4 percent for some services, and are designed to ratchet even further downward over the next three years, especially as non-Medicare payers use the Medicare Fee Schedule.

Chipping away at the practice expense RVUs in the fee schedule has been a favorite target of the primary care lobby because there have been disappointing gains for them during the course of applying the resource-based derivation of physician work RVUs. Their strategy has been to attack the "excessive" payment for practice expenses of surgeons and others that provide high ticket procedural services, and persuade HCFA that they deserve some of that expense money. Because the government imposed a budget neutrality limit on the pool of dollars for Medicare payments, any shift to one group is done at the expense of another group. The method developed by HCFA for changing the practice expense RVUs has clearly reflected that policy with an average negative impact on surgical practices and an average positive windfall for primary care.

In response to this environment, the AANS created the Cost Containment Task Force (jointly sponsored by Congress of Neurological Surgeons). One of the aims of the Cost Containment Task Force has been to collect data on actual neurosurgical practical expenses. We have been able to extract information from our survey that represents data from 163 neurosurgeons, plus 52 other specialists that work in those neurosurgical practices.

We have used this data in our debate with HCFA about what the "actual" expenses of a neurosurgical practice really are, particularly compared to the data from the American Medical Association's Socioeconomic Monitoring Survey (SMS) that was the source for HCFA's input to practice expenses. For example, HCFA used the SMS average total expenses for a neurosurgeon per year of $239,993, while our survey average was over $285,000.

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"The more efficient you become, the less expensive it becomes to perform each task and the higher the capacity rises," Richard A. Roski, MD, FACS, of Quad City Neurosurgical Associates, said.

There are two main components to analyze: personnel and facility resources. The first step in analyzing personnel issues is to review job descriptions to see what employees are supposed to be doing. Next, have employees keep a detailed log of what they do throughout the day and also have them comment on how they think their jobs could be made more simple. Compare the employees' actual daily tasks with their job descriptions and suggestions.

"Finding and eliminating work errors is one of the most effective ways to improve efficiency and reduce costs," Dr. Bean said. "Claims that are incorrectly filled out or payments incorrectly entered may increase the time spent on a claim by as much as eight times and increase the unpaid receivables by tens of thousands of dollars. Most businesses and industries find that rework is probably the single most important correctable cause of unnecessary expense. It is also important to count the physician's time during this process to make sure he or she is maximizing billable time."

Equipment and the office facility should be designed to maximize the number of patients seen, provide high quality service and promote the efficiency of the staff. The computer systems; phone lines; medical record and coding procedures; scheduling process; transcription services; payroll; and patient registration should all be evaluated for efficiency.

"The problem is rarely that people aren't working hard enough," Dr. Bean said. "Often, it is the system and process that is driving up costs because of inefficient design or inadequate communication between employees."

Step Six: Monitor, Evaluate, Revisit

Cost analysis and reduction strategies are not a one-time investment of time and resources. After the initial scrutiny of costs and round of changes, it is essential that practice expenses are monitored and new trends are quickly recognized. Expense reduction strategies and evaluation, along with improving efficiency, need to become a regular feature at staff and board meetings.

Step Seven: Use Expense Data to Make Decisions

If a practice can quickly analyze its expenses, decisions on whether to add a partner, move to a new facility, expand to a satellite office, offer new procedures, merge with another practice, sign a managed care contract, or increase marketing efforts become much more simple and logical.

"Physicians don't go into surgery without thorough evaluation and testing and they shouldn't be making blind business decisions either," Dr. Bean said. "You may not have become a surgeon to learn the finer points of activity-based cost accounting, but if you would like to remain a productive surgeon, you have to master the business side of things as well. How a practice grabs holds of its expenses is going to be a very individual answer." ■

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This data is very helpful when analyzing the management of expenses and other policies within a practice. The Task Force has been working to develop a program that will actually provide on-site analysis and feedback to member practices. The objective is to identify cost reduction and revenue enhancement opportunities, while collecting cost and procedure level information on those same practices. This would be used internally by the practices, as well as compiled into a database that could provide a national reference against which any practice could be compared. This information also would be valuable in our challenges to HCFA's proposed reduction in the practice expense portion of the Medicare Fee Schedule.

Some other data from the survey that can be used to begin to benchmark a practice include the average number of RVUs produced by a neurosurgeon during a year of practice (16,800). This, coupled with an average practice expense of about $18 per total RVU allows for some estimates of both the productivity, as well as the total expenses of your practice. This also allows you to calculate your expense per service or procedure simply by multiplying the total RVUs of the service by the average expense per RVU.

Another measure of productivity is the number of patients seen per week and the number of surgeries or procedures done. Our data shows the average neurosurgeon in private practice sees between 38 and 40 patients per week while performing five to six surgical procedures.

We hope to continue to develop further information that will help neurosurgeons in the battle to reduce practice expenses. If you would like to participate in the survey or have any questions, please call me at (562) 693-6935. ■

Robert E. Florin, MD, is a semi-retired private practice neurosurgeon in Whittier, California. Dr. Florin is a 36-year member of the AANS, and currently serves as Chair of the AANS Physician Reimbursement Committee. In addition, he serves as a consultant to the AANS/CNS Washington Committee and as a member of the AANS/CNS Cost Containment Task Force.

Oklahoma Practice Takes Big Steps to Control Quality, Costs

Stan Pelofsky, MD

Two years ago, my partners and I, along with a small number of spine surgeons and anesthetic pain specialists, decided that the only way to control the quality and cost of care we provide to our patients would be to build and control our own spine hospital. Accomplishing this in Oklahoma City truly required some degree of chutzpah. Though we were prepared to accept the financial and professional risks ourselves, we knew that, as physicians, we could not build the facility without help. Therefore, we solicited the advice of several top-notch professional consultants who assisted us by developing a sophisticated feasibility study, business plan, and mission.

Not only was it important to hire outside consultants, but it also was essential that the physicians involved were able to commit their time, energy, and personal income to the project. In our particular case, the physicians provided 100 percent of the cost to build the hospital, each personally signing a frighteningly large note to see the project through.

Though this may seem extreme, we believed that it was the only way to ensure that the hospital would stay in our control and not end up in the hands of other local hospitals, insurance companies, or national organizations. We understood that in the current and future marketplace, the most important commodity in health care is "value", which is defined as V (value) = Q (quality)/C (cost). In other words, in order to enhance value we must increase the quality of our neurosurgical spine delivery system, while at the same time decreasing its costs.

Decreasing costs while increasing quality may seem oxymoronic until we remember just how many inefficiencies exist in most hospital delivery systems. Physicians are in a perfect position to ferret out those inefficiencies and provide a streamlined approach to hospital care. We are hopeful that physicians who have taken the risk and done their work to minimize inefficiencies will ultimately profit from such an enterprise, though the quintessential prize is the control we gain over our practices and the excellent quality of care our patients receive.

Our project in Oklahoma City is well on its way to completion: construction is underway, staff is being hired, and equipment is being ordered. Though several outside business entities have attempted to buy the hospital outright, or at least buy in, we have resisted and will continue to resist this sort of outcome. This is, after all, an experiment in self-determination and we must retain control medically, surgically, and economically if we are to succeed. In the end, I am confident that Oklahoma City Spine Hospital will become a reality. ■

Stan Pelofsky, MD, is President of the Neuroscience Institute in Oklahoma City, Oklahoma. Dr. Pelofsky, a 23-year AANS member, is Past President of the Council of State Neurosurgical Societies and currently serves as the AANS Secretary.

Examining Practice Trends

Steps to Improve Your Practice's Financial Performance.

What the future holds for medicine and physician practices is uncertain. However, one point does seem to be clear: Physicians need to take a more active role in managing their practices. Socioeconomic factors have created large businesses disguised as medical practices, forcing many physicians to take crash courses in accounting, business and finance.

Now, more than ever, medical practitioners need to be involved in managing their office, anticipating future market needs and responding to those needs with high quality, convenient, focused services. They need to adopt the same management techniques and tools used by successful businesses in other industries if they are going to survive and thrive in the in the world of "big" business.

Future Trends

While I don't pretend to have the ability to see the future, I have attempted to identify three practice management trends that will likely continue and have a substantial impact on the way neurological surgeons view and manage their practices.

First, the medical practice landscape is changing at a rapid pace, and the development of more complex medical groups and affiliations will likely continue to accelerate. As larger, multi-specialty group practices become more prevalent, physicians will need to recognize and anticipate changes in the marketplace, and be able to introduce innovations in the way services are provided.

Second, it is no longer enough to be just a good surgeon or physician. Today, medical practices must possess the resources and competencies to grow revenue while providing cost-effective services to the marketplace. Improvements in technology (both clinical and administrative); competition for patients, patient lives and contracts; a tight labor market and changing demographics; reduced reimbursement; and soaring practice expenses are related challenges that will continue to plague many medical practices.

Last, the healthcare marketplace is more consumer driven. Medical practitioners need to recognize this and successfully adapt to the demands of an increasingly well-educated, market-driven consumer.

Steps to Improve Financial Performance

Given the challenges facing physicians, successful practices must take proactive steps to combat negative trends and improve their overall financial performance.

To improve practice operations, processes can be streamlined to reduce costs; productivity improvements can be implemented by physicians and employees to increase revenue; a reporting structure can be created that allows for better decision making by physicians and employees; and a rewards system can be implemented to recognize hard-working employees.

Terry Peltes is Vice-President of Physician Management Services for Medaphis Physician Services Corporation.

To determine how you can improve your medical practice's performance, consider the following management procedures.

1) Internal Cost Reduction Strategies

Cost reduction strategies focus on reducing the internal costs generated by medical services provided to the marketplace. To offset internal costs, physicians should:

- Maintain tighter control over supplies, reviewing usage against budget and continually looking for suppliers with better prices.
- Review equipment for usage and obsolescence. Underutilized equipment can be sold and obsolete equipment can be replaced with equipment that is more productive and less costly per procedure.
- Sell unused furniture and fixtures.
- Review maintenance and repair expenses. Equipment that has a high maintenance cost may be a candidate for replacement by newer, more productive machinery. Also, take a hard look at maintenance agreements, which may be substantially higher when compared to the reliability of today's equipment.
- Analyze telephone charges for the types of calls made and the length of those calls. Local telephone companies can analyze call patterns and prescribe a cheaper calling solution. Also, make sure you are not paying for lines or equipment that are not used.
- Examine postage expenses and identify increases not related to the rising cost of stamps. Reduce or eliminate the use of next day delivery.

2) External Cost Reduction Strategies

These strategies include the cost of services purchased from outside consultants or vendors. To reduce such costs, physicians should:

- Review the practice's use of office space. Sublet or reduce unused space to free up cash flow and reduce overhead.
- Review insurance policies for adequate, cost-effective protection. Challenge your insurance broker to improve coverage while reducing overall costs.
- Reduce professional fees paid to accountants, attorneys or other professionals. While this expense is generally viewed as a necessary evil, properly managing these relationships

Continued on next page

Continued from page 11

can be a tremendous source of additional cash flow. Be prepared when making calls to these professionals and limit the amount of time you spend on the phone. Request detailed billings, review the bills and ask for additional documentation where questions arise.

- Analyze banking and finance charges. Make sure that you ask for compensating balances to offset bank charges.

3) Asset and Credit Management Strategies

These strategies ensure that you are getting the most value from the resources invested in your practice.

- Refinance higher interest debt. Review leases and renegotiate or restructure high cost arrangements.
- Charge interest on delinquent accounts.
- Negotiate and take advantage of all discount policies offered by vendors.
- Accept credit cards.
- Review billing cycles to maximize the effectiveness of account receivables.
- Establish sweep accounts with your bank to take advantage of the average daily collected balance that sits in your account. The money should be swept into high quality, interest-bearing instruments and swept back to cover checks written.

4) Personnel Resources

When managed properly, personnel costs and productivity can have a substantial impact on practice profitability.

- Review the number of full-time employees in your practice against industry averages.
- Compare wages for all employees in light of the marketplace. For those employees that command a premium over the market, use bonuses instead of annual raises to reduce the long-term effect of continued salary increases.
- Review workers compensation insurance, as well as medical, life and disability insurance to make sure you are getting the most value for your money.
- Review vacation policies to make sure they are competitive in the marketplace but also to ensure that you are not paying out for benefits that have not been earned or accrued.
- Analyze retirement plans. Are the administrative costs too high? Are you paying for the same service from your accountant and the plan administrator? Could you reduce the overall expense to the practice by adding a 401(K) plan that your employees can contribute to? If you integrated your plan with Social Security would it reduce the overall cost of your contributions?

5) Management Reporting

The use of timely, relevant, properly formatted reports to manage your practice cannot be overstated. This is a crucial link between setting financial and operational goals and managing the practice to achieve them.

When generating a practice report, include a monthly balance sheet, income statement and operating report along with revenue projections and expense budgets. This can be done internally or through your outside accountant.

Once the reports are generated, key financial operating ratios should be tracked and analyzed. The accompanying trends should be reviewed in light of your practice budgets and projections, and actions should be taken to impact any negative trends that come to your attention.

6) Revenue Enhancement

Physicians can improve their financial performance by improving their ability to negotiate favorable managed care contracts and reducing practice expenses as a percentage of revenue. To accomplish this, physicians must:

- Review fee schedules on an annual basis. Marginal fee improvements, combined with proper contract negotiations and expense management, will improve overall financial performance.
- Improve the collection of receivables. Monitor gross and net collection percentages, the average number of days revenue is sitting in accounts receivable balance, the average number of days it takes to send out a bill and other indicators of performance.
- Review cash management techniques. Allow the cash collected to work for you by managing the number of times bills are paid each month. By only paying twice each month you get the benefit of the interest on your deposits, while reducing the cost associated with bookkeeping or accounting.
- Maximize collection agency performance. If they are collecting a high percentage of the dollars you turn over, you are probably turning the accounts over too soon and incurring unnecessary additional collection costs. If they are not collecting enough, you may be turning the accounts over too late. Also, negotiate the fees they are charging.

Meaningful, sustainable performance improvement is achieved by setting clear objectives and goals, properly managing revenue opportunities, challenging every expenditure, identifying areas in which you can reduce or eliminate costs, implementing cost cutting measures where appropriate and continuously reviewing practice financials using timely, relevant, properly formatted reports. By following these checks and measures, you will improve your financial performance in the age of declining reimbursement. ■

Terry Peltes is Vice-President of Physician Management Services for Medaphis Physician Services Corporation–a business management company in Atlanta, Georgia, servicing more than 20,000 physicians and nearly 2,000 healthcare organizations across the nation. For more information on Medaphis, call (770) 444-5829 or visit their Web Site at www.medaphis.com

Managed Care Contracting

Issues to Consider Before Signing on the Dotted Line.

Contracting is the starting point for every neurosurgeon in the managed care process. It is not an automatic procedure; neurosurgeons must apply for and be accepted into the plan's contract. As many have observed, the initial stages of contracting can be surprising and, in some cases, an unpleasant experience for neurosurgeons not accustomed to the process.

The Power of Negotiation

The most difficult obstacle for a neurosurgeon entering into a managed care agreement is that he or she will lose a degree of freedom of independent action, as will his or her patients. Everything that is good or bad in a managed care contract depends on how well physicians negotiate agreements. Consequently, neurosurgeons must learn to deal with new issues involving contract analysis and negotiation.

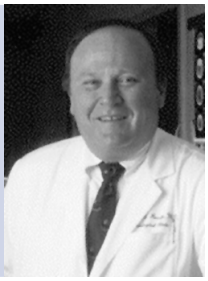
With fixed prepayments and risk sharing, neurosurgeons must conduct a careful review of each page, each paragraph and every term of a managed care agreement. And, before signing on the dotted line, they must seek expert legal assistance from attorneys familiar with health care law and contracting.

Understanding the Contract

Managed care contracts are always state and health care plan specific, and are typically designed for a modified fee-for-service deal or an arrangement covering capitation. In contract negotiation, it is important to know which conditions or terms are negotiable.

For example, certain federal or state language cannot be modified. Sections you must attempt to modify or delete include terminology indicating that the physician holds the health plan "harmless." Such a provision may negate all or part of the physician's malpractice coverage. Consultation with the plan and the insurance carrier should be completed before such an item is included in the contract.

When negotiating with health plan providers, neurosurgeons will want to bring to the table a list of their top 10 or 20 procedures and their usual fee schedule. Because these procedures will account for most of a practice's cash flow and encounters, neurosurgeons must ensure the health plan's proposed payments for these services are adequate. They should be enough to offset any other reductions on the infrequent, but expensive procedure.



John A. Kusske, MD, is Chair of the AANS Managed Care Advisory Committee.

Recognize the Red Flags

Of the many issues that surface in a contract, some bear particular attention. One of these is the impact of withholds. Withholds are a common component of contracts, and result when a portion of the physician's reimbursement is held back by the payer as a reserve to cover unexpected costs.

When reviewing a managed care contract, the agreement must specify how, when and under what conditions any such reserves are to be distributed. Neurosurgeons should note whether the agreement specifies if the withholds are the limit of each physician's risk, or if the physician can be held financially responsible for losses in excess of the withhold. Neurosurgeons should be cautious about some managed care plans' promises of withhold returns or proof of such payments going back several years. The medical environment is too unstable to sign a contract based on the outlook that the record of past payments will continue in the future.

Indications that the plan might be encountering financial difficulties, suggest that a neurosurgeon should not sign an agreement with that organization. Recall that if the plan files for bankruptcy, physicians might be obligated to continue providing services. Physician claims generated before the filing will not be paid until the bankruptcy is resolved.

Neurosurgeons should always obtain information on a plan's financial status, including the amount of reserves, underwriting gain and level of administrative costs. Plans in potentially precarious financial condition will be identified by such data and suggest that the plan may not be capable of paying its claims in a timely manner.

Another issue that affects negotiations is the anticipated volume of new patients. Any promises by the plan of minimum numbers of new patients should probably not be taken as anything more than over-optimistic estimates.

Also, neurosurgeons should be concerned what "new patients" means. If "new" means patients previously unavailable to the practice, then that is positive. However, if the new patients were previously the practice's private patients that have since been enrolled in the local health plan, all the neurosurgeon will be getting are his or her old patients back at a discounted reimbursement level.

Finally, neurosurgeons should negotiate contracts based on the relative size of the patient pool. If the plan is a start-up, or one that does not have significant market penetration, neurosurgeons should take a more aggressive negotiating stance.

Know When to Say No

If at any point in the negotiation process things are not progressing, and the costs and risks are not balanced by real dollars, neurosurgeons must recall and use the overriding principle in all negotiations — know when to say thank you, smile, get up from the table and walk away. ■

Building Your Nest Egg

Selecting a Retirment Plan That Works For You.

By Deia Lofendo

Like many physicians, you may have thought about retirement planning, but are too busy paying off student loans, buying a dream home or saving for your kids' college expenses to do much about it. Well, those days are over.

Certain tax-deferred financial products are available that offer you, as a physician, the opportunity to invest in your financial future. These plans are tailored for the self-employed medical practitioner, as well as the employee of a medical practice or healthcare organization, and are key to helping you build a solid financial foundation to reach your retirement dreams.

Choosing the right plan for your practice, however, is not always easy and depends on many factors, namely your goals for establishing the plan, the size of the annual plan contributions you can comfortably commit to, as well as a wide range of issues specific to your practice.

Qualified Retirement Plans

Certain retirement plans are qualified for special treatment. These plans can serve as one of the most effective means for physicians to shelter their current income from taxes, grow their assets on a tax-deferred basis and provide a significant source of retirement funds.

There are two basic types of qualified retirement plans. One sets the amount of benefits the plan will pay out to the retiree; this is called a defined benefit plan. The other, known as a defined contribution plan, sets the amount of money the employer will pay into the plan each year for an employee. Understanding each plan and determining which one is right for you, is key to building a solid retirement nest egg.

Defined Benefit Plan

Conventional, employer-funded pension plans, known as defined benefit plans, are designed to pay a participant a fixed, predetermined benefit upon retirement. The benefit is based on a calculation that takes into account the participant's age, years of employment and more. Under current laws, the maximum annual pension benefit payout must not exceed $130,000.

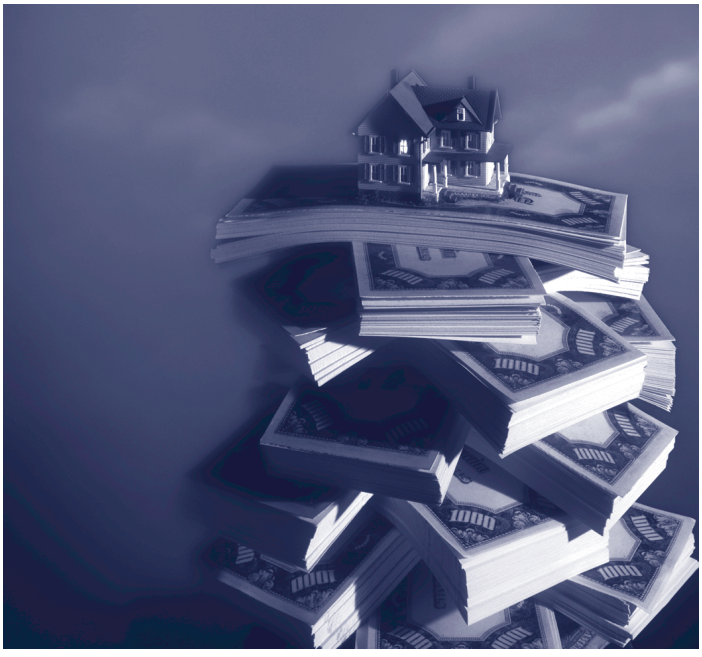
With a defined benefit plan, annual funding is greater for employees who are older at entry into the plan, since the time to fund the benefit is less in the case of an older participant. "This makes defined benefit plans attractive to many physicians because they often adopt retirement plans for their practices when they are older and wish to shelter a significant portion of their income from taxes," said James D. Forcucci, CFP, a Senior Financial Advisor at American Express Financial Advisors, Inc.

Defined Contribution Plan

Defined contribution plans are the most widely used retirement plans by physicians. These plans, often termed money-purchase pensions or profit-sharing plans, are less subject to government regulation and often provide the necessary plan contribution flexibility many doctors are looking for.

Under a defined contribution plan, an employer contributes a fixed amount into a fund for the participant. When the participant becomes eligible to receive benefit payments — usually at retirement or termination of employment — the benefit is based on the total amount in the account. With this type of plan, the employer does not have to guarantee the retirement benefit the participant will receive. Instead, the employer must make contributions to the plan under a formula defined by the plan specifications.

"Defined contribution plans are becoming more popular among physicians because they provide doctors with a greater sense of control, and the flexibility to build retirement assets and reach their personal goals," said Mr. Forcucci. "They are ideal plans for younger physicians because they allow for greater accumulation of tax-



> "Choosing the right plan for your practice is not always easy and depends on many factors, namely your goals for establishing the plan, the size of the annual plan contributions you can comfortably commit to, as well as a wide range of issues specific to your practice."

deferred savings if funding is started at an early age."

Money-Purchase Plan

Money-purchase plans are a type of defined contribution plan where funding is calculated according to a participant's salary. The plan is relatively simple and inexpensive to administer, and provides a benefit based on the total amount of employer contributions in a participant's account. Under this plan, the employer is obligated to annually contribute a specified percentage to each participant's account. This contribution is usually 10 percent of a participant's salary, although funding up to 25 percent is possible.

A common example of a money-purchase plan is a Keogh — a tax-deferred retirement savings vehicle sometimes referred to as HR 10. Keoghs are available to self-employed (non-incorporated) individuals and contributions are deducted from the participant's gross income, making the plan particularly attractive to high-income professionals.

Profit-Sharing Plan

A profit-sharing plan, unlike a money-purchase pension, is a defined contribution plan under which the employer determines the amount of annual funding based on a percentage of salary, rather than a stated contribution obligation. With this type of plan, employer contributions are optional and funding is limited to 15 percent of total employee payroll, or $30,000 per employee per year.

Age-Weighted Pension

An age-weighted pension is a prime example of a discretionary profit-sharing plan. As its name suggests, this plan favors older entrants by allowing employer contributions to be allocated on an actuarial basis according to the participant's age and years of service. This type of qualified retirement plan has two unique advantages: 1) like a traditional profit-sharing plan, age-weighted plans allow for year-to-year contribution flexibility; and 2) like a defined benefit or target benefit pension plan, age-weighted plans offer much larger contributions for older and higher paid owners and employees.

"An age-weighted profit-sharing plan is generally the ideal plan for older, high-income physicians, because it provides an adequate retirement benefit to older employees without all of the costs and complexities of a traditional defined benefit plan," said Mr. Forcucci.

401(k) Plan

Another variation of a profit-sharing plan is a salary reduction plan, commonly referred to as a 401(k). Under a 401(k), employees can defer as much as 20 percent of their wages (up to $10,000) into an employer-selected plan, which may include money market instruments, deposit accounts, stocks or bonds.

The 401(k) is tailored toward the medium- to large-sized practices and offers employees an opportunity to voluntarily contribute to their retirement plan. 401(k) contributions are deductible from current taxable income and all earnings on the contributions grow tax-deferred until withdrawn.

"The 401(k) works best in a practice where the low-wage earning employees defer between 2 percent to 4 percent of their wages, thereby allowing the physicians in the practice to contribute at or near the voluntary contribution cap of $10,000 per year," said Mr. Forcucci. "If the group is able to fund the maximum amount of $10,000 per doctor, then less employer funding will be required to meet minimum contribution requirements for non-physician staff."

Comparability Plan

The new comparability plan is another type of defined contribution plan that has recently become popular in the medical marketplace. With a new comparability plan, employers can divide their workforce into two or more identifiable groups, according to job position, with a certain amount of disparity permitted in the contribution percentages paid for each group. IRS regulations provide a method, based on an analysis of projected benefits at retirement age, to ensure that benefits provided to highly compensated and non-highly compensated employees are comparable, and considered nondiscriminatory.

"Comparability plans are a new type of profit-sharing plan that allow substantial dollars to be funded for the highly paid and, on average, older physician, with a lower rate for the rest of the participant group," said Mr. Forcucci. "These plans are ideal for middle-aged physicians who want to maintain a strong profit-sharing plan, while minimizing the cost of providing benefits for their staff."

Consult a Financial Advisor

Retirement planning is a complicated process and one that often requires the guidance of an experienced financial planner. A qualified advisor will review your total financial picture, customize an appropriate plan and guide you on a path to economic security.

For information on how to find a financial planner in your area, contact the International Association for Financial Planning (IAFP) at 800-945-4237 and request a free consumer brochure titled the *Consumer Guide to Comprehensive Financial Planning* and *Selecting and Interviewing Financial Advisors.* ■

Strategies for Success

Tips for Hiring a Qualified Office Manager.

In today's age of declining reimbursement and soaring overhead, it is critical to hire a qualified office manager who can free you from administrative hassles, help control your practice expenses and maximize your clinical time. However, finding a top-notch employee in an ever-shrinking talent pool is not easy.

Following are steps to help you recruit a professional to manage your practice.

Step One: Determine Your Needs

Assessing your practice's management needs is a critical step in the hiring process. To define your practice's needs, consider elements like patient volume, revenue and overall practice expenses. Identify your practice's strengths and weaknesses and determine what tasks the manager will do and what qualifications he or she must have.

"Not every neurosurgical practice needs a full-fledged administrator," said Karen Zupko, president of KarenZupko & Associates, a practice management consulting firm. "The position may be organized as an office manager or a practice administrator, depending on the size and complexity of the solo or group practice."

Office Manager Versus Practice Administrator

There are generally two types of business administrators, often referred to as office managers or practice administrators. Each has a different educational and managerial background, different skill sets and different roles within the practice.

"Office managers are usually 'A-plus' employees who have some college experience and have earned the title and knowledge through on-the-job training," said Ms. Zupko. "They are typically responsible for every non-clinical activity, such as daily practice operations, staff training and billing and collections." Depending on the size, location and complexity of the practice, office managers usually receive a starting salary of about $30,000.

Practice administrators, on the other hand, are more skilled in business management and marketing. They often have a master's degree in business administration or health administration and experience running a complex, multi-specialty practice. Their responsibilities usually include negotiating managed care contracts, managing relationships with hospitals and third-party payers, supervising billings, and developing the practice's marketing plan.

"Hiring a practice administrator is not cheap," said Ms. Zupko. Salaries typically start at $40,000 and can range as high as $90,000 for experienced administrators servicing a large group practice.

When does the size or volume of the practice warrant hiring an administrator? Ms. Zupko suggests, "If your practice has gross billings in the range of $1 million or more, and you find that you no longer have time to track financials, negotiate managed care contracts, calculate practice revenue or draft the annual budget, then you probably need to hire an administrator."

Step Two: Conducting the Search

Advertising and recruiting are essential to the hiring process. Effective recruiting requires that physicians explore the myriad of search methods available and determine which vehicle is the most appropriate. Word-of-mouth leads, recruitment agencies, online job postings and newspaper advertisements are all effective methods for getting the word out about the position.

When it comes to job advertisements, Ms. Zupko stresses, "Make your ad specific and include information such as managerial responsibilities, educational requirements, desired personality traits and estimated salary range. The more structured your advertisement, the more likely you will attract candidates worth your time to interview."

Step Three: Begin the Interview Process

This is the most critical step in the selection process, because no application form, resumé or letter of recommendation reveals as much about a person as a one-on-one meeting.

It is important to develop a list of key interview questions that focus on areas such as education, managerial experience, leadership skills and decision-making capabilities, such as: "What skills have you learned on your present job that will help you in this position?" or "What are your short- and long-term career goals?"

"You should also develop a second set of interview questions that focus on the candidates' operational and technical knowledge of medical practice management," said Ms. Zupko. These questions should be customized to meet the level of expertise the practice needs in terms of coding and financial management. Questions may include: "What kinds of coding patterns raise suspicions of fraud and abuse in a Medicare audit?" or "What guidelines would you institute for handling cash in the office?"

Step Four: Check References

When the interview process is complete and you have narrowed the candidate pool, check their references. This step requires that you contact the candidates' professional references and discuss their work experience, work habits and competencies, and their character.

"Reference checks are essential because they can provide you with the tools to determine which candidate is right for the position," said Ms. Zupko. "Also, these checks can introduce you to a new list of skills not addressed in the interview process." ■

The information contained in this article was adapted from *Finding the Right Superhero to Manage Your Practice,* a recruitment guide published by KarenZupko & Associates, a practice management consulting firm in Chicago, Illinois. To order the guide, visit their Web site at www.karenzupko.com.

Billing Blunders

Mistakes to Avoid When Billing Electronically.

In an effort to combat declining reimbursement and improve office cash flow, many physicians are shifting away from time-consuming paper claims toward the convenience of a computerized billing system. Such a system allows a physician to electronically chart documentation, post test results, and submit reimbursement claims, while providing the efficiency, expediency, accountability and oversight that could never have been possible via the paper process.

Understanding the steps to properly submit electronic claims is important and key to combating reporting errors that may arise, as well as preventing denied reimbursement.

Understanding the Process

There are several steps that must be followed to initialize electronic billing. First, the physician must file an enrollment form with the carrier. Individual insurers may have a variety of compatible software and hardware requirements necessary for claims submission.

Second, when submitting a claim the physician must specify the submission format being used, such as the National Standard Format or the American National Standard Institute Format. The type and speed of the modem for sending the claim also must be specified and be compatible with the insurer's requirements.

Once the enrollment forms are processed, the physician will receive identification symbols and a password for accessing the insurer's database. The electronic claims software, such as Medicare-compatible Paperless Claims Express or ACCESSplus®, must be loaded with the files and directories needed for claims submission. The type and place of service, as well as provider information must be entered and claims must be formatted according to the individual carrier's requirements, including such information as provider name, receiver identification, patient demographics, and secondary claims requests.

Upon successful log-in, the physician will be prompted to transfer data files to the insurer. Confirmation of receipt can be obtained quickly after data transmission is complete. In fact, the Health Care Financing Administration mandates acknowledgment of receipt, timely payment, and rapid notification of uninterpretable data transmission.

Fewer than half the states have "prompt pay" statutes; however, those with payment regulations require payment of "clean claims" within 15-60 days of receipt. For late payments, interest may range from 8-25 percent annually.

Common Pitfalls in Electronic Billing

Although electronic submission vastly improves processing time and provides rapid confirmation of receipt, the transmitted data must be accurate for successful claims processing. Simple factors that must be accurately entered include patient demographic data and identification numbers. The transposition of such numbers is a common mistake that often results in denied reimbursement.

Improper formatting also is a common reason why electronic claims are denied. For example, some carriers request bilateral procedures to be entered twice with the second code appended with the –50 modifier, whereas others require a single code entered with the –50 modifier accompanied by "two units." Procedures should be listed in descending order of value to prevent application of the multiple procedure rule to higher valued services.

Additional data that must be submitted includes place of service and type of service codes. Some carriers have already linked various services to their appropriate location. Appropriate diagnostic ICD-9 codes must be linked to the physician service CPT codes. A variety of software programs have been developed for the insurers to identify mismatch of diagnostic and procedural codes.

For example, Medicare contracted with regional carrier Administar to create and maintain a database of coding edits to identify incompatible codes, as well as inappropriate unbundling of codes.

Finally, the name and unique provider identification number of the requesting physician must accompany evaluation and management codes describing consultative services.

Despite the advantages of electronic claim submission, several procedural services can't be submitted using this format. For example, auto insurance claims usually require submission of the operative note along with the paper claim. Similarly, workman's compensation claims usually require a paper claim with a copy of the office note or operative dictation.

Advantages Over Traditional Paper Claims

Electronic claims submission offers physicians numerous advantages over traditional paper claims, including adequate confirmation of claims receipt, expediency in processing charges, limited transcription errors and data entry errors, and reduced delays in payment from "lost" paper claims. Cheaper claims processing also has prompted insurers to encourage electronic submissions by offering rapid payment for clean claims.

Although more rapid reimbursement can be achieved, accurate coding and data entry remains imperative, particularly because software programs can identify mismatched coding pairs. ■

Gregory Przybylski, MD, is an Assistant Professor of Neurosurgery at Thomas Jefferson Medical College and a faculty member for the AANS Foundations Reimbursement PDP courses.

Changing Face of Academic Practice

Academic Neurosurgery at the Crossroads.

By Edward C. Benzel, MD

Academic neurosurgery is currently facing perhaps its greatest challenge. In more than half a century of existence, many economic, political and social factors have converged on the academic environment, particularly for neurosurgery. The ability of academic neurosurgery to cope and succeed in this environment is mandatory. Many academic institutions are seeing an increased vulnerability to stresses in the medical environment. This is inextricably tied to an increased level of bureaucracy. Some of the factors affecting this process are addressed here.

Negative Factors Impacting Academic Neurosurgery

■ **Diminished Revenue.** Many neurosurgical programs are facing deep financial trouble as a result of declining reimbursement for services. This, combined with the growth of managed care, soaring University taxes and cuts to Medicare funding, has caused many Program Directors to pull back the reigns on funding for resident education, capital equipment, travel and educational seminars.

■ **Contract Negotiations.** Institutional fears regarding political and social issues have diminished the role of the neurosurgeon as a negotiator with third-party payers. In essence, the neurosurgeon's hands are tied; he has no choice other than to enter into suboptimal contracts with suboptimal reimbursement and excessive clinical obligations.

■ **Billing and Collection Deficiencies.** Institutions that are less privatized usually have less efficient billing and coding systems. Collection rates in University systems are notoriously less than other comparable systems. This, combined with the often exorbinant costs associated with reimbursement services, can result in an excessive overhead/reimbursement ratio.

■ **Taxation.** Excessive taxation brought on by the Universities and state government can increase the overhead of an academic neurosurgical program to unacceptable levels. In some cases, the sum total of this taxation can reach fifty percent of collectible dollars.

■ **Lack of Empowerment.** Department Chairmen are facing their jobs with an ever-decreasing ability to efficiently carry out their mission. In fact, their missions are often unclear. Division Chiefs also are often emasculated in their ability to seek funding for clinical or research endeavors and to function as faculty and resident advocates.

■ **Inefficient Operating Systems.** The function of the inpatient, outpatient and operating room components of patient care become increasingly less efficient as the bureaucratic nature of a system increases. The time and effort required to compensate for the inefficiencies of neurosurgical faculty and residents can be excessive.

■ **Dwindling Research Dollars.** Research and publication are becoming less fiscally rewarded, while the expectations for such are unchanged. This, combined with increasing revenue generation pressures, creates a situation where the time and energy available, as well as the reinforcements for research and creative thought, are diminishing.

■ **Decreased Resident Responsibilities.** The clinical responsibility of neurosurgery residents has been reduced. They no longer can assume the complete care of the patient. This increases the faculty obligation to a greater role. In addition, it diminishes the reward of resident education, while increasing the work and effort required for such.

■ **Increasing Liability.** Medico-legal liability is increasing, particularly in institutions where ancillary support is low. This exposes the neurosurgeon to increased responsibility and risk. Universities are usually the institutions that care for excessive and indigent patient loads. These patient populations tend to be more litigious.

■ **Fraud and Abuse Issues.** Fraud and abuse issues raised by third-party payers, particularly federal reimbursement agencies, are of great concern to neurosurgeons practicing in bureaucratic academic environments where the checks and balances are often inadequate. A neurosurgeon's efforts to compensate for such, and the stresses that fraud and abuse accusations present, can be excessive.

Survival of the Fittest

Institutions and programs that can decrease the bureaucratic overhead and liability of clinical care, and also streamline basic science and clinical research productivity, will fare the best in years to come. Creativity regarding physician reimbursement is required. This will probably involve increasing a neurosurgeon's independence in state institutions. Divisions of neurosurgery must become departments or increase autonomy to function as such. If this does not transpire, the stifling nature of academic medicine will put out the fire of academic neurosurgery.

New sources for neurosurgical basic science and clinical research must be sought. Industry support and partnerships must be developed and nurtured. Moreover, patient care and research performance should be streamlined and its efficiency increased. Institutions must dedicate increasing funds to the resident and faculty core that supports them. This includes, in particular, the funding of research and the provision of time for creative thought. ■

Edward C. Benzel, MD, a neurosurgeon in academic practice for nearly 20 years, is Professor of Neurosurgery at the Cleveland Clinic Foundation and Chair of the AANS Professional Development Program.

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Meet Your New Staff Leader

Dave Fellers, CAE, Named Executive Director of AANS.

By Barbara Peck

Dave Fellers, CAE, assumed the position of Executive Director of The American Association of Neurological Surgeons (AANS) in July, 1999. The Executive Director is the highest staff position in the organization and Mr. Fellers will oversee all organization business and finance operations, including the Annual Meeting; publications; professional development; information services; communications; marketing and sales; membership; and the Research Foundation. Prior to joining the AANS, Mr. Fellers served as Executive Director of the American Society of Plastic and Reconstructive Surgeons (ASPRS) and the Plastic Surgery Educational Foundation.

"Dave Fellers comes to us with outstanding credentials in the field of association management and medical society administration," said Russell L. Travis, MD, AANS Immediate Past-President and Chair of the Search Committee. "His considerable skills in strategic planning and marketing, as well as his knowledge of the socioeconomic issues impacting specialty medicine, will be significant assets to the Association."

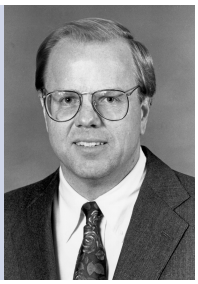
During Mr. Fellers tenure, ASPRS was recognized for several award winning programs, including: ASAE Association's Advance America Summit Award for its breast reconstruction education efforts; a Certificate of Achievement from the American Association for Medical Society Executives (AAMSE) for its Breast Cancer Awareness Month Program; and the Association Forum of Chicagoland for its collaborative efforts with the Food and Drug Administration on breast implant research.

Before leading ASPRS, Mr. Fellers was Director of the Division of Marketing and Public Affairs for the American Nurses Association, and he served as Executive Vice President of both the Texas and Oklahoma Oil Marketers Associations. Mr. Fellers also is a Fellow of the American Society of Association Executives (ASAE) and Past-President of the Oklahoma and Texas Societies of Association Executives. He currently is a member of both the ASAE and AAMSE Board of Directors.

Following are some brief observations by Mr. Fellers as he embarks on his career at the AANS. If you have any questions or concerns for Mr. Fellers, he can be reached at df@aans.org.

What are your top three priorities for your first year at the AANS?

It is my nature to "hit the ground running" and I have several goals for my first year at the AANS. Some of the areas I will focus on include: 1) enhancing the benefits that neurosurgeons receive from the AANS, with emphasis on expanding the public knowledge of who neurosurgeons are and the conditions they treat; 2) continuing to develop a well-rounded and highly-responsive staff and National Office; and 3) updating the AANS strategic plan to enhance the productivity of staff, guide the development and implementation of activities, and assure coordination and cooperation among neurosurgical organizations.



Dave Fellers, CAE, is only the third Executive Director in AANS History.

How do you envision the AANS in five years?

Active and focused. The AANS will continue to be the premiere organization for neurosurgeons with expanded communications initiatives focused on educating the public and medical gatekeepers on the scope of neurosurgical practice; outstanding scientific and socioeconomic publications; and an excellent array of educational programs for members.

How do you think a national organization like the AANS can impact the everyday practice of members?

The AANS is constantly at work behind the scenes, and just about everything we do should impact the everyday practice of our members. The AANS must shift with the changing healthcare marketplace to assure that members receive the most effective educational and practice enhancement opportunities. By providing the most current information and technology on scientific advances and practice management, combined with a national outreach to consumers, the primary care medical community and policy makers, we can position member practices on the cutting edge.

Why do you feel it is important that a small specialty like neurosurgery have a strong national organization?

Because neurosurgery is a small specialty, it would be difficult to influence socioeconomic areas of organized medicine without the AANS pulling the specialty together to present a united front. It is through the efforts of AANS and its Washington Office that reimbursement is appropriately represented and that a national presence of neurosurgery is presented to the legislative branches of government. An active, dynamic national organization is essential if a specialty is going to thrive in the 21st century.

Neurosurgery is somewhat unique in the fact that there are several strong, national organizations. What is your strategy for addressing this issue?

Neurosurgery is fortunate to have a number of outstanding organizations representing its interests. I look forward to working closely

Continued on page 29

KATIE O. ORRICO, JD

Who Will Dictate the Future of Neurosurgery?

Recognizing the Need for Neurosurgeons to be Involved in the Political Process.

Katie O. Orrico, JD, is Director of the AANS/CNS Washington Office.

Elected officials count on, indeed need, constituent input to be effective legislators. Ongoing communication is the *only* way lawmakers will know and understand how you, the voter, feels about particular issues. Therefore, it is imperative that **every** neurosurgeon make the effort to be involved in the political process.

Members of Congress make decisions every day that affect neurosurgeons and their patients. Only those individuals and groups who actively compete in the political process, however, play a role in determining policy. The key is to be a "player" in our competitive political system.

What is Grassroots Advocacy?

The term "grassroots" originated in a speech by Senator Albert Beveridge of Indiana to a delegation at the 1912 Bull Moose Convention. Senator Beveridge stated that theirs was the party of grassroots "… grown from the soil of the people's hard necessities."

Today, the term "grassroots" has evolved to mean organized efforts by special interest groups, particularly at the local level, to promote support for or against specific issues or political candidates. Thomas P. (Tip) O'Neill's argument that "all politics is local" emphasizes the need for interest groups, like the AANS and CNS, to organize at the local or "grassroots" level.

Grassroots advocacy can include any of the following: writing letters to your members of Congress, meeting with lawmakers in their district office or in Washington, D.C., contributing to a candidate's political campaign, hosting political fundraising events, contributing to political action committees, and participating in the state medical and/or neurosurgical societies' policy development processes. The most effective way to be a grassroots advocate is to build a solid rapport with your lawmakers and their staff. By doing so, you will cultivate the legislator's trust and will be more likely to receive political assistance when a critical issue facing neurosurgery comes before U.S. Congress.

Why is Grassroots Advocacy Important?

Organized neurosurgery, through the AANS/CNS Washington Committee, Washington Office staff and the independent American Neurological Surgery Political Action Committee (ANS PAC), maintains a comprehensive government relations program. And, while these elements are certainly critical to promoting our health policy agenda, none of them can replace the power of constituents. Members of Congress only stay elected by the votes of their constituents; thus, they are acutely attentive to messages delivered from voters.

Today, the importance and power of grassroots advocacy is greater than ever. As more organizations compete for the attention of Congress, it is imperative that organized neurosurgery have a robust network of "grassroots activists." Experience has taught us that we increase our success rate when every neurosurgeon gets involved.

Two recent examples are the successes we had in staving off substantial cuts in practice expense reimbursement and the number of co-sponsors we have generated for the collective bargaining legislation since April 1999.

Additional benefits of grassroots political action include:

- Elected officials and individual neurosurgeons develop personal relationships.
- The efforts of individual neurosurgeons lend credibility to the messages that the Washington Office staff deliver.
- Neurosurgeons increase their knowledge about the political process and political campaigns.
- Candidates are elected because of neurosurgeons' efforts.
- The AANS and CNS become more effective in public policy negotiations.

How Can You be a Grassroots Advocate?

The answer to this question is one word: participate. There are many ways in which neurosurgeons can participate in the political process and become effective grassroots advocates (see chart on page 25). Every neurosurgeon does not have to engage in each advocacy activity; however, every neurosurgeon must do something. Typical responses for inaction include: "I don't have time between my professional, educational and family activities to get to know my Congressman." "I'm only one person and my opinion or campaign contribution won't make a difference." "Politics can get dirty and I don't want to lower myself to that level." "The AANS and CNS are representing my interests before Congress, so I don't have to do anything myself."

While there is an element of truth to the aforementioned "excuses" for inaction, in today's competitive healthcare environment, neurosurgeons can no longer afford to be ostriches and bury their heads in the sand. With so many other interest groups — trial lawyers, managed care companies, other medical specialties — trying to get the competitive edge and promote their interests above neurosurgery's in Congress, you must get involved. Remember: neurosurgeons should be the ones dictating the future of

neurosurgery, not some other interest group or uninformed lawmaker.

So, when the AANS and CNS send you a "Grassroots Action Alert," respond by writing a letter, making a phone call or meeting with your lawmaker. When a political candidate you support requests a financial contribution, send them a check. If your lawmaker holds a town hall meeting, attend and speak up. Each of these individual actions take less than one-hour to do, yet if you do them enough, over time you will have built a relationship with your Member of Congress and become an effective grassroots advocate. ■

Katie O. Orrico, JD, is Director of the AANS/CNS Washington Office. For more information on grassroots advocacy, contact her at (202) 628-2072 or visit the socioeconomic section of our Web Site at www.neurosurgery.org

How To Be an Effective Grassroots Advocate

- Meet regularly with lawmakers and their staff in your district and in Washington, D.C., to establish or maintain a close relationship and to present your views on neurosurgical issues.
- Invite lawmakers and their staff to spend a "day-in-the-life of a neurosurgeon." Give them an opportunity to tour the hospital, observe surgery and make patient rounds.
- Establish a healthcare advisory group in the district that can provide expert advice on issues affecting physicians and patients.
- Contribute to your lawmaker's political campaign by hosting political fundraisers and volunteering.
- Join the AANS/CNS "Key Person Program."
- Respond to AANS and CNS "Grassroots Action Alerts" by communicating with your lawmakers on specific issues before Congress.
- Participate in your state neurosurgical and medical societies' policy development processes.
- Stay informed about key health policy issues affecting neurosurgery.

One Neurosurgeon's Experience in the Political Process: A Roadmap for Success

To see how your involvement in the political process can pay off, you need only look to the experience of Troy M. Tippett, MD, a private practice neurosurgeon in Pensacola, Florida. Dr. Tippett exemplifies what it means to be a grassroots advocate. His participation at the local, state and national level of politics and organized medicine has reaped benefits for many physicians in this country, and should serve as an inspiration to neurosurgeons aspiring to get involved in the political process.

According to Dr. Tippett, he first became involved with politics on a state legislative level when he "got tired of complaining and decided to try and do something about it." He recognized early on that "all relationships with politicians begin with money." This requires not only making personal contributions, but also raising money for a candidate from friends and colleagues. Dr. Tippett has done just this for several candidates, including Senator Connie Mack (R-FL), Congressman Joe Scarborough (R-FL), and Governor Jeb Bush (R-FL), for whom he has helped raise a combined total of $400,000.

Dr. Tippett has used his fundraising activities as the starting point to cultivate his relationships with the lawmakers and their staffs (both in the local and national offices). He uses several techniques for reinforcing his relationships. These include attending public forums in the state (and making sure the lawmaker knows he is there), personal meetings, writing letters, and making himself available to the lawmaker and their family to help solve any medical problems.

Whenever he is in Washington, D.C., Dr. Tippett also makes sure he visits Senator Mack and Representative Scarborough's offices. As a result, he has developed friendships that have produced very positive results. For example, Representative Scarborough relies heavily on Dr. Tippett's advice when any medical issue comes before the U.S. Congress, frequently calling Dr. Tippett for his input and opinion. In addition, Representative Scarborough has supported every medical issue that Dr. Tippett has asked him to support, including tort reform (even though Representative Scarborough is an attorney), managed care reform and, most recently, the Campbell Bill.

Dr. Tippett's message to neurosurgeons is simple: "It is very easy to develop a relationship with a candidate. You must raise money and then provide them with what they cannot get from others — sound medical advice. Just remember, if you don't help the candidate get elected, your enemies will!"

Dr. Tippett currently holds a number of political and public policy positions in organized medicine. At the national level, he is Chair of the American Neurological Surgery Political Action Committee, a member of the AANS/CNS Washington Committee and a Florida Medical Association alternate delegate to the American Medical Association. At the state level, he is Legislative Chair of the Florida Neurosurgical Society; member of the Florida Medical Political Action Committee (FLAMPAC) Board of Directors; Chair of FLAMPAC's Congressional Selection Committee; and a delegate to the Florida Medical Association. ■

FLORA JOHNSON SKELLY

Stress Busters

Tips on Recognizing and Managing Physician Stress.

According to medical educator Timothy P. Brigham, PhD, stress is "the basic confusion created when one's mind overrides the body's desire to choke the living daylights out of some jerk who deserves it." A more conventional definition is that stress is what happens when perceived threats chronically activate the body's "fight or flight" response.

However it is defined, stress is an important health concern for today's physicians, agreed experts attending the Third International Conference on Physician Health, sponsored by the American Medical Association, Canadian Medical Association, Federation of State Medical Boards, and Federation of Medical Licensing Authorities of Canada.

Stress Symptoms

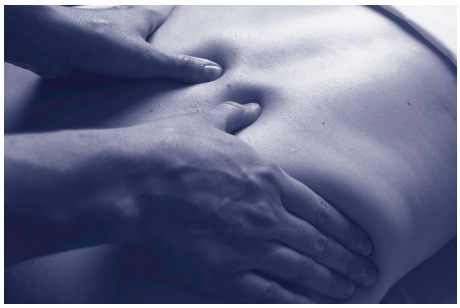
The very characteristics society values in physicians, because they make for better doctors, also make physicians unusually susceptible to the negative effects of stress.

According to psychiatrist Roy W. Menninger, MD, most physicians are "compulsive." This element of compulsiveness is manifested in traits such as attention to detail, hyperconscientiousness, a deep commitment to the patient and the ability to absorb and contain anger and other negative feelings.

In addition, physicians tend to be perfectionists, workaholics, and markedly guilt-prone, noted Dr. Menninger. "In other words," he said, "the average doctor doesn't get much fun out of life." Physicians also tend to be so self-sacrificing that they feel guilty about attention to their own needs. As a result, they usually are the last to admit that they are suffering from stress.

Symptoms of stress may include physical reactions such as cardiovascular, gastrointestinal and respiratory problems. But stress also can manifest itself in other ways, which are "often more obvious to others" than to the doctors themselves, Dr. Menninger said.

People under stress often exaggerate normal behaviors — for example, working even longer hours. They also tend to "become a caricature of themselves: Quiet people become quieter, and loners become more isolated," Dr. Menninger noted. Other behavioral changes may include sleep disturbances, withdrawal from colleagues and friends, decreased work effectiveness (i.e. unaccustomed difficulty managing patients or fear of referring patients) or increased drug and alcohol use.



Emotional reactions can include anxiety (tension, nervousness, jumpiness, inability to relax) hostility (irascibility, anger at minor things), scapegoating (blaming others, fault-finding, being critical or hard to please), and depression. Markedly increased family tensions also are common. These include the appearance of stress symptoms in other family members, fewer stress-free conversations, more fights, fewer shared satisfactions and a tendency by both spouses to become easily upset or angry.

"Frequently," said Dr. Menninger, "any or all of the above symptoms are accompanied by denial from the physician that anything is the matter."

Intimacy as a Stress Buffer

Physicians often use intimate relationships as a buffer against the negative effects of stress. However, Walton E. Byrd, MD, a clinical psychologist, believes that certain behaviors, such as compulsivity and perfectionism, tend to undermine many doctors' intimate relationships.

A particular problem for physician relationships is what Dr. Byrd dubs as the "psychology of postponement." Beginning in medical school, physicians put their time and effort into medicine, while important relationships are neglected. By the time physicians do find time for their marriages, their spouses are angry and resentful, and both parties are lonely and isolated.

Doctors with troubled marriages should dedicate time to getting those important relationships back on track. "Physicians should set aside time each day to talk about themselves," Dr. Byrd said. "They should block out time once a week to go out to dinner or go to a movie, and should try to get away three or four weekends a year to go on vacation with their spouse."

A New Way to Think

All people are not equally stressed by the same environment. The difference often lies in how each person thinks about a potentially stressful experience. "Stress is a reaction to a perceived threat," said Dr. Brigham. "What you're telling yourself about what is happening may be what makes it seem like a threat."

Physicians tend to develop habitual ways of reacting to such threats. These habits, which often open physicians up to increased vulnerability, may include:

- **Deficiency-focusing** — the habit of focusing on the negative at the expense of the positive. No matter how things are going, this habit involves looking for the thing going wrong, rather than the thing going right.
- **Necessitating** — the belief that we **have** to do something rather than that we have a **choice** in doing it.

Every request is translated into a demand, and any failure to live up to demands on the self is expected to result in calamity.

- **Low skill recognition** — the tendency not to recognize the role of the one's abilities and successes. Everything positive is attributed to something external, such as luck or another person. If a person with this habit finds a task easy, he or she thinks that it is not worth doing.

"Fortunately, these habits are not ingrained personality patterns and can be changed," said Dr. Brigham. Although it is easier to change these patterns with expert help, anyone can learn to challenge them. He recommends:

- When deficiency-focusing, ask, "What is right in this situation and how can the obstacles be overcome?" The goal is not to negate or pass off mistakes, but to gain perspectives on them by placing them in the proper context.
- When necessitating, ask, "What can realistically happen if I don't do this?" or "Is there room for negotiation?"
- For low skill recognition, ask, "What did I contribute and what abilities did I show?" The goal is not to ignore limitations, but to recognize growing skills and abilities so one can gain confidence and self-esteem.

Stress-reducing Techniques

Edward Messner, MD, a clinical professor and author of *Resilience Enhancement for the Resident Physician,* has outlined some stress-coping techniques. He emphasized that stress-reducing approaches are useful for practicing physicians and residents alike, and urged doctors to select the technique that best suits their situation. Dr. Messner's stress busters include:

- **Inner Dialogue:** Imagine a conversation about the stressful situation. One speaker is the distressed part of yourself, and the other is your calm, mature side. By playing out this imaginary conversation, you will help stabilize emotional reactions and neutralize feelings of isolation.

"The very characteristics society values in physicians, because they make for better doctors, also make physicians unusually susceptible to the negative effects of stress."

- **Mental Rehearsal:** Imagine, in advance, your response to a stressful situation. For example, when anticipating the encounter with the family of a dying patient, try and imagine the conversation that might ensue, playing out different versions of the same confrontation. This exercise may ease difficult interactions and protect you from responding inappropriately.

- **Expressive Fantasies:** Imagine stress-relieving actions that you would never carry out. "It is important to keep in mind that these scenes are imaginary, not to be put into action," said Dr. Messner.

Many people also find that they can manage stress through physical activity. Activities such as stretching, isometrics or running up and down stairs can be effective stress relievers and release a great deal of pent up tension.

Relaxation techniques also can release feelings of stress and counter stress-induced insomnia, and may include:

- **Autohypnosis** — repeat to yourself a little speech suggesting that you are relaxing or falling asleep. An alternative is to close your eyes and systematically relax different parts of the body. You also can give yourself the suggestion that when you wake you'll feel alert and refreshed.

- **Progressive muscle relaxation** — close your eyes and systematically relax your body. Some people do this best by imagining each segment of the body, others by imagining that a wave of relaxation is flowing over the body.

- **Meditation** — focus on your breathing, thinking about each expiration. Before long, your respirations will slow down and deepen, mimicking those of sleep. It also is possible to repeat the same phrases silently, over and over.

For those physicians who cannot handle stress on their own, Dr. Messner urged them to seek psychiatric care. He said the message is simple: "Recognize the stress and admit it's there. Know that there are accepted ways to reduce your reaction to stress and, if you can't handle it, don't hesitate to ask for help." ■

This article was originally published in the October 24/31, 1994 issue of *American Medical News,* the weekly newspaper of the American Medical Association. It is published in the AANS Bulletin by permission of the author, Flora Johnson Skelly.

This is the first in a series of articles that highlight an issue outside of the practice of neurosurgery.

Supporting the Future of Neurosurgery

The Research Foundation Recognizes Four Researchers.

The Research Foundation of The American Association of Neurological Surgeons continues its excellent track record of supporting worthy neuroscience research. As of June 1999, four clinicians funded by the Research Foundation were completing their projects. It is anticipated that their names will become familiar to you as their research unfolds. Following are summaries of their work thus far.

1997 Research Fellow

Lilyana Angelov, MD, MSc
University of Toronto
Chair: *Charles Tator, MD, PhD*
Sponsor: *Abhijit Guha, MD*

Project Title: *Vascular Endothelial Growth Factor (VEGF) Expression and Receptor Inhibition in Human Peripheral Nerve Tumors.*

Project Update: We postulated that VEGF and its cognate receptor, VEGFR2(Flk-1/KDR), are relevant in the growth of neurogenic sarcomas. First, VEGF expression was evaluated by Northern blot and immunohistochemical analysis from a spectrum of human peripheral nerve tumors (PNTs) representing varying degrees of malignancy, and compared to tumor vascularity. Compared to a normal nerve, VEGF expression was significantly elevated in both Neurofibromatosis (NF)-1(11.6X) and non-NF-1(7.5X) neurogenic sarcomas, and correlated with increased vascularity (90-131 vessels/HPF). In contrast, VEGF expression in benign PNTs (0.1-1.7X) and accompanying vascularity (14 vessels/HPF) were low.

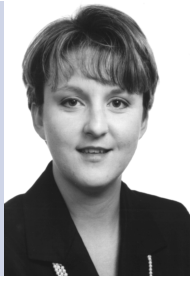
To determine the functional relevance of VEGF mediated tumor angiogenesis in neurogenic sarcomas, a subcutaneous NF-1 neurogenic sarcoma xenograft model in NOD-SCID mice was developed. VEGFR2 activation was inhibited with the small molecule inhibitor SU5416(SUGEN Inc.), with evaluation of tumor burden, tumor vascularity, BrDU labeling and apoptosis (TUNEL).

Daily intraperitoneal SU5416 (25 mg/kg) resulted in 54.8 percent tumor shrinkage ($p<0.02$), decreased tumor vascularity (61.5±7.2 vs. control 119±10.8 vessels/HPF), decreased tumor proliferation (1.6 percent±0.2 percent vs. 25.4 percent±2.2 percent BrDU labeled cells) and increased apoptosis (33.9 percent±1.2 percent vs. 1.7 percent±0.01 percent TUNEL positive cells).

These results demonstrate that grade of human PNTs correlate to tumor angiogenesis and VEGF expression. Hence, strategies to inhibit VEGF mediated tumor angiogenesis may be of therapeutic benefit in controlling local growth and metastasis of human neurogenic sarcomas.

1997 Research Fellow

Amy B. Heimberger, MD
Duke University Medical Center
Chair: *Allan H. Friedman, MD*
Sponsor: *Darrell D. Bigner, MD*



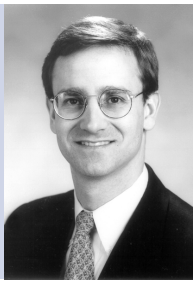
Project Title: *Cytotoxic Lymphocyte Response Against Central Nervous System Tumors.*

Project Update: Our studies are dedicated to the induction of an immunological response against CNS gliomas. The model system is a spontaneously arising, syngeneic, murine astrocytoma (SMA-560) expressing the mutated epidermal growth factor receptor (EGFRvIII) – a tumor specific antigen. Vaccination with peptides corresponding to the mutant splice junction of the EGFRvIII or heat shock protein (gp96) purified from SMA-560 inhibited subcutaneous glioma growth, failed to have efficacy against intracranial gliomas. However, dendritic cells pulsed with SMA-560 extracts increased median survival >285 percent within animals possessing intracranial gliomas without induction of autoimmunity.

The efficacious response is both cytotoxic and humorally mediated. Dendritic cells obtained from glioma patients are phenotypically and functionally normal, thereby making dendritic cell therapy a new and exciting therapeutic intervention for glioma patients.

1998 Rhone-Poulenc Rorer Young Clinician Investigator

Frederick F. Lang, MD
University of Texas MD Anderson Cancer Center
Chair and Sponsor:
Raymond Sawaya, MD



Project Title: *Adenovirus-mediated p53 Gene Transfer Combined With Ionizing Radiation and Antineoplastic Agents Against Wild-type p53 Human Gliomas.*

Project Update: We are examining adenovirus-mediated p53 gene transfer (Ad-p53) as a treatment for human gliomas. Initial studies demonstrated that unlike mutant-p53 gliomas, wild-type (wt) p53 gliomas are resistant to Ad-p53. To overcome this resistance, we combined Ad-p53 with DNA damaging agents.

To date, we have demonstrated that Ad-p53 sensitizes wt-p53 gliomas to IR *in vitro*

Continued on page 29

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with each of these groups to seek ways to collaborate, avoid duplication and, most importantly, to enhance our members' practices and their ability to meet the needs of their patients.

Ultimately, I feel that neurosurgeons will best be served by pooling many of the resources, talents and strategies of the various organizations in a collective effort. There may be many opportunities for consolidation and cooperation, and I will strive to identify these while, at the same time, being sensitive to the valuable contribution each group makes to neurosurgery.

The ASPRS has been quite proactive in developing a relationship with third-party payers. Tell us about your accomplishments in this area and how you feel it has benefited members.

One of the goals in my position with plastic surgeons has been to clearly establish the scope of practice and the necessity of reimbursement for certain procedures. Through direct discussions, exhibits, and the development of guidelines, we learned a great deal from our interactions with third-party payers. While proving the necessity of procedures isn't as large of an issue for neurosurgery, it is essential that we maintain a firm holding for neurosurgeons as the premier physicians for spine, cerebrovascular, skull base and pain procedures, among other areas. A top priority is to communicate the diversity of neurosurgical procedures and assure that third-party payers recognize the value of neurosurgical care and reimburse appropriately.

Over the past few years, you have had to tackle the issue of subspecialization within plastic surgery. How will this experience help you as neurosurgery continues to struggle with this issue?

"Turf" issues are more prominent in plastic surgery than any other specialty. It is critical that every specialty respect and address the issues and concerns of its subspecialty areas. I have learned that open communication channels, cooperation and collaboration, rather than duplication, are fundamental to finding a win-win solution the entire specialty can benefit from.

As the breast implant debates began to surface, what advice did you give to the ASPRS Board of Directors?

My experience with the FDA began three days after I started with ASPRS. Our initial response was to raise $3 million to "fight" the issue in Congress and the FDA. While this was totally supported by membership, we soon learned the key to the issue was appropriate and necessary research to respond to the concerns and questions of the public. My advice to organized plastic surgery was to balance their legislative initiatives with scientific research, or data, that would inform the public and governmental agencies of the value of the procedure, or the device.

Do you have a "golden rule" that you try and instill throughout an organization?

It is the same for leadership and staff...our goal is to identify and respond to members needs. This is best accomplished through research on members' needs and effective strategic planning. It is critical that the AANS know the opinions and attitudes of the membership. Members will be receiving many requests for their opinions on projects, services and direction for the AANS. This input will be very valuable and will be closely evaluated.

What are your hobbies?

I like to work hard and play hard. My wife, Jan, and I enjoy adventure vacations or cruises—such as trekking in Nepal last November; camping and hiking along the Amazon; or biking in Turkey and Greece. We also enjoy biking, golf and tennis. Jan and our eldest daughter, Stacia, have an antique business in Kansas City; and our youngest daughter, Andrea, is a starving actress in Hollywood. ■

RESEARCH FOUNDATION

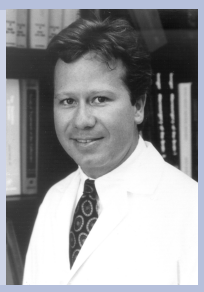
Continued from page 28

by increasing apoptosis. Additionally, Ad-p53 plus IR significantly attenuates the growth of wt-p53 glioma xenografts implanted in nude mice.

This radiosensitization is dependent on the ability of p53 to bind DNA, but is not solely dependent on exogenous p53 levels. Because Ad-p53 does not radiosensitize normal astrocytes, this combination may be clinically efficacious. Similar results are seen when Ad-p53 is combined with cisplatnin.

1998 Shirley L. Bagan Young Clinician Investigator

Carl Lauryssen, MD
Washington University (St. Louis)
Chair: *Ralph G. Dacey, Jr., MD*
Sponsor: *Jack R. Engsberg, MD*



Project Title: *A Computer Analysis Outcome Study of Cervical Spondylotic Myelopathy.*

Project Update: The goal of the study is to objectively evaluate the outcomes of surgically-treated patients with cervical spondylotic myelopathy. Thus far, eight patients with signal change by MRI and five patients without have been enrolled, prospectively. Although the results are encouraging, the final analyses are not complete and enrollment continues. ■

Courses That Work For You

The AANS Professional Development Program Offers Two Comprehensive Reimbursement Courses.

In today's age of declining reimbursement, it has never been more important for neurosurgeons to be up-to-speed on coding and reimbursement requirements. "With the rules and regulations for accurate coding and documentation becoming more complex, and the number of Medicare fraud cases surfacing at a rampant pace, neurosurgeons and key office staff need to have a complete understanding of proper coding procedures to avoid denied reimbursement and, worse, investigations and fines," said Richard A. Roski, MD, FACS.

Since joining the AANS Professional Development team in 1995, Dr. Roski has served as Chair of more than 25 Coding and Reimbursement courses, and has provided participants with valuable insight on coding and reimbursement issues.

"I became interested in the Professional Development Program nearly five years ago," said Dr. Roski. "I had been volunteering with the American Medical Association on several CPT coding initiatives, and recognized that there was a need for a continuing educational course geared specifically toward neurosurgeons, and that was aimed at providing useful information on coding, billing and reimbursement procedures. I found that the PDP's existing Reimbursement Program met all of those needs, and more."

The AANS currently offers two courses: "Reimbursement Foundations: Neurosurgical Billing and Coding for Efficiency" and "Advanced Coding and Reimbursement Concepts in Neurosurgery."

Describing the Reimbursement Course Program, Dr. Roski said, "The Foundations and Advanced Reimbursement courses are unlike any other. They are designed to provide a comprehensive learning experience that covers all aspects of neurosurgical coding and documentation. More important, they are taught by authorities in the field—neurosurgeons and practice management consultants specializing in coding and reimbursement issues."

In the next couple of years, the Professional Development Program will look at enhancing the quality of the Reimbursement Program by focusing on issues that address the changing neurosurgical and socioeconomic climate. According to Dr. Roski, "Our plans for future Reimbursement courses include coupling updates on CPT coding with information on how to effectively manage a neurosurgical practice."

This new focus, coupled with the innovative practice management courses the Professional Development Program is planning, is meant to respond to the changing needs of every practicing neurosurgeon.

Richard A. Roski, MD, FACS, is Chair of the AANS Foundations and Advanced Reimbursement courses.

In addition to serving as course Chair of the Foundations and Advanced Reimbursement courses, Dr. Roski is a strong advocate for developing appropriate neurosurgical CPT codes. He is a member of the AANS/CNS Physician Reimbursement Committee, the AANS/CNS Cost Containment Committee and is Co-Chair of the AANS/CNS CPT Coding Task Force. In addition, he serves as the AANS representative to the CPT Advisory Panel of the American Medical Association.

If you would like to learn more about the Professional Development Program, or register for a Coding and Reimbursement course, please contact the Professional Development Department in the AANS National Office at (847) 692-9500. ■

2000 AANS PDP Courses

The AANS wishes to acknowledge our 1999 Professional Development Educational Partners for their generous support of medical education.

Leica

ZEISS

SOFAMOR DANEK

1 ***Advanced Techniques and Successful Strategies in Image-Guided Neurosurgery: An Intensive Review***
Date and Location TBD

2 ***Spine Surgery—Hands–On: A Comprehensive Approach for Neurosurgeons & Neuroscience Nurses***
June17-23, 2000
Cleveland, Ohio

3 ***Surgical Management of Movement Disorders***
July 27-28, 2000
Location TBD

4 ***Treatment of the Cervical Spine: Hands–On***
August 25-26, 2000
Memphis, Tennessee

5 ***Comprehensive Review Course for Young Spine Surgeons***
October, 2000
Cleveland, Ohio

6 ***Minimally Invasive Neurosurgery: Neuroendoscopy—Hands–On***
November, 2000
Cleveland, Ohio

For more information, call the Professional Development Department at (847) 692-9500.

NEWS.ORG

SectionsCommitteesAssociationsSocieties

New Exhibit on N://OC®

The Cyber Museum of **NEUROSURGERY://ON-CALL®** announces a special exhibit commemorating the 65th anniversary of Richard Upjohn Light's, MD, "Seaplane Cruise Around the World." The exhibit includes excerpts from Dr. Light's flight journal on the *Asulinak* and documents his aviation experiences, as well as his impressions of the medical facilities he visited in 1934-35.

The journal entries will be posted on N://OC® as a four-part series, and coincide with the anniversary date of each leg of Dr. Light's trip.

Part One:
Atlantic, August 20, 1999

Part Two:
Europe, September 17, 1999

Part Three:
Asia, October 16, 1999

Part Four:
North America, January 1, 2000

To visit this special exhibit, go to www.neurosurgery.org/cybermuseum/summary.html

Section News

Section on Disorders of the Spine and Peripheral Nerves The Spine Section, in conjunction with the Outcomes Subcommittee of the AANS/CNS Committee for the Assessment of Quality, is conducting an online outcomes study for the treatment of lumbar disc disease. The study, which evaluates the clinical and functional outcomes of patients treated for lumbar disc herniation, is available on the Outcomes Sciences POINT System Web site (www.outcomesciences.com/research). The outcomes reporting system allows any member of the AANS or CNS to enter all relevant data online, at no cost. There are no patient or surgeon identifiers on the database and the identification code is kept at the AANS office and cannot be accessed through the Internet, making submission of data via this system safe and confidential.

Section on Neurotrauma and Critical Care The AANS/CNS Section on Neurotrauma and Critical Care has established a one-year fellowship, in the amount of $40,000, intended to cover travel and living expenses for a resident who wishes to broaden his or her exposure in the area of neurotrauma and critical care. The fellowship must be undertaken in a reputable North American or European center, and the results of the recipient's research must be presented as a lecture at either the AANS or CNS Annual Meeting, as well as published in a national peer-reviewed journal. Residents interested in applying should send: 1) curriculum vitae; 2) statement regarding the purpose of the proposed fellowship and estimated expenses; 3) letter from the applicant's residency program director confirming the resident's date of completion; and 4) letter of acceptance from the institution where the applicant will seek the fellowship to: Jack E. Wilberger, Jr., MD, Allegheny General Hospital, East Wing Office Building, 420 East North Avenue, Suite 302, Pittsburgh, PA 15212. The deadline for application submission is December 1, 1999.

Section on Tumors The AANS/CNS Section on Tumors urges AANS members to implement the Low Grade Glioma (LGG) Guidelines, developed by the Glioma Outcomes Project through the efforts of a multi-specialty task force that included the Outcomes Subcommittee of the AANS/CNS Committee for the Assessment of Quality and the Tumor Section, into their practices. The Guidelines, which cover a variety of topics such as natural history of LGG, risk factors, diagnostic approaches, resource utilization and treatment methods, are designed to improve patient care and provide a mechanism by which physicians can evaluate and improve their treatment practices. The Guidelines were published in *Neurosurgical Focus* (June 1998) and can be accessed on www.neurosurgery.org. ■

Neurosurgical Shopping Made Easy

NEUROSURGERY://ON-CALL® is pleased to offer cyber surfers the Online Marketplace — an easily accessible online shopping experience on **N://OC®** where visitors can order the full line of AANS and CNS neurosurgical products and publications. Publications available on the site include the *Neurosurgical Operative Atlas* Series, the *Neurosurgical Topics* Series, the Getting SMART Programs and more.

Like other online shopping sites, the Online Marketplace uses a shopping cart concept that allows a visitor to browse through a cyber aisle of products and add purchases to his or her cart. When the visitor is finished shopping, he or she can empty the cart, view a summary screen that totals the order and submit the necessary credit card and shipping information. The buyer will be asked to confirm his or her order and, in turn, the buyer will receive an order confirmation via e-mail. All products purchased online are guaranteed to ship within five business days.

The Online Marketplace also offers cybershoppers convenient search options. By typing in a key word, product title, author name or topic, visitors can locate product photos and descriptions, book reviews, user testimonials and more.

For more information on the products available, or to order online, visit the Online Marketplace at www.neurosurgery.org.

Silent Auction a Success
The Research Foundation of the AANS would like to thank the Young Neurosurgeons Committee (YNC) for their efforts in running the Silent Auction at the 1999 AANS Annual Meeting. Nearly $12,000 was raised in this first-time effort. Thanks to all who submitted winning bids, and to all of the YNC members, especially Adam Lewis, MD, Clara Epstein, MD, and David Jimenez, MD, for their hard work in organizing this event. Proceeds benefit the Foundation's Research Fellowship and Young Clinician Investigator Awards.

AANS Annual Meeting Recognized
Tradeshow Week magazine recently recognized the AANS Annual Meeting as the third largest medical meeting in terms of net square feet. The ranking was based on all medical shows that occurred between January 1, 1999–July 1, 1999.

CSNS Semi-Annual Assembly Report

LYAL G. LEIBROCK, MD, FACS

The Council of State Neurosurgical Societies (CSNS) met in New Orleans, Louisiana, April 23-24, 1999. The Assembly considered a variety of socioeconomic resolutions that will strongly impact the neurosurgical community.

Continuing Medical Education

Attention was focused on the limited number of continuing medical education credits issued to neurosurgeons who attend the AANS and CNS Annual Meetings. Two resolutions were raised requesting the AANS and CNS to consider conducting three 10-hour and one seven-hour Plenary/Scientific Sessions at their Annual Meetings. The sessions would allow neurosurgeons to earn nearly 35 CME credits, as opposed to earning only 20 CME credits as it now stands. The resolutions were referred to the CSNS Communication and Education Committee for report at the next CSNS meeting, which is slated to take place prior to the 1999 CNS Meeting in Boston.

Spotlight on Neurotrauma and Critical Care

The Ad Hoc Neurotrauma Committee presented several resolutions addressing issues surrounding neurotrauma and critical care. First, the Committee requested the Officers of the AANS and CNS to promulgate a position statement regarding the utilization and supervision of mid-level practitioners, including physician assistants and nurse practitioners, in the delivery of emergency neurosurgical care.

Political Action

A resolution in support of HR 1304, the "Quality Health Care Coalition Act," was unanimously passed. The Bill exempts self-employed health care professionals, including doctors in private practice, from antitrust laws and allows them to collectively bargain with HMOs. In addition, the Executive Committee of the CSNS urged neurosurgeons to continue to participate in grassroots activities aimed at providing continued access to emergency specialty care.

Commitment to Young Neurosurgeons

In a report delivered by David F. Jimenez, MD, a suggested mechanism by which each quadrant would select two residents to participate in the CSNS for a period of one year was approved. The CNS and AANS also will appoint two residents to participate in the CSNS deliberations. The CSNS will cover all travel expenses to and from the semi-annual CSNS meetings, and will work with Program Directors to identify residents with interest.

Organization of National Neurosurgery

The Council passed a resolution requesting the AANS and CNS to: 1) develop a joint strategic plan, and 2) consolidate resources. The motion comes after more than one year of debate between the AANS and CNS surrounding meeting management, marketing and other issues. The resolution will go to the AANS Board of Directors and the CNS Executive Committee for approval. Progress on the motion will be discussed at the CSNS session in Boston.

Subspecialty Certification Symposium

Attention was focused on the issue of subspecialty certification. Kenna Given, MD, Chair of the American Board of Plastic Surgery; Wallace Richie, MD, Executive Director of the American Board of Surgery; Donald Quest, MD, Secretary of the American Board of Neurological Surgery and Kim Burchiel, MD, Former Chair of the American Board of Pain Medicine, debated whether the American Board of Neurological Surgery should implement standardized, accredited fellowship guidelines, offer certificates of added qualifications or develop subspecialty Boards. Taking into consideration the arguments addressed by each panel participant, the Executive Committee of the CSNS agreed that accreditation of fellowship guidelines is essential to the future of organized neurosurgery; however, subspecialty certification is not. ■

EVENTS

Calendar of Neurosurgical Events

Brazilian Academy of Neurosurgery and World Federation of Neurosurgical Societies
September 1-7, 1999
Rio Grande do Sul, Brazil
55-51-2225760

Western Neurosurgical Society Annual Meeting
September 18-21, 1999
Coeur d'Alene, Idaho
(619) 268-0562

11th European Congress of Neurosurgery
September 19-24, 1999
Copenhagen, Denmark
45-345-2390

American Association of Electrodiagnostic Medicine Scientific Meeting
October 6-9, 1999
Vancouver, British Columbia, Canada
(507) 288-9928

Review and Update in Neurobiology for Neurosurgeons
October 9-16, 1999
Madison, Connecticut
(203) 421-5886

58th Annual Meeting of the Japan Neurosurgical Society
October 27-29, 1999
Tokyo, Japan
81-3-5800-8853

Congress of Neurological Surgeons Annual Meeting
October 30-November 4, 1999
Boston, Massachusetts
(847) 692-9500

AANS/CNS Section on Pediatric Neurological Surgery
December 1-4, 1999
Atlanta, Georgia
(847) 692-9500

AANS/CNS Section on Cerebrovascular Surgery
February 6-9, 2000
New Orleans, Louisiana
(847) 692-9500

AANS/CNS Section on Disorders of the Spine and Peripheral Nerves
February 23-26, 2000
Indian Wells, California
(847) 692-9500

26th Annual Symposium-Recent Advances in Neurosurgery
March 2-4, 2000
Phoenix, Arizona
(602) 406-3067

Skull Base Surgery 2000
March 17-20, 2000
Scottsdale, Arizona
(301) 654-6802

The American Association of Neurological Surgeons
April 8-13, 2000
San Francisco, California
(847) 692-9500

AANS/CNS Section on Tumors Satellite Symposium
April 13-14, 2000
San Franciso, California
(847) 692-9500

Latin American Congress of Neurosurgery
June 11-16, 2000
Ceara, Brazil
55-85-2485125

World Spine 1: First Interdisciplinary World Congress on Spinal Surgery
August 27-September 1, 2000
Berlin, Germany
49-30-857903-0

28th Annual Meeting of the International Society for Pediatric Neurosurgery
October 2-6, 2000
Istanbul, Turkey
90-232-4630591

15th International Congress of Head and Neck Radiology
October 18-21, 2000
Kumamoto, Japan
81-96-373-5258

4th World Stroke Congress
November 25-29, 2000
Melbourne, Australia
61-3-9682-0288

Calendar of AANS Professional Development Courses

Surgical Management of Movement Disorders
September 17-18, 1999
Chicago, Illinois

Ventral Surgical Approaches for the Thoracic and Lumbar Spine
September 24-25, 1999
San Antonio, Texas

Minimally Invasive Neurosurgery: Neuroendoscopy Hands-On
October 1-2, 1999
Cleveland, Ohio

Comprehensive Review Course for Young Spine Surgeons
October 9-15, 1999
Cleveland, Ohio

Neurosurgery Review by Case Management: Oral Board Preparation
November 14-16, 1999
Houston, Texas

Advanced Coding and Reimbursement Concepts in Neurosurgery
November 19-21, 1999
Phoenix, Arizona

Neurosurgery Review by Case Management: Oral Board Preparation
May 14-16, 2000
Savannah, Georgia

Spine Surgery—Hands-On: A Comprehensive Approach for Neurosurgeons and Neuroscience Nurses
June 17-23, 2000
Cleveland, Ohio

Neurosurgery Review by Case Management: Oral Board Preparation
November 5-7, 2000
Houston, Texas

For more information or to register for an AANS PDP Course, contact the Professional Development Department at (847) 692-9500.

ANS PAC State Coordinators Lead Fundraising Drive

Thanks to the ongoing efforts of Randy Smith, MD, ANS PAC Board Member and Membership Committee Chairman, neurosurgeons from across the country have been recruited to serve as "State Coordinators." These individuals have taken time out of their busy practices to solicit contributions for ANS PAC from all neurosurgeons in their state. The ANS PAC Board wishes to thank all these individuals for their help and ongoing commitment to ANS PAC.

Thomas W. Rigsby, MD
L. Philip Carter, MD
Frederick A. Boop, MD
George H. Koenig, MD
Randall Smith, MD
Karl Stecher, Jr., MD
Gary M. Bloomgarden, MD
Otto R. Medinilla, MD
Gary C. Dennis, MD
Troy M. Tippett, MD
Domenic Esposito, MD
Calvin C. Kam, MD
Timothy J. Johans, MD
Stephen L. Ondra, MD
John G. Piper, MD
Paul M. Arnold, MD
James R. Bean, MD
John F. Schuhmacher, MD
Roger D. Smith, MD
Henry M. Shuey, Jr., MD
Harold Portnoy, MD
David F. Jimenez, MD
Paul Gorsuch, Jr., MD
Robert E. Harbaugh, MD
Robert F. Heary, MD
Jeffrey S. Oppenheim, MD
A. John Popp, MD
C. Scott McLanahan, MD
Stan Pelofsky, MD
Kim Burchiel, MD
Robert B. Page, MD
Mel H. Epstein, MD
William F. Ganz, MD
Clarence B. Watridge, MD
Richard Henry Jackson, MD
Frederick D. Todd, II, MD
James M. Blue, MD
Constantino Y. Amores, MD
John H. Neal, MD

Political Action Committee Activity Increases

As political campaigns have become more expensive, U.S. Congressional candidates have come to rely heavily on contributions from Political Action Committees (PACs). During the 1997-98 election cycle, Congressional candidates raised nearly $800 million. Of this amount, over $208 million came from PACs, $107 million from personal loans and $422 million from individual contributors. Most industries now find it absolutely essential to have a PAC in order to gain access to Members of Congress, and nearly all "players" in the health care debate have created a PAC. The following highlights how much ANS PAC raised during the 1997-98 election cycle compared to other competing PACs.

Physician PACs	1997	1998	2-Year Total
AMA	$2,200,000	$2,400,000	$4,600,000
Anesthesiology	522,000	618,000	1,140,000
Ophthalmology	408,000	347,000	755,000
Emergency Physicians	178,000	220,000	398,000
Thoracic Surgery	230,000	31,000	261,000
Neurosurgery	***157,000***	***101,000***	***258,000***
Pathology	147,000	107,000	254,000
Orthopedic Surgery	194,000	17,000	211,000
Osteopathy	50,000	96,000	146,000
Otolaryngology	52,000	66,000	118,000
Urology	55,000	55,000	110,000
Dermatology	39,000	61,000	100,000
Cataract Surgery	27,000	56,000	83,000
Psychiatry	46,000	34,000	80,000
Plastic Surgery	29,000	26,000	55,000

Source: Federal Election Commission

Other "Competitors" PACs	1997	1998	2-Year Total
Trial Lawyers	$2,800,000	$3,200,000	$6,000,000
Hospitals	694,000	839,000	1,533,000
Health Insurance Associations	353,000	339,000	692,000
Neurosurgery	***157,000***	***101,000***	***258,000***
Pharmaceutical	81,000	46,000	127,000

Other Provider PACs	1997	1998	2-Year Total
Dentists	$749,000	$622,000	$1,371,000
Nurse Anesthetists	498,000	571,000	1,069,000
Nurses	452,000	528,000	980,000
Optometry	379,000	447,000	826,000
Physical Therapy	299,000	292,000	591,000
Podiatry	277,000	271,000	548,000
Occupational Therapy	183,000	328,000	511,000
Chiropractic	186,000	156,000	342,000
Neurosurgery	***157,000***	***101,000***	***258,000***

For more information about ANS PAC, please contact:

Katie Orrico, Assistant Treasurer
PO Box 136
Washington, DC 20044-0136
(202) 628-1996

Highlights from

ANS PAC's Annual Business Meeting

Congressman John C. Cooksey speaks to ANS PAC Members at the ANS PAC Annual Meeting luncheon in New Orleans.

The American Neurological Surgery Political Action Committee (ANS PAC) held its Second Annual Business Meeting on April 24, 1999 in New Orleans, LA. Over 100 ANS PAC members attended the luncheon meeting, which featured The Honorable John C. Cooksey (R-LA).

Dr. Cooksey, a U.S. Congressman (and ophthalmologist) from Louisiana's 5th Congressional District, gave ANS PAC members an update on several key health issues currently being debated by the Congress, including Medicare reform, managed care and practice expense reimbursement. He also encouraged all neurosurgeons to become active in the political process.

Troy M. Tippett, MD, ANS PAC Chairman, presided over the annual meeting. Dr. Tippett highlighted our success in the 1998 elections and encouraged members to visit the ANS PAC booth to renew their membership for 1999. He also presented the slate of nominees for the ANS PAC Board of Directors, which were approved by ANS PAC members. Current ANS PAC Board Members are:

Troy M. Tippett, MD, ANS PAC Chairman presides over annual business meeting.

Troy M. Tippett, MD, Chairman
Gary C. Dennis, MD, Vice Chairman
A. John Popp, MD, Sect/Treasurer
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James R. Bean, MD
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Stephen L. Ondra, MD
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Randall W. Smith, MD
Philip W. Tally, MD
Frederick D. Todd, II, MD
Russell L. Travis, MD

ANS PAC

Raises over $25,000 in New Orleans!

Using the lure of a raffle for a new Palm V organizer, ANS PAC raised over $25,000 at the meeting in New Orleans. Combined with other fundraising efforts, ANS PAC is close to reaching its 1999 fundraising goal of $100,000. Congratulations to John A. Kusske, MD, who was the lucky winner of the drawing!

Gene Barnett, MD, (far left) makes a contribution to ANS PAC. Others at the booth (from left to right) are Lori Shoaf, Randy Smith, MD, ANS PAC Membership Committee Chairman, Katie Orrico, Assistant Treasurer, and ANS PAC Board Members, Jim Bean, MD and Stan Pelofsky, MD

AANS Membership Reaches 5,442

Association Welcomes 202 New Members.

ACTIVE MEMBERS

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P. David Adelson
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Nevan G. Baldwin
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Martin M. Bednar
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Michael J. Burke
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Greg R. Wheeler
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Walter D. Obrist
Paul H. Pevsner
Thomas L. Pittman
Susan M. Reddig
Judith A. Selle

For more information on AANS Membership, or to receive a membership application, contact the AANS Membership Department at (847) 692-9500 or visit www.neurosurgery.org

A Cut Above the Rest

Lexington Practice is Focused on Quality Patient Care.

Name of practice: Neurosurgical Associates

Location: Lexington, Kentucky, with off-site clinics in 14 locations throughout Eastern and Central Kentucky

Number of neurosurgeons: Five

Total number of employees: 19 full-time; six part-time

Number of medical centers served: Four

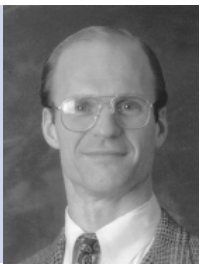
Approximate number of patients cared for per week: 400-450

Practice philosophy: Our practice strives to provide a fullrange of neurosurgical services, with minimal subspecialization; build strong relationships based on responsiveness and accessibility with our referring physicians; and promote team work among our physicians and employees. Our reputation is built on invariable competence, ethical motivation, prompt responsiveness, compassionate concern and unquestioned reliability.

Most innovative back office management solution: Recently, our back office has improved its efficiency and work flow, and our employees have been instrumental in many of these changes. For example, we assigned a person at the check-in desk to record all demographic and billing information, saving later calls and delayed billing; we have hired a full-time telephone operator, rather than expecting all employees to interrupt work for incoming calls; and we have assigned two full-time surgery scheduling clerks to handle all requirements for prior authorizations.

Most innovative approach to managing external relationships: Our most innovative solutions revolve around developing our outside clinics and becoming intimately involved in several local managed care plans.

Currently, we operate 14 rural outreach clinics throughout eastern and central Kentucky. We add, and occasionally drop clinics as opportunity arises or success dictates. The local contact, goodwill, additional referrals, and convenience for local physicians and patients have given the strategy a perennial place in our practice.



James R. Bean, MD, Managing Partner of Neurosurgical Associates and 10-year AANS member.

We also have developed a shared savings plan with a regional HMO. Faced with deeper discounting, we are challenged with the option of dropping participation or negotiating an alternative added reimbursement benefiting both parties. Because the health plan wants cost savings, we are negotiating benchmarks, or targets, for overall costs for common conditions treated by neurosurgeons (or orthopedic spinal surgeons), and comparing the profile of the practice against the regional average costs.

Another way we have addressed managed care is by participating in the organization and governance of a large multi-specialty IPA since 1994, and a Medicaid regional sole source provider-governed HMO product since 1996. The intent has been to take a lead in organizing physicians to negotiate with and oversee management of care by large regional managed care organizations.

Biggest investment you have made in your practice in recent years: This year we spent about $80,000 upgrading our office administrative computer software. It will allow us to track referrals, codes, levels of service, charges, receipts, and more. Adding to, or upgrading our computer information system has been, and will continue to be, the largest capital expense component we face.

Future of neurosurgical private practice: Private practice neurosurgery in a single-specialty group has the advantage of flexibility, adaptability and freedom of action. Solo surgeons cannot share fixed overhead or services, share call, patient care or experience, access expert assistance, or arrange free time as easily. Large multi-specialty groups use specialty revenues to subsidize primary care, general overhead and business expansions; subordinate practice decisions and financing to whole group budget constraints; and take daily management decisions away from those it affects the most. Academic practices face growing future problems of reduced residency and research funding, reduced Medicare payments, exclusive contracting restrictions, and deeper competitive fee discounts, all of which means money taken out of clinical revenues and income. Private single-specialty practice has its own financial challenges, but it is the best arrangement for adapting to rapid environmental change.

Closing thoughts: Your neurosurgical practice should reflect your beliefs, ambitions, talents, ethics, and personality. It should provide the security, opportunity, and support you need to achieve your personal goals and meet your public responsibilities.

Each member of this practice is afforded the opportunity to achieve any and every personal and professional goal desired, and those goals vary widely. Within the practice we have examples of success in academic medical research, medical organization leadership, cutting-edge neurosurgical innovation, public policy influence, regional and national medical politics, and personal publications. The culture, design, flexibility, and management of the practice permit and encourage both practice success and personal fulfillment. ■

Subspecialization is Necessary for Good Patient Care

The question, "Is subcertification good for neurosurgery?" is the wrong question since it implies subspecialization is not a part of neurosurgery. Subspecialization in neurosurgery is a fact. It has evolved just as neurosurgery evolved from surgery, because it was necessary for the best care of patients and for the development of that care. The question that we should be discussing is "How can organized neurosurgery bring neurosurgical residencies into the present era of subspecialization?"

When a major portion of graduating residents elect fellowships because they believe they are necessary to complete training, they are telling organized neurosurgery that the resident training they received is inadequate. When a majority of academic and practice positions list subspecialty training as a requirement, they also indicate residency training is inadequate.

The addition of post residency fellowship training is not the answer. They add years to training, and years mean increased costs for patient care and older, new neurosurgeons. As I have listened to the suggestions, I have not heard how we can correct what is lacking in neurosurgical training, but rather how can we get by this problem with the least upset or change.

To solve the problem, organized neurosurgery needs to restructure residency training so some of the following apply:

1. A core of training for general and defined subspecialty areas that will allow the resident to choose either direction during a residency.
2. Programs without all aspects of general and subspecialty neurosurgical training.
3. Programs for subspecialists who do not need training in all aspects of neurosurgery.
4. Programs with flexibility so a resident or program director can plan resident moves from one residency in a subspecialty or geographic area to another.
5. Programs that allow a resident or certified neurosurgeon to change or enter a program at any time in their career or training in order to change career emphasis or direction.
6. Programs organized so that training in another discipline that is required for subspecialization, can be within a planned residency period.
7. Certification that includes special qualifications for either general neurosurgery, subspecialized portions of neurosurgery or a combination of both.

William F. Collins, MD
Yale University School of Medicine

Part of a Natural Process

Subspecialization, as discussed in the Spring 1999 *AANS Bulletin,* has certainly become a hot topic. The opinions of Kim Burchiel, MD, and Edward Laws, MD, along with the opinion of Peter Adamson, MD (plastic & facial surgery), reveal how controversial this subject is.

I retired from neurosurgical practice in 1986 to become medical director of a 200-bed community hospital, until my second retirement in 1997. Wearing my administrative hat, I had occasion to observe and measure physician behavior during those 11 years.

There has already been *de facto* subspecialization for many years. I'm sure that in your own department there is subspecialization, just as there has been the same process in neurosurgical groups throughout the U.S. Although the financial pressures of managed care/competition have been daunting, from my neurosurgical and administrative experience, I believe that the chief motivation for this trend is efficacy and efficiency. Experience has shown that the integrity of neurosurgeons can be relied upon to continually improve the clinical outcomes and quality of life of their patients.

This trend toward subspecializing is a natural process of maturation of the profession. We should embrace it, and learn to resolve the problems that this process entails, such as, core competencies, specific qualifications, certification, maintenance of skills, minimum volumes of patients and minimum skills for non-subspecialist coverage.

We can't turn back the clock, but we can keep the best of the past and learn to use the new tools to improve the care we give our patients.

Sam Brendler, MD
Longmeadow, MA

Subspecialization Does Not Improve Patient Care

I was dismayed to read the seeming push to encourage subspecialty certificates in neurosurgery. As a private-practice neurosurgeon in my mid-forties, I do not support subspecialization with certification. The nature of neurosurgery is that of nerve pathology in three locations: the central nervous system/brain, spine, and peripheral nerves. If neurosurgeons were excluded because they did not have a certificate, it would cut the number of available neurosurgeons to take care of most "specialty" patients to a small minority. This hardly seems to be in the best interests of the patients.

Private-practice neurosurgeons have risen to the challenges of new technologies, such as spinal instrumentation, endoscopy, and diagnostic modalities, without the necessity of subspecialty certificate. Although the argument has been fostered that the subspecialty certificate rewards the extra work accomplished by physicians in a fellowship program, it clearly undermines the hard work, continuing medical education, and dedication of private practitioners who have sought and gained such knowledge and facility on their own.

It would seem that the goal of subspecialty certification is to chip away at the general neurosurgeon, who is the first line of patient care and shift patients to a more central, academic treatment location. All of this is done without any objective criteria delineating improved patient care. ■

Kurt A. Schroeder, MD
Neurological Associates of Tucson

We Want to Hear From You

The *AANS Bulletin* welcomes letters from our readers. If you have a comment, question or concern on this issue, please send it to: A. John Popp, MD, FACS, Editor, 22 South Washington, Park Ridge, Illinois 60068. Fax us at (847) 692-2589 or e-mail us at info@aans.org.

Evolution of the *Bulletin*

A. John Popp, MD, FACS, Introduces The New Bulletin *Editorial Advisory Board.*

Beginning with the winter 1999 issue, the *AANS Bulletin* has taken on a new look and a new focus, evolving into a more member-friendly publication with a strong focus on socioeconomic issues. This change was in direct response to AANS members' expressed interest in hearing more from the Association about practice management issues, reimbursement concerns and other socioeconomic topics. To date, the feedback on the redesign has been overwhelmingly positive and, while we recognize that we are off to a good start, we believe that further development is necessary.

Editorial Advisory Board

At the AANS Annual Meeting, I met with the AANS editorial staff to discuss the future direction of the *Bulletin* as the socioeconomic publication of the Association. We felt it was important to organize a group of individuals who could not only serve as a sounding board for potential story ideas, but bring to the *Bulletin* a broad base of experience and expertise in such areas as public policy, practice management, outcomes analysis, coding and reimbursement, and more. The diversity of the Board members we have selected, as well as their commitment to addressing challenges in the neurosurgical arena, is sure to make our membership magazine one of the best in the field.

Following is an abbreviated biography on each of our Board Members.

James R. Bean, MD, Associate Editor of the *Bulletin*, is a neurosurgeon in private practice in Lexington, Kentucky. An authority on practice management and public policy issues, Dr. Bean is a member of the AANS Managed Care Advisory Committee and the AANS/CNS Cost Containment Task Force. In addition, he is the former Chair of the Council of State Neurosurgical Societies (CSNS).

Edward C. Benzel, MD, is Professor of Neurosurgery at the Cleveland Clinic Foundation. A consummate physician and educator, Dr. Benzel currently serves as Chair of the Professional Development Program, and is a member of the AANS Coordinating Committee for Continuing Medical Education and member of the *Journal of Neurosurgery's* Editorial Board.

A. John Popp, MD, FACS, Editor of the Bulletin *is Vice President of the AANS and the Henry and Sally Schaffer Chair of Surgery at Albany Medical College.*

Robert E. Harbaugh, MD, FACS, is Professor of Neurosurgery and Director of Cerebrovascular Surgery at Dartmouth-Hitchcock Medical Center. An activist in several national outcomes analysis and quality improvement initiatives, Dr. Harbaugh Chairs the AANS/CNS Committee for the Assessment of Quality and the AANS/CNS Outcomes Subcommittee. He is also a member of the AANS Coordinating Committee for Continuing Education and the AANS/CNS Washington Committee.

David F. Jimenez, MD, FACS, Associate Professor of Neurosurgery at the University of Missouri School of Medicine, is an advocate for young neurosurgeons just entering practice. He currently serves as Chair of the AANS Young Neurosurgeons Committee (YNC), Vice-Chair of the CSNS, YNC Liaison to the AANS Board of Directors, and as a member of the CSNS Young Physicians Committee and the AANS/CNS Task Force on Fellowships.

John A. Kusske, MD, is Chief of Neurological Surgery at UCI Medical Center. A renowned authority on managed care issues, Dr. Kusske currently Chairs the AANS Managed Care Advisory Committee, the AANS/CNS Cost Containment Task Force, and serves as a member of the AANS Physician Reimbursement Committee, AANS/CNS Washington Committee, and the CSNS Health System Cost Control Committee.

Gregory J. Przybylski, MD, is an Assistant Professor of Neurosurgery at Thomas Jefferson Medical College. A recognized expert on coding and reimbursement issues, Dr. Przybylski serves as a faculty member for the AANS Professional Development course on Reimbursement Foundations, as an alternate AANS representative to the CPT Advisory Panel of the American Medical Association, and as Chair of the AANS/CNS Subcommittee of the CPT Coding Task Force on Evaluation and Management.

Katie O. Orrico, JD, is Director of the AANS/CNS Washington Office. For nearly 15 years, she has represented organized neurosurgery on public policy issues ranging from Medicare coverage and reimbursement to managed care reform and E&M documentation. In addition, she serves as Assistant Secretary/Treasurer for the American Neurological Surgery Political Action Committee and as Co-Chair of the AMA/Specialty Societies Antitrust Work Group.

From my personal perspective, we rose to the challenge of transforming the *Bulletin* into a publication that best serves the needs of the AANS membership. We saw a need for a strong, diverse and active Editorial Board, and we met that need through the volunteers we have selected to serve our publication. With our diverse, highly-visible Board of recognized experts beginning to function, we anticipate that the improvements in the *Bulletin* will not only continue, but that the end result will be a first-rate publication for our membership. ■