



# NEUROSURGERY NEWS

THE OFFICIAL NEWSMAGAZINE OF THE CONGRESS OF NEUROLOGICAL SURGEONS

## A Message from the Vice President

**Mark N. Hadley, M.D.**  
Vice President, CNS



The 2000 CNS Annual Meeting and 50th Anniversary celebration of the founding of the Congress of Neurological Surgeons was a terrific success.

Attendance and participation in San Antonio last September surpassed all expectations. Participant's evaluations of the meeting content, organization, and science were excellent. Incorporation of non-neurosurgical keynote speakers was felt to have been a great contribution. As those of us honored to be in leadership roles of the CNS attempt to continue to streamline our efforts to make the CNS most effective and most efficient, I have been asked to address and assess the value of CNS membership. CNS dues are \$285 per year, one of the lowest in organized medicine. For those dues, the CNS offers a broad array of member services to our 5,000-plus members worldwide. The CNS is able to offer a broad spectrum of member services and educational opportunities despite low dues because of the contributions of individual members like yourself. The concept of volunteerism was built into the CNS original design and mission. Volunteerism, individual commitment, and innovative contributions from CNS members over these last 50 years has allowed the Congress to become one of the premiere organizations in medicine.

The mission of the CNS is education, the promotion of the art and science of neurological surgery, and the development and maturation of young neurosurgeons. The goal of the CNS leadership is to accomplish these objectives in the broadest, most comprehensive and contemporary fashion, at the lowest possible expense, providing maximum value for every CNS member. With annual dues of only \$285, the CNS provides exceptional value to its membership.

The CNS provides education:

- An annual, international scientific symposium, the CNS Annual Meeting, with reduced registration fees for members. (2001 Annual Meeting will be held in San Diego, California, September 29–October 4.)
- World-renowned scientific journal, *NEUROSURGERY*, including the online version (annual subscription included in dues structure).
- *Neurosurgery News*, six times per year (included in annual dues).
- *Clinical Neurosurgery*, annually (included in annual dues).
- *Concepts in Neurological Surgery* (included in annual dues).

- *Video Perspectives in Neurological Surgery*.
- *Directory of Neurological Surgeons\** (included in annual dues).
- World Directory of Neurological Surgery online (included in annual dues).
- *Young Neurosurgeons Directory*, free to CNS Resident Members.

- *Neurosurgery://On-Call\** (included in annual dues).
  - Core Curriculum in Neurological Surgery.
  - Eleven distinct Neurosurgical Fellowships.
- The CNS promotes the art and science of neurological surgery:
- The CNS Annual Meeting
  - *NEUROSURGERY* and other CNS publications

Continued on page 2

## WINS Conference at San Diego CNS Annual Meeting

On September 30, 2001, during the CNS meeting in San Diego, California, WINS will be sponsoring a Leadership and Strategic Planning Conference from 12:30-5:00 pm. We

are encouraging all women neurosurgeons to participate in this important and educational session. Women in training are encouraged to present

Continued on page 2



Emily Friedman, M.D., Debra Benzil, M.D., and Suzie Tindal, M.D., in discussion at prior WINS meeting.



WINS members at annual meeting.

### INSIDE THIS ISSUE

A Message from the Vice President	1
Report of the CNS Executive Committee	3
CSNS News	10
Joint Section News:	
Joint Section on Cerebrovascular Surgery	14
Joint Section on Disorders of the Spine and Peripheral Nerves	19
Joint Section on Neurotrauma and Critical Care	21

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## NEUROSURGERY NEWS

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### Vice President's Message

Continued from page 1

- The Washington Committee\* (included in annual dues).
- Support and promotion of six Sections in neurological surgery\* (included in annual dues).
  - Tumor
  - Cerebrovascular Disease
  - Pediatric Neurosurgery
  - Pain
  - Stereotactic and Functional Neurosurgery
  - Spine and Peripheral Nerves
- Support and promotion of the Council of State Neurosurgical Societies\* (included in annual dues).
- CNS International Committee and multiple international scientific endeavors (included in annual dues).
- Independent organizational representation in large national medical societies (included in annual dues).
  - American Medical Association
  - American College of Surgeons
  - American Board of Neurological Surgery
  - Practice Expense Coalition
  - Patient Access Coalition
  - CNS Auxiliary (included in annual dues).
  - CNS Resident Member program (included in annual dues).
  - CNS Fellowship Program (included in annual dues).

\* Jointly sponsored by the CNS and AANS.

The CNS promotes the development and maturation of young neurosurgeons:

- Exceptional CNS Resident Member program: Free annual membership, free Annual Meeting registration, free hotel accommodations at Annual Meeting, free annual subscription to Neurosurgery, other free CNS publications, and participation in Annual Meeting structure (all for the one-time membership \$25 fee).
- Seamless transition for CNS Resident Members to Active CNS Membership
  - Leadership Development Program
  - Variety of CNS Resident Awards
  - Multiple CNS Educational Fellowships
  - CNS Core Curriculum in Neurological Surgery
  - CNS International Committee initiatives for young international neurosurgeons

In all, the CNS offers terrific value for CNS members, young and old, at remarkably low annual dues. Your interest, innovation, and volunteerism have helped the CNS to grow and prosper over the last 50 years. With you, the CNS has evolved into one of the premier, most effective and efficient member service organizations in all of medicine. Thank you for your continued participation. □

### WINS Meeting

Continued from page 1

papers or posters at the meeting so they may also attend the leadership conference. Residents may also be eligible for the Louise Eisenhardt Resident Scholarship Award and are encouraged to send their abstracts to WINS for consideration. Information on the WINS scholarship can be obtained from the WINS Web site ([www.NeurosurgeryWINS.org](http://www.NeurosurgeryWINS.org)). Deadlines for submission of such abstracts/papers is in spring 2001. □



## WINS Meeting

### Mark Your Calendars

Lynn Martin

former Secretary of Labor  
and Congresswoman

WINS 8th Annual Ruth  
Kerr Jakobus Lecturer

Tuesday, April 24, 2001

AANS Toronto, Ontario,  
Canada

An unparalleled authority on modern workplace issues, Lynn Martin has championed the rights of all workers, particularly women and minorities, by providing comprehensive solutions to these issues



## 2001 ANNUAL MEETING CONGRESS OF NEUROLOGICAL SURGEONS



San Diego Convention Center  
San Diego, California  
September 29 through October 4

### Michael L. J. Apuzzo, Honored Guest

Douglas S. Kondziolka, Meeting Chairman  
Richard Ellenbogen, Program Chairman  
Howard Tung, Local Arrangements Chairman  
Michael L. Levy, P.R. and Marketing

## Report of the CNS Executive Committee: September 2000

### Mark N. Hadley, M.D.

Past Secretary, CNS



Mark N. Hadley,  
Past Secretary, CNS

**A**s we celebrate our 50th anniversary of member service and organizational productivity, I am privileged to offer the 2000 Congress of Neurological Surgeons Annual Report. Our founders envisioned

a professional neurosurgical organization, founded on education and science, driven by volunteerism, without discrimination in membership. Fifty prosperous years later, those key principles continue to guide our organization. Our founders would be proud of the legacy they initiated and pleased with the breadth and depth of the member service offerings the CNS presently provides. At no time in our history has the CNS been stronger, more financially secure, and more involved in the myriad of issues and activities that face our ever-expanding neurosurgical membership.



Vincent Traynelis  
Annual Meeting  
Chariman

The mission of the CNS is education and the professional development and promotion of our membership. Last year's spectacular Annual Meeting is a testimony to our commitment to our educational heritage and mission. Annual

Meeting Chairman Vincent Traynelis and Scientific Program Chairman Douglas Kondziolka created one of the most innovative, diverse, and contemporary international scientific symposia ever. Never before have more members reached the podium to deliver scientific presentations. Never before was such effort made to include neurosurgeons, their related medical field colleagues, their spouses, and even the public in the content and fabric of the Annual Meeting. At comparatively low Annual Meeting registration rates, the CME return on CNS member investment is very, very high. Our founders would be delighted by the attendance and magnitude of last year's meeting and impressed by its complexity, scale, and technical innovation. That our membership now exceeds 4,700 physicians, residents, and international scientists would not surprise them. Our broad reaching, international, nondis-



Douglas Kondziolka,  
Scientific Program  
Chariman

criminatory membership policy is exactly how they designed it.

Last year's Annual Meeting was the site of yet another CNS "first" member service: complete on-line registration. Much like the CNS "first" at our Annual Meeting in 1998 when we first offered online abstract submissions, online meeting registration has allowed hundreds of participants at the symposium to register and confirm room reservations electronically.

In celebration of our 50th anniversary, Past President Daniel Barrow added further to the rich CNS legacy by creating an honored annual keynote lec-



Daniel Barrow  
Past President

tureship entitled the CNS Walter Dandy Oration, and by naming Senator John Glenn as the first to serve in that prestigious role. Finally, Dr. Barrow, Vincent Traynelis, Douglas Kondziolka, and the Publications Committee

has chronicled our glorious 50-year history in a complimentary book entitled *50 Years of Neurosurgery: The Golden Anniversary of the Congress of Neurological Surgeons* available to all CNS members. This historical text will surely be valued by all those who have benefited by CNS membership during the last five decades.

The other major vehicle of our education mission besides our Annual Meeting, our journal, *NEUROSURGERY*, has enjoyed unparalleled success and circulation. Under the artistic and articu-

Continued on page 4

## CNS Executive Committee

Continued from page 3



Michael L.J. Apuzzo  
Editor, *NEUROSURGERY*

late stewardship of Editor Michael L. J. Apuzzo, *NEUROSURGERY* surpasses its competition in value, scientific merit, and innovation and is arguably the most "in demand" contemporary journal of our profession. *NEUROSURGERY* is available in printed form and online, and past volumes of the journal are available on CD-ROM. The number of pages of scientific information has increased steadily, and its circulation and prosperity continue to flourish. Resident members of the CNS receive *NEUROSURGERY* free of charge, thanks to the terrific educational corporate support of David Hable and our many friends at Codman, Johnson & Johnson, Inc.

The CNS, led by Vincent Traynelis and the CNS Education Committee, has recently undergone a rigorous ACCME recertification process under new, more comprehensive, and more rigid CME criteria. The CNS received a 4-year accreditation (the maximum) by the ACCME reviewers, and received the highest, most positive organizational reaccreditation score in the 3-year history of the new ACCME certification process. In addition to reaccreditation, the Education Committee of the CNS, driven by membership need and our educational mission, is working on a host of other member services and educational offerings. They have recently completed a Core Curriculum in Neurological Surgery to assist residents-in-training and training programs alike in the effort to provide comprehensive, contemporary education and training for our future leaders.

*Neurosurgery://On-Call*, the jointly supported, jointly owned Web site of organized neurosurgery has been completely revamped and made cost-effective by the individual efforts of William Friedman, a Past President



Joel D. MacDonald,  
Editor,  
*Neurosurgery://On-Call*

of the CNS, John Oro, former Editor, and Joel MacDonald, the current Editor. Dr. MacDonald and his committee have completely revamped the CNS portion of the Web site and have provided updated linkages to other electronic sites including Section Web sites, Guidelines, and, with leadership from John Popp, Public Pages. *Neurosurgery://On-Call* has become one of the premier, most visited Web sites in organized medicine today.

The Publications Committee of the CNS has been recently revamped and

reorganized by the CNS Executive Committee. The Committee, led by Christopher Loftus and Douglas Kondziolka, provides a broad and diverse number of educational member offerings, including *Concepts in Neurological Surgery* and *Video Perspectives in Neurological Surgery*, as well as several directories of neurological surgery, including the CNS-developed, directed, and produced *World Directory of Neurological Surgeons* and the *Young Neurosurgeons' Directory of Residents and Fellows in Training* in North America. The CNS Newsletter has been reformatted and is now entitled *Neurosurgery News*, with Michael Levy as the Editor. *Neurosurgery News* has an expanded magazine format and includes important CNS organizational information and news of membership offerings, member candidates, and bylaws changes. Stimulated by a request of the Council of State Neurosurgical Societies, it also includes other important newsworthy reports and presents a forum in which Section activity may be reported and by which the CSNS can reach the CNS membership at large.

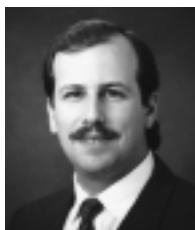
The Leadership Development Committee, led by Chair Isabelle Germano continues to promote and encourage resident members and young neurosurgeons to become involved in the workings and leadership of the CNS.



Isabelle M. Germano  
Chairman, Leadership  
Development  
Committee

Dr. Germano and her committee recruit young neurosurgeons and other CNS members to a variety of committee responsibilities to enhance the number and quality of CNS member services and educational opportunities. The efforts of the Leadership Development Committee serve to groom future leaders of organized neurosurgery for even greater responsibilities. Most recently, the Leadership Development Committee recruited 20 young international members to assist the CNS International Committee in their expanding relationship with the Foundation for International Education In Neurological Surgery (FIENS).

The Resident Committee, led by Richard Ellenbogen, and the Placement Committee, led by P. David Adelson offer resident members and young neurosurgeons a variety of terrific benefits, opportunities, research awards, and prizes to encourage participation in the CNS and to enhance the scientific effort of young, developing neurosurgeons. Resident members of the CNS pay a onetime membership fee of \$25. They receive free registration at the Annual Meeting, free hotel accom-



P. David Adelson,  
Chairman,  
Placement Committee

modations at the Annual Meeting, and a new benefit that began last year, free annual subscriptions to the official journal of the CNS, *NEUROSURGERY*. There are a variety of resident prizes and awards available to stimulate our young men and women in neurosurgery to participate in the process and the science program of the Annual Meeting. The CNS placement service helps to link young neurosurgeons with career opportunities within North America.

The CNS is proud to offer a variety of exceptional educational opportunities to its membership in the form of fellowships. Douglas Kondziolka has chaired this committee with energy and enthusiasm. He has developed a standardized approach for application. There are now 11 different and prestigious fellowships available to CNS members:

- CNS Cushing Clinical Fellowship
- CNS Dandy Clinical Fellowship
- CNS/DePuy Acromed Spinal Clinical Fellowship
- CNS/Medtronic Sofamor-Danek Clinical Fellowship in Image-Guided Neurosurgery
- CNS Charles Plante Public Policy Fellowship
- CNS Wilder Penfield Clinical Investigation Fellowship
- CNS Sean Mullan Neuroendovascular Surgery Fellowship
- CNS Elekta Lars Leskell International Fellowship
- CNS Kenichiro Sugita International Fellowship
- CNS George Ablin International Fellowship
- CNS Traveling Fellowship

The budget for fellowship support on an annual basis now exceeds \$260,000. The CNS leadership and the CNS Marketing Committee are working diligently to secure corporate support and endowment dollars as a means of fellowship support, reducing individual member dollar contributions for these important educational opportunities.

The International Committee of the CNS, led by outgoing Chairman Richard Perrin and new Chairman Nelson Oyesiku, has been very active over the last year. Under their direction and leadership CNS International Membership has increased and liaisons to international organizations and underserved areas of the world have been expanded. The International Committee of the CNS has established focused linkage with FIENS. Together the CNS and FIENS will work to provide greater international educational assistance with improved efficiency. The International Committee is considering the development of new potential areas of assistance under the "Zimbabwe Project" umbrella. These potential sites include India and Morocco. Three International Fellows were awarded fellowship posi-

tions in the United States for the year 2000, Dr. Tulio P. Murillo, Dr. Vladimir Katuch, and Dr. Ketan Desai. Under the leadership of the International Committee, the CNS is participating in a variety of valuable and important altruistic international education-based initiatives.

The CNS has an important leadership voice in organized neurosurgery's response to the government, to state regulatory agencies, to third-party insurers, and to the FDA. The CNS provides half of the leadership and half of the financial support for the important jointly sponsored Washington Committee. The Washington Committee, led by John Popp (with key assistance from Katie Orrico), has had the task of organizing a concise, firm, yet multifaceted neurosurgical strategy to combat HCFA and their proposed changes in Medicare fee schedules. Washington Committee efforts have been essential in protecting neurosurgery's interests in this arena as well as many others.

*The diverse and impressive agenda of these joint activities is a tribute to the collegial, "equal voice" and "equal pay" relationship between the CNS and the AANS.*

The Washington Committee has established multiple liaisons with government agencies, regulatory agencies, third-party insurers, and the executive and legislative branches of the United States government. The focused voice of organized neurosurgery, directed through the potent, effective Washington Committee, has never been stronger, better organized, or more persuasive. Support of the Washington Committee is the single largest budgetary item in the CNS annual budget. As far as dollars spent for services to CNS members, they are of terrific value.

The CNS provides support for half of all joint activities offered by the CNS and the American Association of Neurological Surgeons. This includes numerous manpower hours of volunteer effort and almost three quarters of a million dollars a year in financial outlay. This considerable commitment includes support of the Washington Committee, Joint Officers, the Council of State Neurosurgical Societies, *Neurosurgery://On-Call*, the seven Sections of the CNS and AANS, and several other joint activities.

Without two interested, prosperous, and influential yet culturally different parents, these joint activities (joint ventures, if you will) would not be possible. The influence of neurosurgery in the world of politics, government agencies, medical organizations, and corporate America would not be as great if only one

Continued on page 5

## CNS Executive Committee

Continued from page 4

healthful neurosurgical organization existed instead of the two we have today. The diversity of member services we can offer to CNS and AANS members would also suffer.

The efforts and activities of the CNS are guided by its Mission Statement and the fabric of the CNS Strategic Plan. Our Strategic Planning Committee, led by President Issam Awad, has worked over the last year to update the Strategic Plan of the CNS to make it a more contemporary and effective tool of organizational guidance. The CNS is a distinct, important, and powerful organization in medicine and in neurosurgery. It is uniquely different than the organization of the AANS. While serving a similar membership, the CNS has a different focus and a different mission than that of the AANS. The essence of the CNS is education, member service, the promotion of the art and science of neurological surgery, and the promotion and development of the young neurosurgeon. To that end, the CNS has a vested interest in the future and an even greater responsibility to neurosurgeons practicing in North America today. We have our entire lives before us and virtually our entire careers ahead of us. It is critically important and entirely appropriate that the youthful CNS provide equal input, leadership, and action to the voice of organized neurosurgery in North America.



Issam Awad,  
President

The CNS is keenly interested in a healthful, collegial relationship with our sister organization, the AANS. To that end, we have offered joint strategic planning on issues important to all of neurosurgery, and have proposed developing a joint venture with the AANS to develop, distribute, and finance member services for maximal efficiency and cost savings. We will continue to work toward reasonable compromises that will allow the realization of such efficiencies and savings, yet preserve the inherent good and unique, distinct features, history, and culture of the two organizations. Whether compromise is reached in the near future or not, the CNS is a mature and healthy 50 years old. We have followed the blueprint for success our founders left in legacy for our organization, and we have built from their blueprint one of the most efficient and effective volunteer-driven, educational organizations in medicine today.

Education, value, member service, and attention to fiscal priorities are the hallmarks of our 50-year-old organization. The spectrum of educational offerings discussed previously, the variety of member services, and the important,

expanding joint activities provided and contributed to by the CNS is all accomplished with one of the lowest dues structures in organized medicine. At \$285 per year, active membership in the CNS represents the best bargain in medicine today.

I have appreciated providing you this summary of the focus, health, and activities of the CNS over the last year. I hope you will embrace the celebration of our 50th anniversary. Before I conclude this report, I would like to ask a moment of silent recognition for the following CNS members who have died since our Annual Meeting in 1999:

Stanley Batkin, M.D.

Joe D. Beals, M.D.

Aaron Beller, M.D.

William R. Bernell, M.D.

Richard E. Buckley, M.D.

Jack Cooper, M.D.

Edward Gates, M.D.

D. Gioia, M.D.

William E. Hunt, M.D.

John Kennedy, M.D.

William R. Lipscomb, M.D.

Richard H. Lye, M.D.

George C. Manning, M.D.

Douglas L. Polk, M.D.

Shlomo Pomeranz, M.D.

Morris Sanders, M.D.

Thomas E. Scott, M.D.



## CNS Leadership Development Committee Report

### Isabelle M. Germano, M.D.

Chairman, Leadership Development Committee



The Leadership Development Committee continues to promote and encourage resident members and young neurosurgeons to become involved in

the workings and leadership of the CNS. To maintain the volunteer spirit of the CNS that has been so characteristic of the organization since its beginning, the Committee serves as a repository for all requests for involvement in the CNS organization and assigns individuals to the CNS committee structures. Additionally, to ensure that meritocracy is respected within the CNS structure, the Committee developed a database to carefully track the work of hundreds of committee members involved in the CNS and attempts to reward those with continued interest with progressively more challenging assignments.

For 50 years, the CNS has been able to provide education to national and international members through the volunteerism of many individuals with an emphasis on the promotion of the art and science of neurological surgery and the development of young neurosurgeons. One of the goals of the Leadership Development Committee is to ensure that minority groups, such as neurosurgeons in private practice and women neurosurgeons, will continue

to be included in the new leadership of the CNS. In most occasions, a perceived lack of opportunity might represent an error of omission rather than commission. The database will be aimed to track individual participation and performance errors of omission will become less frequent.

To ensure that the young neurosurgeons are aware of the opportunity to serve in the CNS leadership, we recently mailed a welcome letter to all first year neurosurgery residents informing them of this opportunity. Additionally, we are working closely with the International Committee to ensure an active participation of our international members in various CNS activities.

The Leadership Development Committee is currently recruiting young neurosurgeons and other CNS members to a variety of committee responsibilities to enhance the number and quality of CNS member service and educational opportunities provided. This effort serves to groom future leaders of organized neurosurgery for even greater responsibilities. If you have a particular area of interest or expertise or are interested in serving a specific committee, please contact Isabelle M. Germano, M.D. at the address below:

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Department of Neurosurgery, Box 1136  
Mount Sinai Medical Center  
New York, NY 10029-6574  
Phone: 212-241-9638  
Fax: 212-831-3324  
e-mail: [igermano@mssm.edu](mailto:igermano@mssm.edu) □

## CNS Membership: Applications in Progress

The following individuals have applied for Membership to the Congress of Neurological Surgeons. Commentary or questions should be directed to Christopher Getch, M.D., Chairman Membership Committee, phone: 312-695-6279; e-mail: [cgetch@nmff.nwu.edu](mailto:cgetch@nmff.nwu.edu).

C. Michael Cawley  
Maeng-Ki Cho  
Bohdan W. Chopko  
Ronald L. L. Collins  
Enrique Concha-Julio  
Todd Stewart Crawford  
Matt El-Kadi  
Ashraf Elkerdany  
Thomas Ellis  
Ersin Erdogan  
Mohamed Fahmy  
Thomas Falloon  
Frank Fichtel  
Victor Freund  
Peter Gerszten  
Peter O. Holliday III  
Bermans J. Iskandar  
Zvi Israel  
J. Kevin Kaufman

Michael Kilburn  
Ali Krisht  
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Theodore H. Schwartz  
John Steck  
Robert Sumkovski  
Bradley Weprin  
Eric Wolfson

## CNS Clinical Fellow in Jamaica

### Odette A. Harris, M.D.

I have just recently completed my externship in international neurotrauma under the auspices of the CNS Clinical Fellowship. I would like to thank the Committee for affording me this opportunity and inform them of the various projects my funding has enabled.

During November and December of 1999, I worked at Kingston Public Hospital (KPH) in the inner city of Kingston, Jamaica. This hospital serves the indigent and uninsured of the island. Along with the University Hospital of the West Indies (UWI), KPH is also a referral center for island-wide trauma. I worked with the island's Neurosurgery team, two consultants at KPH, and one professor at the University. I served as the primary neurosurgical resident at KPH and, as such, participated in admissions, routine ward and ICU care of neurosurgical patients, all trauma cases, elective and emergency neurosurgical cases, and conferences at both KPH and UWI. Resources were severely limited at KPH. We worked with only a basic radiology facility (CT and MR imaging required transport to an outside facility and prepayment). In addition, the availability of laboratory studies, medication, and operative equipment was severely limited. This experience served to enhance skills of autonomy, basic physical diagnosis, and self-reliance.

While part of the surgical community, I participated in all conferences and professional meetings. I was the Guest Speaker at the Association of Surgeons in Jamaica (November 20, 1999) and at Neurosciences Grand Rounds at the University Hospital of the West Indies (December 4, 1999). I was also able to participate in clinical research and have presented the results of one of my stud-

ies at the CNS in September 2000, *Guidelines for the Management of Minor Traumatic Brain Injuries in the West Indies*.

One of the primary goals of my externship in the Caribbean was to develop solutions to the challenges of limited resources, access to technology, medical supplies, education, and prevention. To this end, I worked closely with the medical community of the island, the National Road Safety Council, and the Minister of Health in establishing the first branch of Think First. The program was officially launched during the week of May 29 to June 2, 2000 (spanning National Child and Road Safety months) and endorsed by the Prime Minister and the Minister of Health. To date we have reached over 500 students island-wide with this peer education-based program of prevention. The program will continue year round. We are currently funded by the National Road Safety Council and private donations. We are also working on corporate sponsorship. Our goal is to address the public health issue of trauma from the standpoint of prevention. We hope this will not only save lives and limit morbidity, but also enable reallocation of scarce resources. We are also critically analyzing the current management of trauma at KPH in an attempt to better deliver quality care in a cost-effective manner. I will begin my MPH in epidemiology in August of this year (2000). I hope to continue the work I was able to start under my CNS Clinical Fellowship. I intend to continue a dialogue with the Minister of Health in developing solutions for the many challenges facing the practice of neurosurgery in this setting. I also hope that these skills will help prepare me for my next externship in an underserved community of the United States, specifically inner-city Oakland, and my ultimate goal of a career in academic neurosurgery. □

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## CNS Bylaws Changes

**The following Bylaws changes and proposed Bylaws Amendment were discussed at the Annual Executive Committee Meeting in San Antonio and are being published for your consideration.**

### Proposed Bylaws Change

*Creation of New Standing Committee on Information and Technology*

22 September 2000

### Article VII, Section 1. Standing Committees. X.

The CNS Information and Technology Committee shall be composed of a Chairperson and Members who shall review all computer and technology related activities of the Congress of Neurological Surgeons (including the Executive Committee and other Standing Committees) and shall make recommendations regarding new projects and utilization of technology to advance the educational mission of the Congress of Neurological Surgeons. The Committee will meet biannually coincident with the annual meetings of both the Congress of Neurological Surgeons and the American Association of Neurological Surgeons and shall make reports to the Executive Committee and other standing committees as necessary. A specific directive of this Committee will be to involve younger neurosurgeons with computer expertise to encourage their participation in the activities of Congress of Neurological Surgeons. The Chair shall be appointed by the President of the CNS to a 3-year term. Members of the Committee will be jointly appointed by the President, the Executive Committee, and the Chairperson.

### Proposed Bylaw Amendment

CNS Executive Committee

22 September 2000, San Antonio, Texas

### Article VII, Committees, Section 1. J.

The Council of State Neurosurgical Societies

#### *Intent of Change:*

Need for a CNS-delegate Chairperson to coordinate Council premeeting communication between CSNS, the CNS, and CNS-appointees.

Need for leadership during the CNS and AANS meetings of the Council to coordinate the efforts of our CNS-appointee volunteers.

Need for instruction to the newly designated CNS-appointees regarding responsibilities.

Need for reporting to the Leadership Development Committee on a quarterly or semi-annual basis on the performance of CNS-appointees

### Proposed Version of Section 1. J. *(changes in italics)*

The Council of State Neurosurgical Societies shall be established jointly by the Congress and the American Association of Neurological Surgeons. The CSNS will be comprised both of elected delegates from the State Neurological Societies and of members appointed by the Presidents of the American of Neurological Surgeons and the Congress. The purpose of the CSNS is to provide a national forum for the State Neurosurgical Societies of the United States. This forum is primarily for discussion, consideration, and proposal of action regarding socioeconomic issues concerning neurological surgery. The rules and regulations governing the operation of the CSNS are those that have been approved by the Board of Directors of the AANS and the Executive Committee of the Congress. Amendments to the rules and regulations are subject to approval of the Board of Directors of the AANS and Executive Committee of the Congress.

*The Chairperson of the CNS-appointees shall be appointed by the CNS President to a 3-year term. The Chairperson should have experience as a State or Regional delegate or as a CNS-appointee to the CSNS. The responsibility of the Chairperson is to promote attendance of the CNS-appointees at the two annual meetings of the CSNS and provide leadership during the weekend activities of the CSNS. The Chairperson shall report to the Leadership Development Committee on the performance of the CNS-appointees.*

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## Neurosurgery:// On-Call Update

**Joel D. MacDonald, M.D.**

Editor, *Neurosurgery://On-Call*



One of the primary missions of *Neurosurgery://On-Call* is to provide educational resources for the general public.

Increasingly, patients are utilizing the Internet to seek out credible health information. In an effort to reach out to the public and also to support the efforts of practicing neurosurgeons, *Neurosurgery://On-Call* has decided to reverse the order of its opening home page. Visitors to *Neurosurgery://On-Call* will now be greeted with the Health Resources page. The Health Resources page is dedicated to providing information to patients. The "What is Neurosurgery?" button provides a detailed description in layman's terms of the nature of neurosurgery and the types of disorders treated by neurosurgeons. On this same page, there is a history of neurosurgery as well as a glossary of common terms. The

Health Resources section also provides a number a number of patient resources. Foremost among these is the Find a Neurosurgeon Directory. Find a Neurosurgeon Directory provides a search engine through which patients can identify neurosurgeons in their community. The directory can be searched on the basis on the area code, last name, city and state, or by country.

One of the most popular aspects of the Health Resources page is the monthly featured article. This article provides a comprehensive discussion of a given diagnostic entity with associated graphics and frequently asked questions. The Quick Find menu is a rapid link to the spectrum of topics covered which range from basic anatomy to cerebrovascular disease, head injury, spine disease, Parkinson's disease, and many others. These articles are concise and easy to understand and are prepared with the editorial input of neurosurgeons. They serve as an excellent resource for patients who are interested in further clinical information. Feel free to refer your patients to *N://OC* for credible information.

A final popular component of the Health Resources Section is the Ask a Neurosurgeon system. The Ask a Neurosurgeon system is an e-mail-based response system through which patients may pose a question to practicing neu-

Continued on page 8

# Think First: Where We Were, Where We Are, Where We Are Going

**P. David Adelson, M.D.,  
F.A.C.S., F.A.A.P**



The year 2000 marks the end of the first 10 years since the founding of the Think First Foundation as neurosurgery's community service arm to

provide brain and spinal cord injury prevention education across the country. The Foundation has served as the instrument of distribution and implementation of injury prevention programming, education, and awareness nationally through the grassroots growth of local chapters connected to the national central office/foundation. The history and growth of the Think First Foundation and its programs are well known by many since it was initiated by two neurosurgeons. After tiring of treating children with spinal cord injuries, they rightly believed that the best treatment for these children was prevention. Their program, once fully developed, was eventually supported and formally endorsed by the two major neurosurgical organization, the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS) in 1986. The Think First Foundation was then founded in 1990 to facilitate the further development of injury prevention programming, dissemination, and implementation of the education curricula. The number of children reached by Think First programs over the past 10 years has steadily increased, with almost 1 million children having gone through a Think First program last year. The total number of children who have been reached to date is upwards of 8.5 million.

Presently, the Think First programs have consisted of the Think First for Teens and the Think First for Kids programs. Think First for Teens is an assembly-based program with one individual providing background information, including basic information of anatomy, mechanisms of injury, and issues of prevention and another individual with previous brain or spinal cord injury who teaches the children the "facts of life" after an injury. Think First for Kids is a curriculum-based program for children in grades 1 through 3 that is taught in the schools by teachers in each of the classes. It is a 6-week module of information regarding brain and spinal cord anatomy, injury prevention tips, and other educational materials and activities geared to encourage children to adopt injury prevention behavior. This can be combined with classroom presentations by individuals involved with the program. Bicycle safety, gun violence, and other aspects of injury and injury prevention are covered in an age-appropriate manner. Initiated in the first grade, it is repeated in grades 2 and 3. There are presently 43 states that have Think First programs that have been represented in 19 state chapters. There are international chapters as well, either providing existing programs or in development including Canada, Mexico, South America, and Europe. The goal of the Foundation is to expand even further to involve all 50 states and, with the development of multilingual and culturally applicable programming, in countries around the world. To do this, we will need to recruit additional volunteers and program directors who are willing to sponsor and develop programs in their communities.

To date, the Think First Foundation has been supported through the generosity of private donors, including many neu-

rosurgeons, and corporate and governmental sponsorship. In the past, in its exuberance to expand and reach the maximum number of children and cross a broad range of communities as quickly as possible, the Foundation increased its expenses such that it impacted on the percentage of donated dollars that actually went to programming. Over the past couple of years, the Foundation recognizing this weakness, has reigned in its expenses from a high of 65% to less than 30% for this fiscal year. Of note, established organization such as the United Way, the American Heart Association, etc., are doing well if their fundraising percentage is below 25%, and doing excellently if they are able to keep it under 20%. In this fiscal year, the Think First Foundation fundraising percentage was 19%, with only 10% of donated dollars going toward administration. Clearly, the Foundation has turned around its previous difficulties and can now proudly announce that 71% of donated dollars go directly to children's injury prevention programming. With expenses under control, the Think First Foundation can now look forward to a very positive and productive second decade, reaching out to more and more children.

For the future, it is quite clear that 1 million children being educated a year is not enough to get across the injury prevention message and have the impact that we all would like to have. The goals of the Foundation are to have 3 million children a year go through one of its programs by 2003 and 5 million a year by 2005. Part of this expansion will

need to be achieved through developing further programming for those aged children who presently do not benefit from either the Think First for Teens or the Think First for Kids programs. Think First is presently in the early stages of developing programs for grades 4-7. This program and its development, as well as distribution, will likely cost over \$1 million dollars. As well, the present programs, having benefited from studies of efficacy and education, need to be updated and expanded. To achieve all of these initiatives, the Foundation is going through its next phase of fundraising to significantly increase its endowment. The goal of \$3 million dollars in the next 3 years to the endowment will create funding for all of its expenses for its administration and fundraising needs for the future. All other funds raised either through grant support, donations, corporate sponsorship, or any other funding will go directly for further curriculum development and new educational materials for injury prevention for children. The next few years will be exciting times for the Foundation as it expands its programming and educational initiatives. We look forward to the continued support of neurosurgery and neurosurgeons alike.

If you are interested in developing a chapter in your community or just helping out with the Foundation, please contact William Biebuyck, CEO or Deb Johnson at the Think First Foundation office at 1-800-THINK56. □

## **N:/OC Update**

Continued from page 7

rosurgeons. These questions are answered in general terms and returned to the patient. Direct and specific advice or referrals are not provided and patients are cautioned that the information from Ask a Neurosurgeon should not substitute for a thorough evaluation by their doctor.

The professional side of *Neurosurgery://On-Call* welcomes a new important addition. Through the combined efforts of the CNS and AANS, a new online directory of fellowship opportunities has been assembled. This directory is accessible through many parts of the site including the Young Neurosurgeons page and the Residents Corner. The direct URL is <http://www.neurosurgery.org/sections/fellowships/>. The directory is searchable by institution name, geographic region, or subspecialty. The *Neurosurgery://On-Call* staff endeavors to maintain an up-to-date listing of all postresidency fellowship opportunities, ranging from cerebrovascular disease to epilepsy to general clinical practice to interventional neuroradiology, neuro-oncology, neurotrauma, critical care, pediatric neu-

rosurgery, peripheral nerve surgery, skull base surgery, spine surgery, stereotactic and functional neurosurgery, and others. The online fellowships directory provides an important resource for those interested in honing their subspecialty skills. From the same page, there is a hyperlink provided that lists numerous sources for grant support.

*Neurosurgery://On-Call* is pleased to present streaming video content from the 2000 CNS Annual Meeting in San Antonio. Those of you who did not have an opportunity to attend the meeting or those wishing to review a presentation, may view features from the general scientific sessions and special symposia. The streaming video files include live video and synchronized PowerPoint slides (where available). The files are offered in QuickTime format and are thus cross-platform compatible with both Macintosh and Windows-based systems. The menu of available presentations is accessible through the CNS home page on *Neurosurgery://On-Call*. Please log on and view them today. □

## **CALL FOR ABSTRACTS**

The Congress of Neurological Surgeons is pleased to announce the Call for Abstracts for the 51st Annual Meeting. Abstracts may be submitted through the Online Abstract Center at *Neurosurgery://On-Call* at <http://www.neurosurgery.org/abstractcenter/>.

The theme for the 51st Annual Meeting of the Congress of Neurological Surgeons will be "Reinventing Neurosurgery."

The meeting will be held in San Diego, California, September 29-October 4, 2001.

The deadline for submission of abstracts is March 16, 2001.

Send in your abstract today!  
We look forward to seeing you in San Diego.



## OBITUARY

### Cordell Eugene Gross, M.D.

(May 2, 1942–April 3, 2000)

Martin M. Bednar, M.D.



Cordell Eugene Gross, M.D.

On April 3, 2000 the neurosurgical community mourned the passing of Cordell Eugene Gross, M.D. Cordell's distinguished neurosurgical career included 12 years as Chairman of Neurosurgery at the University of Vermont following appointments at the University of Colorado Health Sciences Center and at the University of Iowa. It is abundantly clear that regardless of Cordell's academic position or geographic location, his presence improved both the medical and surgical care of the patients and also advanced neuroscience research. He was truly a Renaissance man.

Cordell was born in Hartford, Connecticut on May 2, 1942. His early education as an undergraduate and medical student at the University of Florida (Gainesville) provided him with a mastery of the fundamental skills that would serve as the foundation for his career. Between 1965 and 1971, Cordell was awarded his B.S. (biology), M.S. (radiation biophysics), and M.D. degrees. However, Cordell's wisest decision while at the University of Florida was his marriage to Linda, who has been his constant companion over the past 30+ years. Together, they raised two outstanding children, Mahlon and Jennifer.

Cordell and Linda left Florida and went briefly to Yale to do a surgical internship before heading to Syracuse, NY, where he did his neurosurgical training under the direction of Dr. Robert King. While at Syracuse, Cordell met Dr. Mahlon Kriebel and their mutual interest in electrophysiology resulted in the discovery of miniature end-plate potentials at the synapse. Their findings were well ahead of their time, and the implications of their research are only now

starting to be understood. Following residency, Cordell developed his interest in cerebral ischemia while at the University of Iowa and at the University of Colorado. His studies led to an improved understanding of the pathophysiology of cerebral ischemia. He recognized, long before many others, that cerebral ischemia is indeed amenable to therapy and that its treatment would optimally require a drug "cocktail" approach. Among Cordell's many talents was his ability to operationalize these concepts, to translate these novel approaches to the bedside. It was also clear that Cordell was a gifted technical surgeon. One of techniques he established was an algorithm for safely performing carotid endarterectomy. His outcomes serve as a superb benchmark for both neurosurgeons and vascular surgeons alike. Whether in the operating room, at the bedside, or in the cerebrovascular laboratory, one of Cordell's greatest delights was teaching these applications and concepts to his residents. When recently asked what he missed most about actively practicing the answer was quick and emphatic—teaching the residents.

Following his decision to take the Chair of Neurosurgery at the University of Vermont, his interest in cerebral ischemia became both intensified and refined. Given the heritage of the University of Vermont, this direction seemed very appropriate. Indeed, Dr. "Pete" R. M. P. Donaghy had been the first Chairman of Neurosurgery at the University of Vermont and was a pioneer in both cerebrovascular surgery and in the application of the microsurgical technique to neurosurgery. The development of an animal model that could accurately predict clinical outcome following cerebral ischemia continued to be an elusive goal for neuroscientists. Cordell combined his many talents and interests to develop such a model soon after his arrival at the University of Vermont. This was quickly applied to two interventions, thrombolytics and antiplatelet/antineutrophil therapy. The former helped to lay the foundation for the safe use of t-PA in stroke 5 years later, while the concept of using antiplatelet and antineutrophil therapy for acute cerebral ischemia is currently being examined in clinical trials. Cordell's background in radiation biophysics and his interest in cerebral ischemia led to his active participation in and endorsement of endovascular procedures by neurosurgeons. Cordell devoted a significant amount of time to this goal, both within the United States and at the University of Vienna. Several of his most recent articles discussed his findings in significant case series of endovascular procedures performed for intracranial lesions.

Despite the intensity of his professional life, Cordell was very devoted to his



Cordell with his wife Linda and his two children, Mahlon and Jennifer.



Cordell (front row, second from right) with the staff at the University of Colorado Health Sciences Center.

family. He enjoyed discussing airplanes with his brother, Ralph, and ultimately obtained his pilot's license. His brother and his sister Debbie continue to live in Florida. A proud father, Cordell's son, Mahlon, and daughter, Jennifer, have brought him much delight. With his wife, Linda, they have both persevered through life's challenges and enjoyed the triumphs together. They all share his wonderful sense of humor.

During the past 5 years, Cordell needed to balance his professional life with his battle with colorectal cancer. Over the last few years, Cordell's declining health slowed his body, but not his spirit, imagination, or passion. Cordell approached his illness in the same way he approached all of life's other challenges: with intensity, creativity, a heavy dose of science, and a small dose of philosophy. When he could no longer continue his medical practice, he still maintained his laboratory projects, of which there were many: holographic interferometry to measure spinal stress, porous shunt systems for hydrocephalus, mathematical modeling of intracranial pressure, correlation of computer mapped EEG with cerebral blood flow and clinical outcome, antiplatelet and antineutrophil therapy for the treatment of acute cerebral

ischemia, electrophysiologic and laser techniques to examine changes in vascular tone, and atomic force microscopy to study subcellular structural cell changes and cell culture as a surrogate for ischemic and traumatic central nervous system insults.

Cordell was truly a Renaissance man—and in all that he did, he did it with passion. When he wasn't involved with patient care, it was very likely that you could find him in the laboratory. In either setting, he was always the thoughtful innovator. When new technology became available, it was embraced, assimilated, mastered, and taught. He employed this strategy in a variety of forums, from neuroscience study sections at the NIH to his long-standing involvement and commitment with the RUNN course for neurosurgeons. For Cordell, neurosurgeon and inventor, medicine and science were inseparable. Concept became reality, laboratory hypotheses quickly reshaped medical therapies. He enjoyed the laboratory as he enjoyed patient care. With Cordell's careful guidance, the Department of Surgery at the University of Vermont enjoyed a truly golden era of research.

Cordell's greatest professional achieve-

Continued on page 10

## CSNS NEWS

### Chairman's Corner

**Lyal G. Leibrock, M.D., F.A.C.S.**

Chairman, CSNS



The most exciting news for the Council of State Neurosurgical Societies is the recent approval by the two parent organizations to proceed

with implementing the National Leadership Development Conference in Washington, DC. The initial day will be a practice management educational effort, taught by people who are gifted in conveying information regarding successful neurosurgical practice. This portion of the course may be of value particularly to neurosurgeons practicing in the region. These individuals will benefit from this education at a reduced rate. The second component of the conference is the political education section. Each state should mandate a politically active individual to attend who will serve as a network person for neurosurgical issues to their local governors, legislatures, congressmen, and senators. All politics are local and must be addressed in this fashion. Included are preliminary programs for the practice management Training course and the Political Action Training for the NLDC

(Table 1). The Council encourages interested neurosurgeons in states who have not yet registered to come to the meeting to determine whether there is someone interested in political action that has access to individuals who could be of use to the Washington Committee. The Council would appreciate the state societies identifying these individuals and sending them to the leadership development conference. Also included is a list of states that already have individuals coming to the leadership development conference and, more importantly, a list of states where individuals have not registered for the conference (Table 2). The Council needs to identify individuals who will help "carry the water for neurosurgery in political action" from those states that will benefit the entire community of neurosurgery. Anyone interested in attending may contact Dr. Randall Smith at 858-268-0562 (see Table 3). Alternatively, registration may be done over the Internet at the *Neurosurgery://On-Call* site.

At the CNS Annual Meeting in San Antonio, there were three resolutions and three reports. The initial resolution was to support the development of trauma systems throughout the United States and to obtain monies for hospitals to reimburse for trauma coverage, particularly if they were receiving more trauma than surrounding hospitals. The Council referred this to the Washington Committee, which has already been working to continue this vigorous effort. The second resolution was a policy

statement regarding the use of helmets in recreational activities such as biking, skiing, and other activities where there could be head injury. The third was a resolution regarding an educational program on neurosurgery for medical students in training across the United States. Education of medical students on relevant neurosurgical issues continues to be a low priority across the board. Educational content and problems with access to the students was discussed. This is a complex and regional issue that was referred to the Communications and Education Committee of the Council for further review. The Council will determine what documents are already available in neurosurgery and work through the Association of American Medical Colleges with our representatives Dr. Mel Epstein and Dr. Long to assess whether neurosurgery can make a more logical and progressive effort to get information about neurosurgical diseases, diagnostics, and therapeutics into the hands of medical students.

The initial report dealt with the neurotrauma survey dealing with a reimbursement for trauma coverage. A preliminary report without any statistical review was presented (no scientific validity) that will be helpful in trying to define what areas of the country were being reimbursed for trauma coverage



and what areas were not, and what the trauma coverage expectations were in different areas of the country. Dr. McVicker and the Neurotrauma Committee have presented this in an article to follow.

The second report, also from the Neurotrauma Committee, was an effort brought to the attention of the Council by the California State Neurosurgical Society. It detailed an effort to move risk management behavior into the core curriculum of school systems to help prevent injury. This program passed the California legislature and was then vetoed by the governor. The Neurotrauma Committee put packets together with prototypical legislation regarding this issue that individual delegates, alternates, or state societies could obtain from the Council. Efforts should be directed towards local state legislatures, state departments of education, or teachers' associations regarding this

Continued on page 11

## COUNCIL OF STATE NEUROSURGICAL SOCIETIES EXECUTIVE MEETING MARCH 10, 2001 CHICAGO, ILLINOIS



Cordell during an aneurysm clipping at the University of Vermont.

### Cordell Eugene Gross, M.D.

Continued from page 9

ments are not measured by the positions he held (though he was Professor and Chairman of Neurosurgery) or by the number of publications he authored (though these numbered well in excess of 100). Rather, he would be most pleased that his choice of neurosurgery as a career did indeed provide him with

the "stimulation to last a lifetime" that he often spoke of. What made Cordell truly exceptional was his uncompromising integrity and his humanity. As one childhood friend recently stated, "Cordell was the genuine article."

I once asked him how he viewed his role as Chairman. As a physician, he said, the patient always came first. His patients, like his family, friends, and colleagues, loved him—they were grateful for his medical talent and they loved

him for his genuine concern, his devotion to medicine, and for his gift of time. Patients always had as much time as they needed to discuss their concerns and fears. As a Chairman, Cordell did not view his position as a platform for personal advancement, but rather as a responsibility to provide an environment that would allow his colleagues and residents to develop and flourish. He recognized the unique talents of



Cordell with his Cherokee Piper airplane in Burlington, Vermont.



Cordell Eugene Gross, M.D.

each individual. His greatest pleasure was guiding the careers of many young neurosurgeons. Cordell would clearly see this as his greatest legacy. Those who were fortunate enough to do their neurosurgical training with Cordell will serve as a continual reminder of this remarkable individual and of how a single person could make such a significant difference in the lives of so many. □

**CSNS NEWS**

Continued from page 10

issue. The goal would be to gain support at the educational level (the teacher's association or the state traumatic brain injury association) so that primary educators can participate in this important activity benefiting students in schools throughout United States.

The third report was given by the Medical Practices Committee and involved the organizational survey. After much testimony, the CSNS, with the advice and consent of the CNS and AANS, completed the final form of the survey, which was to be mailed to all neurosurgeons in October or early November 2000. We hope that most will be returned by early 2001 to be analyzed.

A report of the results will be presented at the AANS Meeting in Toronto.

The Chairman hopes that this information provided to practicing neurosurgeons will encourage them to continue their efforts in the local state neurosurgical societies to support the socioeconomic efforts of neurosurgery throughout our country, at local, regional, and national levels. The Chair-

man would reiterate again, as we did in our last column, that there is immediate access regarding issues of importance to local neurosurgeons to the leadership of neurosurgery via the CSNS by simply contacting your delegate or alternate who attend the Council on an every 6-month basis.

Continued on page 12

**TABLE 1:  
NEUROSURGICAL LEADERSHIP DEVELOPMENT  
CONFERENCE (NLDC)**

**July 22-24, 2001  
Washington Court Hotel**

**Tentative Agenda**

Date	Time	Meeting
<b>Sunday, July 22, 2001</b>	8:00 AM - 5:00 PM	Education and Practice Management Course
	8:00 AM - 8:15 AM	Introduction & Welcome David F. Jimenez, MD
	8:15 AM - 9:00 AM	How & Why You Should Build Your Own Specialty Hospital Stan Pelofsky, MD
	9:00 AM - 10:15 AM	Compliance: Protect Yourself and Your Practice John A. Kusske, MD
	10:15 AM - 10:30 AM	Break
	10:30 AM - 12:00 noon	Current E&M Documentation Requirements Gregory Przybylski, MD
	12:00 PM - 1:00 PM	Lunch
	1:00 PM - 1:30 PM	PATH/Practice Audit Factors Samuel Hassenbusch, MD, Gregory Przybylski, MD
	1:30 PM - 3:00 PM	Implementing/Maintaining a Compliance Plan Samuel Hassenbusch, MD, Pollock
	3:00 PM - 3:30 PM	Development of RBRVS Gregory Przybylski, MD
	3:30 PM - 4:00 PM	Break
	4:00 PM - 4:30 PM	Create Fee Schedule/Determine Costs Pollock
	4:30 PM - 5:00 PM	Financial Benchmarks Pollock
	6:00 PM - 8:00 PM	NLDC Opening Reception
<b>Monday, July 23, 2001</b>	7:30 AM - 5:30 PM	<b>NLDC Political Action Conference</b>
	7:30 AM - 8:30 AM	Continental Breakfast with Exhibitors
	7:30 AM - 11:30 AM	Exhibits Open
	8:30 AM - 8:45 AM	Welcoming Remarks Lyal Leibrock, MD
	8:45 AM - 12:30 PM	Grassroots Advocacy Training: Politics, Power and You Michael E Dunn
	10:45 AM - 11:15 PM	Beverage Break with Exhibitors
	12:30 PM - 2:00 PM	Luncheon with Guest Speaker Member of Congress TBA
	2:00 PM - 4:00 PM	Public Speaking Training Melinda Ferris
	4:00 PM - 5:00 PM	Effective Communication with Congressional Offices Panel of Congressional Staff TBA
	5:00 PM - 5:30 PM	Update on What's Happening on the Hill and Preparation for Hill Visits Katie O. Orrico
6:00 PM - 7:00 PM	<b>Wine and Cheese Reception</b>	
7:00 PM	<b>Dinner on Own</b>	
<b>Tuesday, July 24, 2001</b>	8:00 AM - 12:00 PM	<b>NLDC Political Action Conference</b>
	8:00 AM - 9:00 AM	Hill Visit Rally with Continental Breakfast
	9:00 AM - 12:00 PM	Congressional Visits

**TABLE 2:  
NEUROSURGICAL LEADERSHIP DEVELOPMENT  
CONFERENCE (NLDC)**

**States with depositors:**

- Alabama
- Alaska
- California
- Colorado
- Connecticut
- Florida
- Illinois
- Iowa
- Kansas
- Kentucky
- Louisiana
- Maryland
- Massachusetts
- Michigan
- Mississippi
- Missouri
- Nebraska
- New Hampshire
- New Jersey
- New Mexico
- New York
- Ohio
- Oklahoma
- Pennsylvania
- South Dakota
- Tennessee
- Texas
- Washington

**States without depositors:**

- Arkansas
- Arizona
- Washington, DC
- Delaware
- Georgia
- Hawaii
- Idaho
- Indiana
- Maine
- Minnesota
- Montana
- Nevada
- North Carolina
- North Dakota
- Oregon
- Rhode Island
- South Carolina
- Utah
- Vermont
- Virginia
- West Virginia
- Wisconsin
- Wyoming

**TABLE 3:  
NEUROSURGICAL LEADERSHIP DEVELOPMENT  
CONFERENCE (NLDC)**

In July 2001, the Council of State Neurosurgical Societies is sponsoring its first Neurosurgical Leadership Development Conference (NLDC) in Washington, DC. The purpose of the NLDC is to train individual neurosurgeons on how to be effective "grassroots" leaders so they can develop relationships with their Members of Congress and become effective "lobbyists" for neurosurgery. To expand neurosurgery's influence in Washington, it is absolutely CRITICAL for policy makers to hear directly from the people who are impacted by the laws and regulations that they make—YOU.

**Preliminary Program**

Saturday, July 21	Conference Participants Arrive in Washington, DC
Sunday, July 22	Education and Practice Management Course (CME Credits) Building a Booming Practice Controlling Practice Expenses Compliance: Protect Yourself and Your Practice Coding and Reimbursement Opening Reception
Monday, July 23	Grassroots Advocacy Training How to Be an Effective Grassroots Advocate— Politics, Power and You Washington Update Getting Ready to Go to "The Hill" Dinner
Tuesday, July 24	Congressional Visits Depart for Home

Speakers at the conference will include experts in the practice management and coding, grassroots advocacy and political education, members of Congress and other government officials, and neurosurgical leaders. The expected registration fee for this 2 1/2 -day program will be approximately \$500, plus travel expenses.

**Register Your State's Participation TODAY!**

YES! Representatives from my state will attend the NLDC      Number Attending \_\_\_\_\_

Name \_\_\_\_\_ State \_\_\_\_\_

Please remit your \$100 deposit Payable to "CSNS":      **Randall Smith, M.D.**  
7920 Frost Street, Suite 400  
San Diego, CA 92123-2736

## CSNS NEWS

Continued from page 11

## CSNS Neurotrauma Committee Reports Survey Results

John McVicker, M.D.

The CSNS Neurotrauma Committee reported the results of an Internet survey on neurosurgical trauma coverage arrangements at the annual meeting of the Council of State Neurosurgical Societies in San Antonio in fall 2000. The survey was undertaken in response to a CSNS resolution in 1999 that directed the committee to develop, distribute, collate, and analyze a national survey on key socioeconomic parameters of emergency neurosurgery and neurotrauma. The survey was to address the national spectrum of contractual and practical agreements between neurosurgeons and the hospitals and systems in which they practice. The topic is growing in importance, as neurosurgical groups increasingly seek contractual means to modulate trauma system expectations for neurosurgical participation and to address the additional workload of trauma call participation in an environment where cost shifting is no longer an option.

Of the 263 respondents, 91% actively participate in trauma, approximately half urban and half suburban or rural. A total of 62% of respondents are in private practice, 28% are in academics, and 10% are salaried. Level I trauma centers account for 40% of the institutions, with Level II approximately 30%, and Level III and undesignated approximately 30%. Approximately one in three respondents have a formal contract for neurotrauma coverage with their institution.

Stipends for call coverage are more frequent than is commonly believed, with 19% of respondents taking call reimbursed for their availability. In addition, over 31% of call participants receive some form of financial incentive, such as a guaranteed percentage of billings, hospital billing services, or malpractice coverage or supplementation. Call stipends are about twice as frequent in private and salaried practices (21%) as in academic practices (11%), and tend to be in a lower range (mode \$500–1000) in academics and salaried positions than in private practice (mode \$1000–1500). As a general rule, call coverage is more frequent, less likely to be reimbursed (or reimbursed at a lower rate), and more likely to be mandatory at Level III and undesignated trauma centers than Level I or II centers. Nev-

ertheless, over 75% of all respondents report call coverage to be mandatory at their institution.

On the basis of limited prior surveys, neurosurgical contracting with hospitals for the development of neurotrauma programs and the provision of trauma care is becoming more prevalent. It may provide the funds necessary to bring additional needed neurosurgical workforce to a community and may be the only way some neurosurgeons can afford to remain active in neurotrauma. A number of creative arrangements have been developed. Additional details are available by contacting the author at [mcvicker@rmna.net](mailto:mcvicker@rmna.net).

In response to a request for implementation of another CSNS resolution, the CSNS Neurotrauma Committee has also developed a legislative action packet to assist neurosurgeons in bringing primary and secondary school trauma education curriculum to their home state. CSNS Resolution 5: Spine and Brain Injury Prevention Education Curriculum (Spring 2000) seeks to integrate the learning methods developed by the Think First Foundation within a core curriculum that promotes the elimination of violent or risk-taking behavior. Although introduction of core curriculum into state legislation may take different routes dependent on individual state law and political reality, this packet serves as a general model and includes model legislation used in California and sample letters to legislators and others who may be interested in promoting such legislation. The packets were distributed at the CSNS meeting in San Antonio and may be obtained through the CSNS office.

In related neurotrauma news, the CSNS also passed a position statement supporting the use of helmets in recreational sports that have a high risk of head injury; a resolution endorsing budgetary support for the Trauma Care Systems Planning and Development Act was also passed. The text of these resolutions is available on the *Neurosurgery://On-Call* Web site. Look for a report to the United States Congress by the General Accounting Office in May 2001 outlining the impact of EMTALA on hospital emergency departments and physicians covering emergency department call. The report is projected to include estimates of uncompensated costs to on-call physicians throughout the United States, as well as the extent to which regulatory requirements and enforcement of EMTALA have expanded beyond the legislation's original intent and become an unfunded mandate.

Text of a resolution endorsing budgetary support for the Trauma Care Systems Planning and Development Act is available on the *Neurosurgery://On-Call* Web site.

## Washington Report

Katie O. Orrico, J.D.

Director, AANS/CNS Washington Office

### Grassroots Neurosurgery Contributes Record Amount to ANS PAC



In 1995 and 1996 when the issue of establishing a PAC for neurosurgery was first being discussed by neurosurgeons from California and elsewhere, there was not

much support for the idea, especially within the leadership of organized neurosurgery. Despite this fact, grassroots neurosurgeons, through the CSNS, demonstrated their support for a neurosurgical PAC. In 1997, the independent American Neurological Surgery Political Action Committee (ANS PAC) was formed. Because of the ongoing persuasion of a few respected and dedicated believers, and the tireless efforts of individuals like Randy Smith, Troy Tippet, and others, ANS PAC is pleased to report that neurosurgeons from around the country contributed a record number of dollars to ANS PAC for the 2000 election cycle.

Approximately \$280,000 was raised during the 1999/2000 period, from about 712 contributions, or an average contribution of nearly \$400. This compares to the 1998 cycle (1997/1998), whereby ANS PAC raised about \$255,000 from 687 contributors for an average individual contribution of about \$370. The percentage of neurosurgeons contributing to ANS PAC has remained fairly constant at approximately 10%. Neurosurgeons from every state but three (North Dakota, Vermont, and Wyoming) have made contributions to ANS PAC. Participation within the leadership ranks of organized neurosurgery are also much improved.

### ANS PAC Supported Candidates Victorious in 2000 Congressional Election

In an historic election, most of the ANS PAC-supported candidates won victories in their respective congressional races. While we suffered some tough losses, ANS PAC backed several losing candidates who were extremely supportive of the issues facing neurosurgery, and hence were philosophically the right choices. One of the most notable losses for us was Marc Flitter, M.D., a neurosurgeon and democratic candidate from the 21st district of Pennsylvania. Another disappointment was Rick Lazio's (R-NY) loss to Hillary Rodham Clinton, who was elected to the

U.S. Senate from the state of New York. Finally, medicine suffered a huge loss when Rep. Tom Campbell (R-CA) was defeated by Senator Dianne Feinstein (D-CA).

Overall, ANS PAC contributed to 77 candidates in the 2000 election (48 Republicans and 29 Democrats), and contributed nearly \$170,000 to these individuals (\$103,000 to Republicans and \$67,000 to Democrats). In addition to direct candidate contributions, ANS PAC made \$15,000 contributions each to the Republican and Democratic National Committees. Thus, total election dollars spent were \$200,000. ANS PAC had an election success rate of approximately 88%, with 41 Republican wins, 6 losses, and 1 retirement. In the Democratic column, we had 26 wins and 3 losses.

The following chart highlights the candidates that ANS PAC supported and the outcome of each race. (Note: this is based on information available on November 8, 2000 at 12:00 pm and may change slightly when the results of each election are final). For complete information on all congressional races, ANS PAC members can visit CNN's Web site at: <http://www.cnn.com/ELECTION/2000/results/>.

### ANS PAC Convenes First "Good Government" Luncheon in San Antonio

During the CNS Annual Meeting in San Antonio, ANS PAC held its first "Good Government" luncheon, featuring keynote speaker Ambassador Alan Keyes. Over 80 people attended the luncheon, at which Ambassador Keyes gave an inspiring talk entitled the "Foundation of our Freedom." The ANS PAC Board of Directors is currently reconsidering the timing of future luncheons to improve the attendance, while not conflicting with other important activities convened during either the AANS or CNS annual meetings.

### CSNS to Sponsor Leadership Conference in Washington, DC

On July 22–24, 2001, the CSNS is sponsoring its first Neurosurgical Leadership Development Conference (NLDC) in Washington, DC. To expand neurosurgery's influence in Washington, it is absolutely **CRITICAL** for policy makers to hear directly from the people who are impacted by the laws and regulations that they make. Therefore, the purpose of the NLDC is to train individual neurosurgeons on how to be effective "grassroots" leaders so they can develop relationships with their members of Congress and become effective "lobbyists" for neurosurgery.

Continued on page 13

## CSNS NEWS

Continued from page 10

STATE/DISTRICT	CANDIDATE	CONTRIBUTION \$	VOTE %	WIN/LOSS
<b>Alabama</b>				
6th	Spencer Baucus (R)	\$1,000	89	Win
<b>Arizona</b>				
Senate	Jon Kyl (R)	2,000	79	Win
4th	John Shadegg (R)	4,559	64	Win
<b>Arkansas</b>				
2nd	Vic Snyder, MD (D)	1,000	57	Win
<b>California</b>				
1st	Mike Thompson (D)	1,000	66	Win
14th	Anna Eshoo (D)	1,000	71	Win
21st	Bill Thomas (R)	3,000	72	Win
30th	Xavier Becerra (D)	1,000	84	Win
49th	Brian Bilbray (R)	1,500	45	Loss
51st	Duke Cunningham (R)	1,000	64	Win
<b>Connecticut</b>				
6th	Nancy Johnson (R)	2,000	63	Win
<b>Delaware</b>				
Senate	William Roth (R)	1,000	44	Loss
<b>Florida</b>				
Senate	Bill McCollum (R)	3,000	47	Loss
1st	Joe Scarborough (R)	6,972	Unopposed	Win
5th	Karen Thurman (D)	1,000	64	Win
9th	Michael Bilirakis (R)	2,000	82	Win
13th	Dan Miller (R)	2,000	64	Win
15th	Dave Weldon, MD (R)	5,000	59	Win
16th	Mark Foley (R)	1,500	61	Win
22nd	Clay Shaw (R)	3,000	50	Win
<b>Georgia</b>				
5th	John Lewis (D)	1,000	78	Win
7th	Bob Barr (R)	2,000	54	Win
8th	Saxby Chambliss (R)	2,000	59	Win
10th	Charlie Norwood, DDS (R)	5,000	63	Win
<b>Illinois</b>				
6th	Henry Hyde (R)	2,000	59	Win
8th	Phil Crane (R)	3,000	61	Win
10th	John Porter (R)	1,000		Retired
14th	Dennis Hastert (R)	1,000	74	Win
16th	Don Manzullo (R)	2,000	67	Win
<b>Indiana</b>				
8th	Paul Perry, MD (D)	5,000	46	Loss
<b>Iowa</b>				
4th	Greg Ganske, MD (R)	5,000	62	Win
<b>Kansas</b>				
3rd	Dennis Moore (D)	3,000	51	Win
<b>Kentucky</b>				
6th	Ernie Fletcher, MD (R)	5,053	53	Win
<b>Louisiana</b>				
4th	Jim McCrery (R)	1,000	71	Win
5th	John Cooksey, MD (R)	5,000	69	Win
<b>Maryland</b>				
3rd	Ben Cardin (D)	1,000	76	Win
5th	Steny Hoyer (D)	2,000	65	Win
8th	Connie Morella (R)	2,000	52	Win
<b>Massachusetts</b>				
4th	Barney Frank (D)	500	74	Win
9th	Joe Moakley (D)	1,000	77	Win
<b>Michigan</b>				
1st	Bart Stupak (D)	1,000	59	Win
4th	Dave Camp (R)	1,000	68	Win
6th	Fred Upton (R)	1,000	68	Win
10th	David Bonior (D)	2,000	65	Win
12th	Sander Levin (D)	2,000	65	Win
14th	John Conyers (D)	2,000	91	Win
16th	John Dingell (D)	2,000	72	Win
<b>Mississippi</b>				
Senate	Trent Lott (R)	3,000	67	Win
<b>Missouri</b>				
3rd	Dick Gephardt (D)	4,000	58	Win
4th	Ike Skelton (D)	500	68	Win
5th	Karen McCarthy (D)	4,000	69	Win
<b>Montana</b>				
Senate	Brian Schweitzer (D)	5,000	48	Loss

**New Jersey**

Senate	Bob Franks (R)	1,000	48	Loss
2nd	Frank LoBiondo (R)	1,000	67	Win
3rd	Jim Saxton (R)	1,000	58	Win
4th	Chris Smith (R)	1,000	64	Win
5th	Marge Roukema (R)	1,000	66	Win
6th	Frank Pallone (D)	2,000	68	Win
11th	Rodney Fellinghusen (R)	500	69	Win

**New York**

Senate	Rick Lazio (R)	2,000	44	Loss
3rd	Peter King (R)	500	60	Win
10th	Ed Towns (D)	2,000	90	Win
13th	Vito Fossella (R)	1,000	65	Win
15th	Charlie Rangel (D)	3,000	91	Win
20th	Benjamin Gilman (R)	1,000	58	Win
23rd	Sherwood Boehlert (R)	1,000	60	Win

**Ohio**

4th	Mike Oxley (R)	1,000	68	Win
6th	Ted Strickland (D)	1,000	58	Win
13th	Sherrod Brown (D)	8,000	65	Win

**Pennsylvania**

21st	Marc Flinger, MD (D)	5,000	39	Loss
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**Texas**

4th	Ralph Hall (D)	2,000	61	Win
6th	Joe Barton (R)	1,000	89	Win
29th	Gene Green (D)	2,000	74	Win

**Utah**

Senate	Orrin Hatch (R)	5,000	66	Win
2nd	Merill Cook (R)	1,000		Lost Primary

**Vermont**

Senate	Jim Jeffords (R)	2,000	66	Win
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**Virginia**

8th	Jim Moran (D)	1,000	64	Win
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**Wyoming**

1st	Barbara Cubin (R)	1,000	67	Win
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## Ohio State Neurosurgical Society Holds Annual Meeting

**Joung Lee, M.D.**

On September 9, 2000, the Ohio State Neurosurgical Society (Joung H. Lee, President) held its annual meeting in Cleveland, Ohio. The meeting, organized by William Bingaman, was the most successful OSNS meeting held in recent years, attended by over 50 members.

The exciting program, the main theme of which was the socioeconomic of neurosurgery in the evolving U.S. health care system, included as special speakers the current presidents of the AANS, CNS, and CSNS, Drs. Stewart Dunsker, Daniel Barrow, and Lyle Leibrock. In addition, all of the current chairmen of academic neurosurgery departments in the state of Ohio, Drs. John Tew, Marc Mayberg, Robert Ratcheson, and Michael Miner, spoke on the socioeconomic impact on academic neurosurgical practice, resident education, and research. Drs. Dale Braun, Robert Schwetschenau, and Mario Sertich provided their perspectives on the impact of managed care and decreasing reimbursement for private practitioners in the state of Ohio.

Katie Orrico, Director of the AANS/CNS Washington Office, summarized the role of the Washington Committee and updated us on current events on the political front. Rep. Sherrod Brown (D-OH) also gave an insightful talk on Medicare reform.

The meeting highlight was the presentation of the Society's highest honor, the Neurosurgeon of the Year Award. This year's recipient, Dr. John Tew, was honored for his lifelong contribution to the field of neurosurgery.

At the business meeting, Dr. Al Cohen was elected as the new President, and Dr. William Bingaman as President-Elect. The society will meet again during the AANS meeting in Toronto. The date of the annual meeting for 2001 will be established at that time. Anyone interested in joining the OSNS or attending the meetings please contact Dr. Al Cohen or Dr. William Bingaman.

## CPT Coding Corner 2001

**Rhonda Petruziella**

CPT 2001 has some very significant coding changes for the neurosurgeon, which will undoubtedly impact reimbursement. There are six new CPT codes and six codes were revised without any deletions. The spine specialist will now have a more accurate way of

Continued on page 14

## CSNS NEWS

Continued from page 10

billing the "Re-do" laminectomy, and the cerebrovascular specialist has been provided two new codes to help distinguish between a simple and complex repair of aneurysm.

The new codes are as follows:

**61697**-Surgery for complex intracranial aneurysm, carotid (**87.85 total RVUs**)

**61698**-Surgery for complex intracranial aneurysm, vertebrobasilar (**84.56 total RVUs**)

**62252**-Reprogramming of programmable CSF shunt (**2.18 total RVUs**)

**63043**-"Re-Do" laminotomy (hemilaminectomy) ea. cerv. intersp. (**RVUs not yet assigned**)

**63044**-"Re-Do" laminotomy (hemilaminectomy) ea. lumb intersp. (**RVUs not yet assigned**)

**64614**-Chemodenerivation of muscle(s); extremity(s) and/or trunk (**3.17 total RVUs**)

The revised codes are as follows:

**61700**-Surgery of simple intracranial aneurysm, carotid (**90.12 total RVUs**)

**61770**-Stereotactic localization, incl. burr hole(s) w/insert. catheter(s) or probe(s) for placement of radiation source (**40.38 total RVUs**)

**62350**-Implantation, revision, or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via external pump or implantable reservoir/infusion pump; w/o laminectomy (**11.20 total RVUs**)

**63040**-Laminotomy (hemilaminectomy), with decompression of nerve root(s) including partial facetectomy, foraminotomy, and/or excision of herniated disk, reexploration, single interspace, cervical (**37.52 total RVUs**)

**64612**-Chemodenerivation of muscle(s); muscle(s) innervated by facial nerve (e.g., for blepharospasm, hemifacial spasm) (**3.49 total RVUs**)

**64630**-Destruction by neurolytic agent; pudendal nerve (**0.29 total RVUs**)

Physicians should become familiar with the new and revised codes and should begin the process of revising their charge records to accommodate these new changes. It also makes great sense for physician practices to review the Medicare fee schedule from your local carrier to determine how the new codes will impact future reimbursement.

The *Federal Register* (November 1, 2000) has published an increase in the conversion factor from \$36.61 to \$38.26 (+\$1.65) along with the new RVUs for all CPT codes that suggests an overall increase in Medicare's fee schedule.

For the neurosurgeon practicing in the state of Ohio, there is a new local Medicare policy for arthrodesis that contains very specific information on CPT and ICD-9 codes that are allowed for this procedure, and it is advisable that you become familiar with this policy to ensure proper coding techniques.

HCFA has also redefined the coding edits for CPT 61795-stereotactic guidance, which, as some of you may be aware for 2000, contained verbiage that allowed billing for its use during a spine procedure, but was then overturned by HCFA and has once again been overturned because of the efforts of the AANS. Neurosurgeons need to understand this policy to determine when you can bill separately for stereotactic guidance; this rule is also found in the *Federal Register*. The AANS has advised physicians who have experienced denials because of this edit to resubmit all claims for payment.

As usual, practices should begin using the new CPT and ICD-9 codes as early in 2001 as possible, but should keep a close watch on reimbursement for those new procedures to be sure that insurance carriers are recognizing them with adequate reimbursement.

Finally, it's advisable for physicians to play a proactive role not only in their coding, but reimbursement issues as well, to identify opportunities to optimize and improve in both areas. □

## JOINT SECTION ON CEREBROVASCULAR SURGERY

## CV Program at the CNS 2000 Annual Meeting

**B. Gregory Thompson, M.D.**  
Editor, AANS/CNS Section on Cerebrovascular Surgery

The Cerebrovascular Section program at the 2000 San Antonio CNS meeting was loaded with insightful debate and controversy. Participants were presented with a broad venue discussing state-of-the-art management and decision-making analysis on current issues in cerebrovascular surgery.

## To Clip or Not to Clip

One of the clear highlights of the meeting was the point-counterpoint presentations of the second annual Charles Drake lecturers, Dr. Robert F. Spetzler and Dr. David Piepgras. Dr. Piepgras, in a lecture titled "The Argument for No Treatment of Unruptured Intracranial Aneurysms," reviewed the published results of the ISUIA regarding the natural history of unruptured intracranial aneurysms. This important study published in December 1998 in *The New England Journal of Medicine* continues to significantly impact the management of these lesions. He also shared insights on the upcoming data from the perspective portion of the study. He again argued for the low likelihood of rupture of small intracranial aneurysms. Dr. Spetzler, in his lecture titled "Argument for the Surgical treatment of Unruptured Intracranial Aneurysms: The Risks and Efficacy," proposed a different opinion. Providing a mathematical argument, he argued that the likelihood of aneurysmal rupture has to be greater than that proposed in the study. In addition, he discussed the risks involved in the treatment of unruptured aneurysms. The management of unruptured aneurysms remains a charged issue, and will clearly continue to be a subject of intense discussion and investigation.

## State of the Art in Endovascular Neurosurgery

There were insightful presentations on the decision strategies regarding the treatment of vascular pathology and new developments in endovascular neurosurgery. Dr. Giuseppe Lanzino delivered a fascinating presentation on the biology of blood vessels and the future applications.

## Carotid Stents versus Endarterectomies

The second cerebrovascular session focused on the treatment of occlusive

cerebrovascular disease. This session included a discussion of the role of carotid angioplasty and stenting versus endarterectomy by Dr. Nick Hopkins and Dr. Christopher Loftus. Dr. Robert Harbaugh and Dr. Marc Mayberg discussed outcome studies and trials in the treatment of carotid disease.

Other highlights included the plenary session presentation by Dr. Ralph Dacey revealing a futuristic view of the use of a magnetically controlled intracerebral navigation device in the use of challenging endovascular procedures. The recipient of the Galbraith Award, Dr. Gordon Tang, presented provocative data on the use of intraoperative angiography in the treatment of aneurysms.

The next CV section meeting will take place in beautiful Hawaii jointly with the American Society of Interventional and Therapeutic Neuroradiology. This year's Joint Section meeting is being jointly organized with our Japanese counterparts. I urge all CV Section members to attend the meeting, and I look forward to seeing you there. In Astronaut-Senator John Glen's words, who shared his thoughts with us at the meeting, we need to continue to shoot for the stars.

## Confirmed New Members in 2000

CV Section North American and international membership continues to grow at a healthy pace. Cumulative membership in all categories of the Section is now at more than 650, making it one of the largest of the AANS/CNS sections.

A brief historical review demonstrates how the cumulative section membership has grown since 1994:

Following is a list of new members approved in 2000:

Benitez, Ronald; Philadelphia, PA; Candidate (Rosenwasser, Bederson)

Blatt, David; Brentwood, TN; Active (Rhoton, Blatt)

Caragine, Louis; Detroit, MI; Candidate (Diaz, Melgar)

Cawley, Michael; Atlanta, GA; Resident (Day, Barrow)

Friedlander, Robert; Cambridge, MA; Candidate (Steig, Scott)

Friedman, Jonathan; Rochester, MN (Piepgras, Meyer)

Field, James; Crodova, TN; Active (Ray, Clark)

## FUTURE MEETINGS—CONGRESS OF NEUROLOGICAL SURGEONS

The following are the planned sites and dates for future annual meetings of the Congress of Neurological Surgeons:

2001	San Diego, CA	September 29-October 4
2002	Philadelphia, PA	September 21-26
2003	Denver, CO	October 18-23
2004	San Francisco, CA	October 16-21

## FUTURE MEETINGS—AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS

The following are the planned sites and dates for future annual meetings of the American Association of Neurological Surgeons:

2001	Toronto, Ontario, Canada	April 21-26
2002	Chicago, IL	April 6-11
2003	San Diego, CA	April 26-May 1
2004	Orlando, FL	May 1-6

## Joint Section on Cerebrovascular Surgery

Continued from page 14

Forget, Thomas; Philadelphia, PA; Candidate (Rosenwasser, Thomas)

Ho, Hector; Grand Blanc, MI; Active (Batjer, Bederson)

Huh, Seoung; Seoul, Korea; Int'l (Batjer, Lee)

Mertol, Tansu; Izmir, Turkey; Int'l (Morcos, Bederson)

Norbash, Alexander; Boston, MA; Adjunct Associate (Ogilvy, Bederson)

Ramos-zuniga, Rodrigo; Guadalupe, CP; Int'l (Loftus, Bederson)

Sanan, Abhay; Tucson, AZ; Active (Piegras, Bederson)

Singer, Robert; Nashville, TN; Active (Steinberg, Ogilvy)

Sinson, Grant; Philadelphia, PA; Active (Bederson, Flamm)

Stoodley, Marcus; Randwick, Australia; Int'l (Bederson, Awad)

Sunshine, Jeffrey; University Heights, OH; Adjunct Associate (Tarr, Selman)

Tranmer, Bruce; Burlington, VT; Active (Wallace, Harbaugh)

Van Der Veer, Craig; Charlotte, NC; Active (Selman, Bederson)

Wascher, Thomas; Appleton, WI; Active (Zabramski, Bederson)

Zauner, Alois; Richmond, VA; Resident (Young, Bullock)

Zipfel, Gregory; St. Louis, MO; Resident (Dacey, Day)

For additional information about membership categories, and an application, please look at the CV Section Web site: <http://www.neurosurgery.org/cv/index.html>.

Questions about membership can be addressed to the membership Chairman, Joshua Bederson, M.D. at [jbederson@mssm.edu](mailto:jbederson@mssm.edu).

## AANS/CNS On-Line Carotid Stenosis Outcomes Study

### Robert E. Harbaugh, M.D., F.A.C.S.

Professor of Surgery (Neurosurgery), Dartmouth-Hitchcock Medical Center and Chairman, AANS/CNS Outcomes Committee and Committee for the Assessment of Quality

The American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS) have made a commitment to developing the resources and infrastructure necessary to conduct national and international outcomes studies in neurological surgery.

As part of our strategic plan, we have recruited a committee with representatives from each of the clinical sections of the AANS/CNS to assure clinical expertise in all areas of neurosurgery. The committee also includes neurosurgeons and non-neurosurgical consultants with expertise in clinical epidemiology and information technology.

In collaboration with the Information Services group at the AANS and Outcome Sciences, we have deployed a reliable and secure user name and password protected, Internet based, outcomes reporting system (the POINT system). This system allows neurosurgeons from around the world to download outcomes reporting instruments to their personal computers, submit data electronically to a centralized database, obtain feedback about their outcomes, and compare outcomes indicators in their practice to the same indicators in the universal data set. Data submitted to the central database do not have patient or surgeon identifiers, thus assuring patient and physician confidentiality. Data verification and monitoring can be accomplished, however, by use of the user name and password key, which is kept at the AANS office.

This system offers numerous advantages regarding data submission, storage, analysis, and feedback and may become the standard for conducting multicenter clinical research. Outcomes analysis over wide geographic areas can be conducted efficiently and small private practice groups will be able to participate as easily as large academic centers. Analysis of data in the central database can be carried out to find best clinical practices and the lessons learned from these practices can be disseminated to the larger group. Because the cost per patient decreases as the number of patients increases, the system may allow national and international outcomes studies to be done for a fraction of the cost of present outcomes studies. Use of the system is free of

charge to all members of the AANS and CNS. We believe that this system allows the kind of meticulous practice monitoring that will result in improved patient care at reduced costs.

We are presently conducting a study on the surgical and endovascular treatment of patients with carotid artery stenosis. We would encourage all members of the Section on Cerebrovascular Surgery who treat patients with extracranial cerebrovascular disease to enroll patients in this database. Information about how to obtain your user name and password is available on the Practice Management page of *Neurosurgery://On-Call* (<http://www.neurosurgery.org>).

## Washington Update

### Katie O. Orrico, J.D.

Director, AANS/CNS Washington Office

### Protect Yourself to Minimize the Risk of Federal Prosecution

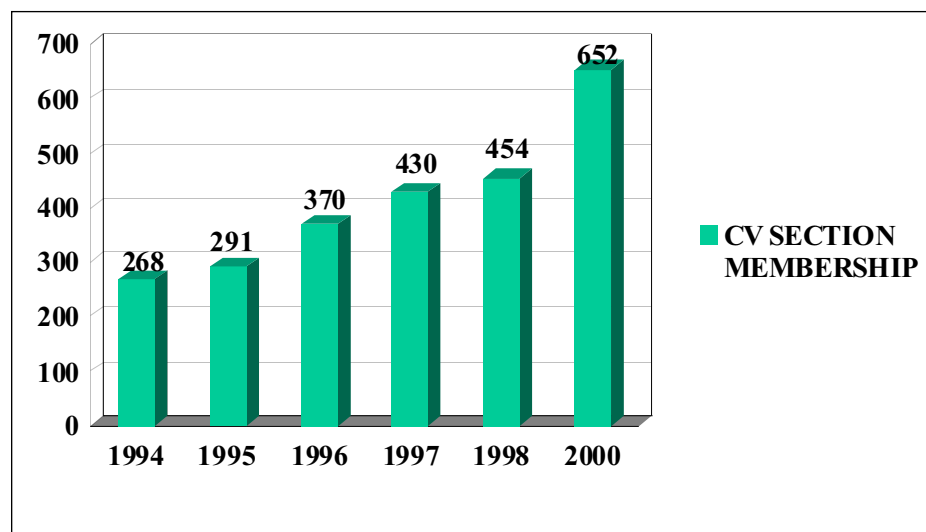


Gone are the days when physicians only had to care for their patients. To maintain a successful medical practice, in addition to an M.D., it now almost a

requirement that physicians also hold M.B.A. and J.D. degrees. Neurosurgeons can no longer afford to have an ostrich mentality when it comes to running a practice, and they must be intimately involved in the day-to-day business aspects of their practice. This means, of course, that you will have to continue to educate yourself about the rules and regulations promulgated by the government and others.

### OIG Issues Physician Compliance Guidance

"We are the government and we are here to help you." Sound familiar? Well, in part, there is a genuine effort on the part of the Department of Health and Human Services Office of Inspector General (OIG) to give health care providers some guidance so they do not run afoul of the Medicare rules and regulations. In an effort to help small physician groups develop a plan to "identify both erroneous and fraudulent claims and help ensure that submitted claims are true and accurate," on September 25, 2000, the OIG issued the final "Compliance Program Guidance for Individual and Small Group Physician Practices." The "compliance program guidance is intended to assist individ-



## CHAIRS OF THE JSCVS

1975-1976	J. Garber Galbraith (Deceased)
1976-1977	Thoralf Sundt (Deceased)
1977-1978	Russell H. Patterson
1978-1979	John M. Tew
1979-1980	Robert G. Ojemann
1980-1981	Albert L. Rhoton
1981-1982	Edward F. Downing
1982-1983	James T. Robertson
1983-1984	Sydney J. Peerless
1984-1985	Christopher B. Shields
1985-1986	James W. Correll
1986-1987	Robert R. Smith
1987-1988	Charles R. Neblett
1988-1989	Arthur L. Day
1989-1990	Robert A. Ratcheson
1990-1991	David G. Piegras
1991-1992	John R. Little
1992-1994	Gary G. Ferguson
1994-1996	L. Nelson Hopkins
1996-1998	Steven L. Giannotta
1998-2000	Christopher M. Loftus
2000-2001	Issam A. Awad

Continued on page 16

## Joint Section on Cerebrovascular Surgery

Continued from page 15

ual and small group physician practices in developing a voluntary compliance program that promotes adherence to statutes and regulations applicable to the Federal health care programs.”

The problem with the document, however, is that it is so complicated and burdensome in its own right, making it unworkable for small physician practices with limited resources. In addition, the document does not guarantee a “get-out-of-jail-free” card for physicians who make a good faith effort to adhere to the elements of the compliance program. The AANS and CNS submitted comments to the OIG in July 2000. The OIG did make some changes as a result of these and other recommendations from physician organizations. Nevertheless, the AANS and CNS remain extremely concerned about the complexity of this program and will continue to work with the AMA and others to see that changes are made to make the program more viable for physicians to implement.

### To Implement or Not to Implement (and If So How)?

If the compliance program is so complex and difficult to implement, why, then, would any neurosurgeon want to undertake such an effort? The answer is simple: the six criminal statutes highlighted in Appendix B of the report and the four civil and administrative statutes highlighted in Appendix C of the report!

The OIG has identified seven basic components of a voluntary compliance program. These are:

- Conducting internal monitoring and auditing through the performance of periodic audits
- Implementing compliance and practice standards through the development of written standards and procedures
- Designating a compliance officer or contact(s) to monitor compliance efforts and enforce practice standards
- Conducting appropriate training and education on practice standards and procedures
- Responding appropriately to detected violations through the investigation of allegations and the disclosure of incidents to appropriate government entities
- Developing open lines of communication, such as (1) discussions at staff meetings regarding how to avoid erroneous or fraudulent conduct and (2) community bulletin boards, to keep practice employees updated regarding compliance activities
- Enforcing disciplinary standards through well-publicized guidelines

The OIG acknowledges that full implementation of all the above components may not be feasible for all physician practices, but physicians would be well advised to attempt to implement some type of program. Note, however, that there is a general feeling that the lesser of two evils is to not have any compliance program as opposed to having one but not complying with it. Make sure, therefore, that you set in place a realistic plan and adhere to it!

A full copy of the document is available on the World Wide Web at <http://www.hhs.gov/oig/modcomp/cpc.pdf>.

## Documenting and Billing for Critical Care in Neurovascular Surgery

**Veronica Chiang**  
Instructor of Neurosurgery

**Issam Awad**  
The Nixdorff-German  
Professor of Neurosurgery  
Yale University School of Medicine

The care of critically ill patients is an essential component of the practice of neurological surgery. This is particularly true in neurovascular surgery where a significant fraction of a patient's illness, and care rendered, are in an intensive care unit (ICU). There has often been confusion as to when a neurosurgeon may bill or be reimbursed for critical care services. Accurate documentation and coding are an essential aspect of the process under the current HCFA reimbursement system, like all other areas of neurosurgery, and similar rules are often invoked by other private payors. An accurate understanding of the process can maximize legitimate reimbursement for services rendered and lower the risk of fraud allegations in audit situations.

### Compliance Definitions of Critical Care Services

Unique CPT codes are provided for the billing of critical care services. No specialty training or certification is required to bill for critical care, although hospitals may restrict privileges for critical care to certain specialties. The definition of the specialty of neurological surgery by the American Board of Neurological Surgery specifically emphasizes training and competence in critical care of neurologically ill patients.

Critical care services are defined in the American Medical Association's Current Procedural Terminology 2000 code book as: "... the direct delivery by a physician of medical care for a critically

ill or critically injured patient. A critical illness or injury impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition. Critical care involves decision making of high complexity, to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient's condition. Examples of vital organ system failure include but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic and/or respiratory failure. Although critical care typically requires interpretation of multiple physiologic parameters and/or application of advanced technology(s), critical care may be provided in life threatening situations when these elements are not present. Critical care may be provided on multiple days, even if no changes are made in the treatment rendered to the patient, provided that the patient's condition continues to require the level of physician attention described above."

Critical care cannot be billed for the day of discharge from critical care. Note that the setting for critical care need not be in the ICU and is defined by any setting in which critical care services are provided. Hence, a neurosurgeon may bill for critical care involved in the resuscitation of patients in the emergency room or for the intensive monitoring of ill patients during endovascular intervention (as long as documentation and compliance rules are specifically fulfilled)

### Documentation for Billing of Critical Care Services

For clinical activity to qualify for billing of critical care services chart documentation must currently fulfill three criteria (CPT 2000 definitions):

**1. Clinical condition criteria:** "... High probability of sudden, clinically significant or life threatening deterioration in the patient's condition that requires the highest level of physician preparedness to intervene urgently." Thus it is important to document the actual organ dysfunction diagnoses that require attention and that led to the patient being admitted to the critical care setting along with their ICD-9 codes (e.g., acute coma 780.39, vasospasm 435.9, cerebral herniation 348.4, etc.). This condition can also be used in the preoperative setting for acutely admitted individuals. For each additional 24 hours that the patient continues to need critical care, there needs to be a revision of the list of organ failure diagnoses along with the documentation of the relevant evidence for each diagnosis listed. A patient with designated DNR status may still qualify for critical care services.

**2. Treatment criteria:** "... Require direct personal management by the physician. They are life and organ sup-

porting interventions that require frequent, personal assessment and manipulation by the physician. Withdrawal of, or failure to initiate, these interventions on an urgent basis would likely result in sudden, clinically significant or life threatening deterioration in the patient's condition." Thus it is important for the billing physician to actually be present for the performance of the procedure and the procedure needs to be related to the correction or stabilization for an imminently failing organ system. The involvement and supervision of a resident requires the addition of a -GC modifier in the billing of Medicare cases to allow procedure notes by the resident to be included in billing.

**3. Documentation of time:** The crux of critical care billing is that it is a time-based code. The physician's progress note must contain documentation of the total time involved providing critical care services. If the time is not legibly and unequivocally documented the claim will be subject to recoding or denial. For any given period, the physician is expected to pay full attention to the patient and therefore cannot provide services to any other patient during the same time period. Essentially this means that the total amount of critical care time billed for each physician (including all patients) each day in an ICU cannot exceed 24 hours. Time involved with residents in the care of specific patients for specific diagnoses (as above) is legitimate for ICU billing. Care rendered by residents without actual attending physician presence cannot be billed for ICU services.

The CPT codes 99291 and 99292 are the mainstay of billing in the ICU. The two codes are distinguished only on a time basis. Code 99291 can only be billed if more than 30 minutes (up to a maximum of 74 minutes) was spent caring for the patient within a 24-hour period. If less than 30 minutes was spent, then one of the E/M codes listed below should be used (usually 99222 or 99223). A code 99292 is then billed for each additional 30 minutes of service provided on top of the 99291 (i.e., 75–104 minutes = 99291 ¥ 1 and 99292 ¥ 1, 105–134 minutes = 99291 ¥ 1 and 99292 ¥ 2, etc.). These codes are used independent of the individual physician providing care so that if a physician hands over or shares care of the patient, the second physician cannot then bill for a new 99291. Included in the services provided within the 99291 code are the assessment, manipulation and support of circulatory, respiratory, central nervous, or other vital system functions to prevent or treat single or multiple organ failure.

The physician does not need to be physically at the patient's bedside continuously during the documented amount of time. The physician may be engaged in work directly related to the individual patient's care elsewhere on the floor or

Continued on page 17

## Joint Section on Cerebrovascular Surgery

Continued from page 16

unit. This includes time spent reviewing laboratory tests and x-rays, discussing the patient's care with other medical and allied health staff and documenting critical care services. Time spent teaching residents and other staff, even if patient-related, cannot be billed as critical care time unless it is rendered as part of the critical care of a specific patient.

When patients are unable or incompetent to participate in their own care, discussions with family members or surrogate decision makers, whether in person or by telephone, can be counted as critical care time as long as documentation exists that the conversation was pertinent to decision making essential for continued critical care management. Conversations that include medical history taking, reviewing patient condition and prognosis, or discussing benefits and limitations of treatment are all relevant to patient management. Documentation within the progress note for the day needs to state: "(i) the patient was unable or incompetent to participate in giving history and/or making treatment decisions as appropriate, (ii) the necessity of the discussion" (e.g., because the patient was deteriorating so rapidly I needed to discuss treatment options with family immediately), "(iii) the treatment decision for which the discussion was needed" (e.g., whether or not to initiate dialysis or transfusions or withdraw care), "and (iv) the substance of the discussion as related to the treatment decision" (i.e., the note must link the family discussion with a specific treatment issue and explain why the discussion was necessary on that day). Time spent routinely updating family members on the patient's condition and time spent outside the ICU taking calls about the patient, however, cannot be included as critical care time.

## Services Included and Excluded in the 99291 / 99292 Codes

Commonly provided services that are bundled into the critical care codes and therefore cannot be billed separately when billing the 99291 and 99292 codes include:

1. blood gas interpretation (99090), pulse oximetry (94760, 94761, 94762) and ventilator management (94656, 94657, 94660, 94662)
2. chest x-ray interpretation (71010, 71015, 71020)
3. cardiac output measurement interpretation (93561, 92562)
4. computer data analysis, e.g., BP, EKG, etc. (99090)
5. gastric intubation (91105)
6. vascular access procedures: venipuncture and arterial puncture (36000, 36410, 36415, 36600)

7. blood draw for specimen (HCPCS G0001)

The following procedures are NOT included in the critical care codes and therefore can be billed separately in the critical care patient (when performed independent of a surgical procedure where these may be bundled in the global fee):

1. endotracheal intubation (31500),
2. central venous access (36489),
3. arterial line (36120) or
4. pulmonary artery catheter placement (93503),

5. lumbar puncture (62270), ventricular puncture (61105) or ventriculostomy or intraparenchymal ICP monitor placement (61107)
6. conscious sedation (99141)

Any other procedure not listed in the above list can also be billed separately. The modifier -25 needs to be added to the critical care code (i.e., 99291-25) to indicate that the procedure was performed as part of the critical care service. Note that the time spent on these procedures (when billed separately) cannot be also included as part of general critical care time.

## Other Billing Codes

Codes available for patients who are in a critical care setting but do not qualify for the 99291 and 99292 codes include the following E/M codes:

Subsequent Hospital care codes 99231-3  
Initial Inpatient consultation codes 99251-4  
Follow-up Inpatient consultation codes 99261-3

Continued on page 18

## Joint Section on Cerebrovascular Surgery

Continued from page 17

Examples of patients included in this group are those requiring frequent nursing observation or receiving medications that can only be given in a monitored setting

Billing in each of these categories depends on the usual levels of complexity and time spent on history taking, physical examination, and problem management.

### Billing in the Nonsurgical Patient or in the Preoperative Period

Critical care and other E/M services may be provided to the same patient, on the same day, by the same physician. If a patient is initially admitted in a noncritical condition and then later needs critical care then both an initial E/M code and a critical care code can be documented and reported. If the change in status then results in the need for surgery on the same day as admission then the -57 modifier (preoperative decision) can be added to the E/M

or critical care code to allow for billing of both the initial consult and the surgery.

Nonoperative consults seen in the critical care setting also requiring the performance of bedside critical care procedures (e.g., intracranial pressure monitor placement) can be billed as a consult (E/M code 99251-25) and a separate critical care procedure if justified by diagnosis and time-based criteria as indicated previously. The name of the referring physician and the "medical necessity" reason for consultation need to be clearly documented in the progress notes.

Critical care procedures, such as Swan-Ganz catheter placement for cardiac optimization preoperatively or prior to interventional neuroradiological procedures, in a noncritically ill patient can be billed as a separate code to the above E/M codes. The modifier -25 needs to be added to the E/M code (e.g., 99222/3-25) and the procedure code is then listed separately.

### Billing in the Postoperative Period

Critical care services are often rendered to postoperative patients. The concept

of the global fee has prevented surgeons from submitting charges for postoperative care in the 90 days after surgery. It is important, however, to recognize that if services are provided for diagnoses different from the operative diagnosis then separate billing is appropriate. The specific diagnosis(es) warranting ICU care (distinct from surgical diagnosis) and time spent in the ICU care related to these specific diagnoses must be clearly documented as different from the original preoperative diagnosis or E/M service and coupled with its organ failure ICD9 diagnosis, e.g., surgery for ruptured aneurysm versus critical care for respiratory failure, coma, or vasospasm. Postoperative care in the ICU cannot be billed separately (by the surgeon or a different physician) unless coupled to a different diagnosis (organ failure, sepsis, etc.) which warrants critical care service.

During the first 24 hours after surgery, the performance of a separate bedside procedure for a treatment of organ failure separate from the reason for surgery requires the use of the -79 modifier (Unrelated Procedure or Service by the same physician, e.g., for central line or ventriculostomy placement). The modifier attached to the surgical code alerts the carrier that different diagnoses are involved and avoids automatic denial of payment for the ICU procedure performed postoperatively.

After the first postoperative 24 hours, the same physician can bill critical care time as long as separate diagnoses of organ failure can be documented. To perform a bedside procedure in the global (90 day) period the modifier -24 (unrelated E/M service by the same physician during a postoperative period, i.e., critical care time) needs to be attached to the critical care code, i.e., 99291-24. The procedure code is then listed separately and the modifier again alerts the carrier that critical care services separate from standard postoperative care is being delivered. Note that CPR (code 92950) can also be billed separately during the global period.

When critical care only is provided in the postoperative global period by a physician other than the neurosurgeon (or neuroradiologist) then intensivist and surgeon can bill separately. If, however, routine postoperative care also has been transferred to the intensivist then the -54 and -55 modifiers need to be used by the surgeon, neuroradiologist and intensivist respectively and the progress notes must clearly document the transfer of care to allow for postoperative care billing by the intensivist.

Critical care services may be rendered simultaneously by more than one physician or team, but each must clearly document distinct diagnosis(es) and time spent, and the specific diagnosis(es) and time required in rendering ICU care must be justified separately, and must in each instance warrant ICU care. A neurosurgical team might deliver ICU care for ICP monitoring, treatment, and management of barbi-

turate coma in a patient simultaneously receiving ICU care for multiple trauma (by a surgical ICU team) or liver failure (by a medical ICU team), as long as the diagnosis(es) and time of ICU care by the different teams are separately and appropriately documented. The delivery of ICU care by any physician for a given diagnosis does not preclude consultation by another expert for the same condition (i.e., cardiology consultation for myocardial ischemia), provided the consultant does not also deliver (document and bill) critical care service for the same diagnosis.

### Documentation for Non-Medicare Carriers

It is important to recognize that the above are regulations have been published by HCFA only for Medicare, Medicaid, and Child Health program patients. While the above can be used as guidelines for other carriers the reimbursement rates may be different and the documentation required may also differ from those imposed by Medicare. An example of this is the continued bundling of bedside procedures such as central venous access and Swan-Ganz catheterization into the critical care codes by Blue Cross/Blue Shield in many states. This results in the denial of payment for these procedures separately but allows the inclusion of the time spent doing these procedures in the overall critical care time. Understanding these differences is particularly important in cases that may be related to workers' compensation or other insurance carriers which do not allow or have limited appeal capabilities.

### Conclusion

In many settings, neurovascular surgeons remain actively and appropriately engaged in the critical care of their patients in the ICU. A lack of understanding of the ICU billing codes and compliance criteria, and the fear of being accused of noncompliance or even fraud, have generally restricted neurovascular surgeons from documenting and billing for extensive hours of care provided to their often critically ill patients. A better grasp on the intricacies of the reimbursement should help the neurovascular surgeon remain at the forefront of critical care of his/her patients, with fair compensation for services rendered.

### References

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## CONGRESS OF NEUROLOGICAL SURGEONS/ AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS JOINT SECTION CHAIRMEN

### Cerebrovascular Surgery:

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New Haven, Connecticut

### Disorders of the Spine and Peripheral Nerves:

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### Neurotrauma and Critical Care:

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□

## JOINT SECTION ON DISORDERS OF THE SPINE AND PERIPHERAL NERVES

### A Tribute to Dr. Ralph Cloward



On November 13th, 2000, Dr. Ralph Cloward passed away at the Queen's Medical Center in Honolulu, Hawaii. Many of us knew him personally.

His pleasant mannerisms and unassuming attitude in the face of tremendous experience and knowledge allowed him to become an icon for both orthopedic and neurological surgeons alike. The impact this single individual has had on the field of spinal surgery remains unparalleled; Dr. Cloward has been a founding father of our specialty. Even though he is

no longer with us, the respect he earned during his career will live in perpetuity. He is missed by all who knew him. The obituary below is reprinted, with permission, from the *Honolulu Star Bulletin*, November 15, 2000.

### Steroids and Spinal Cord Injury: A Questionnaire

The Joint Section on Disorders of Spine and Peripheral Nerve Disorders of the AANS/CNS is interested in your treatment of patients with spinal cord injuries. Current neurosurgical care of these patients, particularly with respect to steroid administration, has been the subject of much debate. While guidelines committees are working towards

Please submit your response on-line at <http://thinker.neurosurgery.org/scisurvey>.

#### 1. Are you a

- a) Neurosurgeon
- b) Orthopedic Surgeon
- c) Research Scientist
- d) Resident / fellow in training
- e) None of the above

#### 2. Do you manage spinal cord injured patients?

- a) Yes
- b) No

#### 3. How many acute SCI do you manage a year?

- a) < 10
- b) 10 – 40
- c) > 40

#### 4. Do you currently follow

- a) NASCIS I guidelines
- b) NASCIS II guidelines
- c) NASCIS III guidelines
- d) A Generic steroid protocol
- e) I do not give my acute SCI patient steroids

#### 5. Should methylprednisolone be considered

- a) A Standard of care for all non-penetrating SCIs
- b) A Recommended treatment
- c) A Treatment option
- d) An Experimental therapy
- e) Not recommended in the treatment of acute SCI

#### Storied Island Neurosurgeon Ralph B. Cloward Dies at 92

*He created landmark innovations during a long and distinguished career.*

Dr. Ralph Bingham Cloward, a neurosurgeon whose career spanned treating casualties in the Pearl Harbor attack to creating landmark surgical innovations, died Monday at Queen's Medical Center. He was 92. Cloward began his Honolulu practice in 1938. A specialist in treating spinal injuries, he developed a technique using bone grafts to help fuse discs. "Most surgeons only remove the troublesome disc, but this doesn't cure the problem," he told the Star-Bulletin in 1986. Instead, he removed the damaged discs and replaced them with small plugs of bone, taken from the patient or from a cadaver. For this procedure, he set up the first bone bank in the United States, and other bone banks sprang up around the country.

Dr. Paul M. Lin, an editor of a medical book that reprinted Cloward's article on his technique, called him a "technical genius." "Dr. Cloward was so far ahead of his time in technical skill that he made others appear inferior," Lin said. Cloward also perfected a technique that became famous: a way to operate on cervical discs in the neck from the throat, called an anterior approach. Before this, surgeons had operated from the back of the neck.

The most publicized case using this technique occurred in 1965 after a husband-and-wife team of Polish doctors wrote to him on behalf of their 16-year-old daughter. They explained that a tumor on her spine might be fatal. Cloward's role as a Rotarian paid off: the Rotary Club of Honolulu paid all the expenses to bring mother and daughter here, and the operation was a success. Cloward also developed more than 100 surgical instruments that bear his name and are widely used.

His Pearl Harbor Day memories included rushing to Tripler Hospital to aid the wounded. Doctors worked nonstop as the injured kept pouring in. On the evening of the fourth day, Cloward headed home after having performed more than 40 operations. The headlights on his Ford had been painted black except for a half-inch blue strip in the middle. In the blackout, his car dropped into a unseen, deep ditch on School Street. But his surgical performance earned him mention in national magazines. Time reported he saved lives and wits of "a large number" of sailors and soldiers.

Cloward continued to patch up people into his late 70s. He was born in Salt Lake City, graduated from McKinley High School here in 1926 and studied at the universities of Hawaii, Utah and Chicago. He was chief of staff of the Neurosurgery departments of Queen's, St. Francis and Kuakini hospitals, and a consultant in Neurology and Neurosurgery. He authored scores of technical articles in medical journals, going back to 1937.

A man of many talents, he was a clarinetist with the Royal Hawaiian Hotel Orchestra in 1927 and played first clarinet.

an analysis of the available data, the value of the cumulative clinical experience and attitudes of surgeons around the country is important to consider.

The Spine Section has designed a simple 1-minute electronic questionnaire to survey attitudes towards the use of steroids in the acutely injured spinal cord injured patient. Regardless of your present participation in managing these patients, your point of view on this topic is important to us. We would like your input to see how you are dealing with this contentious issue.

#### More on the 16th Annual Meeting, February 23–26, 2000, Renaissance Esmeralda Resort, Palm Springs, California

#### Rogue's Gallery



Do you recognize these people? The golf tournament was a great success at the California meeting, despite participation of individuals like this, whom

Continued on page 20



## Joint Section on Spine and Peripheral Nerves

Continued from page 19

you might also find on the FBI's most wanted list. We're still not sure if these gentlemen can actually play golf, but they're all threatening to enter the tournament this year in Phoenix as well.

Congratulations to our anonymous tennis champion (pictured above on the right) who won the tournament in February at the Renaissance Esmeralda. We'll publish an update if our efforts to

find a name come to fruition. In the meantime, look for a similar venue this year in Phoenix!

REMEMBER! THE  
17TH ANNUAL  
MEETING WILL  
BE HELD  
FEBRUARY 14-17,  
2001 IN PHOENIX,  
ARIZONA.

## Awards

**Research Funding:** The AANS/CNS Joint Section on Disorders of the Spine and Peripheral Nerves has established two Research Grants: the *Larson Award* and the *Sonntag Award*. They are intended to establish funding for clinical projects related to the spine and peripheral nerves, and to provide a means of peer review for clinical research projects to help improve the quality of the proposal and therefore,

enhance competitiveness for National Institutes of Health (NIH) funding. The awards are also meant to provide continued funding on an annual basis to establish the AANS/CNS Spine Section as a known source for quality clinical research aimed at answering questions pertaining to the treatment of disorders of the spine and peripheral nerves.

The awards range from \$15,000–\$30,000 and are intended for primary investigators of planned clinical studies requiring national level funding to support the preparation of grant proposals and external consultations and to assist in the development of the proposal, planning meetings, and the collection of pilot data. Work that can be completed without such support (such as literature review and preliminary protocol design) should be completed before applying for the Larson or the Sonntag Awards.

The format of the proposal should follow that of the NIH grant package. Specifically, applications should not exceed five single-spaced pages. The applicants should address their specific aims, pertinent literature review and previous studies review, include a brief summary of the proposed study, and a plan for utilization of the funds, as well as a detailed budget and budget justification. The budget should not include salary support for the primary investigator or co-investigators.

Application details for research grants are available from Michael G. Fehlings, M.D., Ph.D., The Toronto Hospital, 399 Bathurst St., Suite 2-417, Toronto, Ontario M5T 2S8, Canada (tel. 416-603-5627), or check out our website at [www.neurosurgery.org](http://www.neurosurgery.org). The application deadline for grants to be awarded for 2002 is Dec. 1, 2001.

**Fellowship Funding:** The *Cloward Fellowship Award* is sponsored by Medtronic/Sofamore Danek and is awarded annually to one or two U.S. or Canadian trained neurosurgical residents to provide supplemental funds for advanced education and research in disorders of the spine or peripheral nerves in the form of fellowship training. The amount of the award is \$30,000.

Application information for the Cloward Fellowship Award can be acquired from Ziya Gokaslan M.D., MD Anderson Cancer Center, 1515 Holcombe Blvd., Houston, Texas 77030-4095 (tel. 713-792-2400) or check out our Web site at [www.neurosurgery.org](http://www.neurosurgery.org). The application deadline for the 2002 Cloward Fellowship Award is Sept. 14, 2001.

**Resident Awards:** The *Mayfield Award* is presented annually by the Joint Section on Disorders of the Spine and Peripheral Nerves to the neurosurgical resident who authors an outstanding research manuscript detailing a laboratory or clinical investigation in the area of spinal or peripheral nerve

Continued on page 21

## Joint Section on Spine and Peripheral Nerves

Continued from page 20

disorders. Two awards are available, one for clinical research and one for basic science research. Each award is valued at \$500.

For further information and submission forms, please contact Keith R. Kuhlengel, M.D., 1671 Crooked Oak Dr., P.O. Box 10247, Lancaster, PA 17605-4207, Phone (717) 569-5331, e-mail: [kkuhleng@redrose.net](mailto:kkuhleng@redrose.net), or check out our Web site at [www.neurosurgery.org](http://www.neurosurgery.org).

### DEADLINES

September 14, 2001: Cloward Fellowship Award

September 14, 2001: Mayfield Awards

December 1, 2001: Sonntag and Larson Clinical Research Grants 2002

## Joint Section Nominating Committee

The following names have been put forward by the Nominating Committee, for the positions listed below:

Chairman Elect:  
Nevan Baldwin

Secretary Treasurer:  
Charles Branch

Member at Large:  
Robert Heary

Terms will commence February of 2001. Voting will take place at the Section's annual business meeting from noon to 12:30 on Friday, Feb. 16, 2001 in Phoenix.

## Coding Corner

Greg Przybylski

### The Debate over Coding Approach to the Anterior Thoracolumbar Spine

The purpose of current procedural terminology (CPT) is to summarize physician work performed during treatment of a patient. However, there are circumstances in which more than one physician shares the work of a single CPT code. For example, some neurosurgeons request the assistance of an otolaryngologist to perform the nasal approach to the sella for hypophyse-

tomy. The -62 cosurgery modifier was developed to describe this situation, allowing two physicians to share the work described by a CPT code. The Health Care Finance Administration (HCFA) developed a payment policy through the Medicare program in which the total payment attributed to the CPT code is increased by 25% and then divided evenly between the two surgeons. This results in an ultimate 62.5% reimbursement of the allowable payment to each physician.

Although the -62 modifier reflects shared efforts of two primary surgeons performing the work of a CPT code, it does not imply that one surgeon performs an approach whereas the other performs the definitive procedure. For example, a neurosurgeon and otolaryngologist can share the work of removing a vestibular neurilemmoma. However, there are circumstances in which the surgical approach is typically performed by one surgeon and the definitive procedure by another. This scenario prompted development of specific codes for extracranial and intracranial approaches, definitive procedures, and secondary closures for skull base surgery several years ago. With improved technology to facilitate anterior thoracolumbar spinal surgery, there has been an interest in creating a similar coding structure for anterior spinal surgery.

Since a method for describing this work presently exists with the -62 modifier, one may question the need for revising a substantial proportion of spinal surgery codes, particularly since these were rewritten and revalued only 5 years ago. However, several limitations of the current coding method have been identified. Although Medicare recognizes the -62 modifier, other third party payers do not, causing reimbursement problems for the approach surgeon and spine surgeon. Confusion among surgeons regarding proper coding has resulted in varied coding submissions including use of exploratory thoracotomy or lumbotomy codes to separately describe the approach, which is considered by the AMA to be included in the definitive procedure code. Surgeons have also raised concern about the even split of the reimbursement, particularly since the proportionate work of the approach and spine surgeons may vary across the range of spinal problems. Finally, spinal surgeons have raised concern about whether the value of the approach was actually included in anterior thoracolumbar spinal procedures when these were surveyed, since the approach surgeons were never included in the survey process and many spinal surgeons responding did not perform the approach themselves.

Recognizing these difficulties several years ago, representatives of the American College of Surgeons and Society of Thoracic Surgeons in cooperation with orthopedists and neurosurgeons from five other specialty societies began exploring various ways to describe the

## JOINT SECTION ON NEUROTRAUMA AND CRITICAL CARE

### Message from the Chairman

M. Ross Bullock, M.D., Ph.D.  
Chairman



The AANS/CNS Section on Neurotrauma and Critical Care has widened its scope of activities tremendously over the last 2 years. Under the leadership of Brian Andrews and Michael Fehlings, the membership has increased to an all-

work of anterior thoracolumbar surgery. This was further stimulated by a change in CPT in which the language of -62 allowed its use only once per operative session, thereby reducing the reimbursement for two surgeons who shared the work of more than one code. The issue was brought to the forefront of the CPT Editorial Panel when a neurosurgeon and general surgeon in Pennsylvania formally proposed creation of anterior lumbar approach codes to the Panel.

The past 2 years have been spent by these various society representatives investigating the benefits and limitations to -62 when compared with the development of approach codes. Although initial efforts focused on the creation of approach codes, the society representatives identified concerns with the methodology of evaluating the differential work involved. Initially, a consensus could not be reached among the seven specialty societies. Quarterly presentations were made to the CPT Editorial Panel without agreement. Finally, despite a consensus agreement to modify the language of -62 by the societies, the Panel mandated reconsideration of approach code development.

The society representatives met again and additionally included discussion with HCFA representatives to explore the concerns about valuing approach codes, identifying the variable postoperative work involved, and the limitations imposed upon approach surgeons from performing other procedures after completing the approach. Although a written resolution to the various concerns was not achieved, an understanding was attained among the representatives that resulted in a second consensus proposal from the seven specialty societies. However, the preferred method among the society representatives for describing the work remained in altering the language of the -62 modifier. Continued concerns among HCFA, payer representatives, and other panel members resulted in a request to revisit the issue again.

time high of over 1,500 members. Our financial standing is excellent, and the opportunities are now greater than ever for the Section to significantly impact patient care and to serve the needs of its members.

Over the next 2 years, the efforts of the Section leadership will focus especially on the following areas:

- Improve reimbursement for neurotrauma care delivery by neurosurgical providers.
- Complete the neurotrauma guidelines effort.

Continued on page 22

Although drafting approach codes and vignettes is fairly straightforward, the process of evaluating the physician work given the varied practice across the country is substantially more difficult. In addition, the constraints of budget neutrality require a clear understanding of the pools of money that are currently used by HCFA to reimburse for these procedures in order to develop a valid methodology for presentation to the Relative Value Update Committee (RUC). Finally, commitment from HCFA regarding the approach surgeons' concerns is imperative to reconsideration of the approach methodology for anterior thoracolumbar spine surgery. Given the current timetable of CPT and RUC, changes are not expected earlier than 2002.

In order to better portray the concerns of our society members, your experience with coding and obtaining reimbursement for anterior thoracolumbar surgery performed with another surgeon would be quite helpful. You are encouraged to share your observations through the Coding and Reimbursement Committee via email to our staff representative, Ms. Cherie McNett, at [CMcNett@neurosurgery.org](mailto:CMcNett@neurosurgery.org).

## Comments, Submissions, or Suggestions for the Newsletter?

Please e-mail John Hurlbert at [jhurlber@ucalgary.ca](mailto:jhurlber@ucalgary.ca) or contact through surface mail: Dr. R. J. Hurlbert, University of Calgary Spine Program, Foothills Hospital and Medical Centre, 1403 29th St. N.W., Calgary, AB Canada T2N 2T9. □

## Joint Section on Neurotrauma and Critical Care

Continued from page 21

- Enlarge the numbers of fellowships, scholarship awards and grants to encourage young neurosurgeons to enter the trauma field.
- Increase awareness of neurotrauma among neurosurgeons and the community in general.
- Initiate data-collecting initiatives to determine the outcome of modern neurotrauma management nationwide.
- Create teaching aids in neurotrauma.
- Foster international collaboration to teach better neurotrauma care worldwide.
- Enhance collaboration between the Section and other neurotrauma groups such as the Neurotrauma Society, Brain Trauma Foundation, and Brain Injury Association.

Work on many of these projects is already well under way. Dr. Don Marion has begun working with the Wash-

ington Committee to improve reimbursement for trauma care. Dr. Brian Andrews is working on a position statement concerning the hours on call that neurosurgeons should be available to provide trauma and other emergency care. Dr. Jam Ghajar and the Brain Trauma Foundation have begun to work closely with the Section to significantly advance the Guidelines initiative. A survey is being conducted to determine patterns and amounts of reimbursement paid to neurosurgeons by Level I and Level II trauma centers to provide trauma coverage. This is a first step towards standardizing this important aspect. Over the next few years, we should thus significantly improve the problems which are limiting neurosurgical involvement in trauma care.

To best serve the needs of its members, however, the Section needs input and feedback regarding its activities. These aims can only be achieved with coordinated input from neurosurgeons with an interest in trauma. We urge you to contact members of the Executive Committee, to let us know your views, and to help us in these endeavors. Thanks for all your help!

Below, you will find a listing of the committee chairs and office bearers who have agreed to serve the Trauma Section over the next 2 years.

## Update from the Brain Trauma Foundation

Jamshid Ghajar, M.D., Ph.D.

### 80,000 EMT's to Receive Training in Traumatic Brain Injury Treatment from the Brain Trauma Foundation—Guidelines for the Prehospital Management of Traumatic Brain Injury

In 1998, supported by a grant from the U.S. Department of Transportation, National Highway Traffic Safety Administration, the Brain Trauma Foundation initiated a program to develop and teach the *Guidelines for the Prehospital Management of Traumatic Brain Injury*. The program is called "Assessment, Treatment and Transport of TBI Patients: A Program for Prehospital Personnel." Its primary purpose is to significantly decrease the mortality and morbidity due to severe traumatic brain injury and to reduce the high economic costs incurred to society for long-term care of individuals with severe head injury.

The goals of the program are:

- To educate EMS providers in the assessment and management skills of TBI in the prehospital setting so that these practitioners are equipped to provide patients with optimal care. The program includes oxygenation, blood pressure, ventilation and inter-rater reliability in Glasgow Coma Scale scoring.
- To encourage the incorporation of the *Guidelines for Prehospital Management of TBI* into the national standards curriculum.
- To demonstrate in the field that optimal management of TBI in the prehospital setting makes a difference in patient outcomes.

The implementation has occurred in three phases:

1. With the assistance of a national group of emergency medical service experts, BTF developed the first ever scientific evidence-based document for EMS, *Guidelines for the Prehospital Management of Traumatic Brain Injury*, during the first phase of the program.
2. BTF developed supplementary training and educational materials including an algorithm and chart for use in ambulances, two training videos, several CD-ROMS, instructor and provider lesson plans, slide sets, and other aids. These materials were tested at five pilot sites in the fall of 1999: metropolitan Birmingham, Alabama; Anchorage and surrounding

regions, Alaska; Navajo Nation, Arizona and New Mexico; the District of Columbia; and the greater Galveston area, Texas. Feedback from the prehospital personnel who participated in the pilot training sessions was used to revise the educational products.

3. A national roll-out of the program began in 2000 with nine states (Alabama, Delaware, Florida, Georgia, Maryland, Mississippi, Tennessee, Virginia, and West Virginia) plus the District of Columbia. Implementation in each state varies to accommodate local system needs and differences, but all are initiated with state Public Health officials and regional Medical Directors. Future sites for the program are planned for 19 additional states (Alaska, Arizona, Connecticut, Kentucky, Louisiana, Massachusetts, Michigan, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Texas, Utah, and Vermont).

For more information about this program, or for information about purchasing the *Prehospital Guidelines*, please contact Pamela Walker, Project Director, Brain Trauma Foundation, 212-772-0608. The Prehospital (and in-hospital) Guidelines can be reviewed at the BTF web-site, [www.braintrauma.org](http://www.braintrauma.org).

Described below are updates on other major BTF initiatives:

**New York State Demonstration Project:** The Brain Trauma Foundation, supported by a grant from the New York State Department of Health, completed its first phase of a demonstration project for acute care of Traumatic Brain Injury (TBI) that BTF will use nationwide. The demonstration project enables us to "field test" training seminar materials, a Web-based patient database, and outcome assessment tools, before a state-by-state roll-out.

Five trauma centers that handle a high volume of severe head injuries are participating. The key elements of this program include training for all appropriate personnel in the latest scientific evidence-based treatment protocols for TBI, implementation of a quality assurance treatment and outcome database (TBI-tractm), and follow-up visits to track patient outcome for 1 year after injury. The Brain Injury Association of New York State is conducting the patient outcome portion of the project.

**U.S. Trauma Center Survey Project Complete:** In early 2000, BTF completed the process of identifying and contacting every trauma center in the nation where severe head injuries are treated. The survey identified the current level of TBI practice that is in accordance with evidence-based recommendations in the *Guidelines*. It has been ascertained by the survey that of the 924 trauma centers

Continued on page 23

## AANS/CNS SECTION ON NEUROTRAUMA AND CRITICAL CARE

### Office Bearers and Committee Heads

Chairman	Ross Bullock, M.D., Ph.D.
Secretary/Treasurer	Alex B. Valadka, M.D.
Chairman-Elect	Donald Marion, M.D.
AANS Liaison	Brian T. Andrews, M.D.
ABIC Liaison	Raj K. Narayan, M.D.
CNS Liaison	Nelson M. Oyesiku, M.D., Ph.D.
Fellowships/Awards	Michael G. Fehlings, M.D., Ph.D.
Guidelines	Jam Ghajar, M.D., Ph.D.
Head Injury	Peter B. Letarte, M.D.
International Outreach	Nelson M. Oyesiku, M.D., Ph.D.
Internet/Media	David M. McKalip, M.D.
Membership	Jamie S. Ullman, M.D.
Organ Donation	Jamie S. Ullman, M.D.
Pediatrics	P. David Adelson, M.D.
Prevention/Think First	Michael J. Caron, M.D.
Reimbursement and Coding	Donald W. Marion, M.D.
Resident Liaison	Geoffrey T. Manley, M.D., Ph.D.
Spinal Injury	Michael G. Fehlings, M.D., Ph.D.
Sports Medicine	Julian E. Bailes, Jr., M.D.
Washington Committee Liaison	Donald W. Marion, M.D.
Member-at-Large	Robert C. Cantu, M.D.
Member-at-Large	John H. McVicker, M.D.

## Joint Section on Neurotrauma and Critical Care

Continued from page 22

identified, approximately half of the centers stabilize the patients and transfer them to another trauma center. The remaining centers care for severe traumatic brain-injured patients; however, the level of compliance with the recommendations in the *Guidelines* remain low, which emphasizes the need for a national education program.

**International Brain Trauma Foundation:** Brain Trauma Foundation launched an affiliate organization in Vienna, Austria that will concentrate on improving TBI outcomes in Europe and other countries around the world. The International Brain Trauma Foundation (IBTF) is an independent non-profit, non-governmental organization, that will exclusively use BTF's educational materials and curricula.

## Attention Neurosurgery Residents: Consider Joining the Joint Section on Neurotrauma and Critical Care (JSNTCC)

**Jamie Ullman, M.D.**  
Membership Committee

You are the future. We want you to help to increase participation in the Neurotrauma Section and to promote awareness of the importance of neurotrauma-related issues. The leadership of the Neurotrauma Section has therefore decided to offer JSNTCC membership to all resident members of the AANS or CNS membership, with waiver of dues for the duration of residency.

The purpose of our Section is to represent the interests of all neurosurgeons on issues related to head injury, spinal cord injury, sports medicine, critical care, and injury prevention. The fact that trauma is one of the largest of the Joint Sections is testimony to the fact that neurosurgeons deal with these problems every day, whether by evaluating a minor head injury in the office, performing the initial emergency room evaluation of a patient with a spinal cord injury, or caring for a patient with a prolonged ICU stay after an elective craniotomy. We believe that your membership in the Section now and in the future is the best way to ensure participation and input from as many neurosurgeons as possible.

## NEW PRODUCTS

### Axon Instruments Introduces Clinical Micropositioner

Axon Instruments, Inc. has proudly announced the release of the Clinical Micropositioner, its newest product for use in human neurosurgery. The Clinical Micropositioner is a precisely controlled electromechanical device that allows the accurate placement of probes in the brain during functional neurosurgery. It was developed by Axon Instruments' engineers to meet the requirements of world leaders in the field of



neurosurgery at Emory University, the University of California (at San Francisco), Baylor College of Medicine, the University of Toronto, and Stanford University.

The Clinical Micropositioner can move a probe (such as an electrode) through the brain over a 60-mm range in steps as small as 1 micron. It mounts on standard stereotactic frames (Leksell and CRW), and it comes with an X-Y stage that allows sub-mm repositioning of the electrode without moving the arc. This enables the neurosurgeon to make parallel electrode penetrations with great ease, accuracy, and reliability.

The *Guidelines for the Management of Severe Head Injury* is the most recent high-profile project of the Section. These guidelines will undergo continuous revision to ensure that they remain current. Other "hot" issues concern the involvement of individual neurosurgeons in caring for head and spinal cord injuries, and cooperation and conflict among neurosurgeons, general surgeons, and critical care specialists in the ICU. Educational programs for the general public are also one of our major priorities, including supporting the Think First head and spinal cord injury prevention program. Other activities include helping to organize fellowships, lectureships, meetings and workshops in neurotrauma and critical care, distribution of a newsletter to keep members updated on ongoing activities, and coordination of educational funding from various pharmaceutical and medical supply companies to benefit the greatest number of our members.

As a resident, you might be particularly interested in learning that the JSNTCC has created a Neurotrauma/Critical Care Young Investigator Award to cultivate even greater interest in neurotrauma and critical care among young neurosurgeons like you. This award will be presented at each AANS and CNS Annual Meeting to the young investigator who has submitted the most outstanding abstract relating to neurotrauma or critical care.

Your membership helps to promote activities in these and other areas related to trauma and critical care. We share the common goal of ensuring the best possible outcome for patients with neurotrauma. Please consider joining this Section. If interested, please contact Jamie Ullman, M.D., head of the Membership Committee at [jamiu@aol.com](mailto:jamiu@aol.com) or phone 212-241-0050.

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This new product comes on the heels of Axon Instruments' already well received Guideline System 3000 for intraoperative microelectrode recording. With already over 30 installed sites worldwide since 1998, the Guideline System 3000 is contributing significantly to the refinement of neurosurgical procedures. □

### ERRATUM

In the Fall 2000 issue of *Neurosurgery News*, in the New Products section on page 23, the name of the Silicon Valley surgical software company CBYON was misspelled as "CYBON." The correct headline should read "CBYON Introduces Surgical Anatomy Visualization and Navigation Tools." The Publisher regrets the error.

## FEDERATION NEWS UPDATE

### Letter from the Editor

**Dear Colleagues:**

Information from the WFNS can now be sent to your personal e-mail addresses.

We are able to do this just with the 4500 addresses we have already listed in our E-mail Directory.

This will provide demographic information to WFNS, as well as, with your cooperation, confirm and enlarge the database of the WFNS E-mail Directory.

I would appreciate it if you could provide us the e-mail addresses of the colleagues whom this e-mail did not reach and would like to receive information from the WFNS (or ask them to register directly at our site at <http://wfns.org>).

During the next few weeks we will start using the Web site as an educational tool. We will post banners indicating the dates of the clinic-pathological conferences. The first was by Dr. Michael Walker and Dr. Peter Black from Harvard Medical School. At the end of the presentation of the patient there will be an Open Forum On-line aimed primarily for residents and young neurosurgeons.

I appreciate all your suggestions to improve and make the WFNS Web site more useful for each one of you.

Warm regards,

**Eduardo A. Karol, M.D.**  
Editor  
WFNS Publications

**Manuel Dujovny, M.D.**  
Associate Editor  
WFNS Publications

### Letter from the President

**Dear Colleagues:**

I wish to remind you that the Administrative Council of WFNS has created a Foundation for the purpose of supporting neurosurgeons worldwide who have difficulties in treating their patients, due to lack of funds for purchasing the necessary equipment, for carrying out certain neurosurgical procedures, etc.

One of the initiatives to raise funds for this rather newly established Foundation is the creation of a special Certificate available to all neurosurgeons who are members of a WFNS member society having full membership status with WFNS. The cost of the Certificate is US\$ 100.00. The Certificate will serve as a document of recognition as being a "Fellow" of WFNS and will be signed by the President and Secretary.

Applications for this Certificate should be sent in writing to the Secretary of the Society of which you are a member, together with a cheque for the amount of USD \$100.00 (addressed to the World Federation of Neurosurgical Societies. Please mark the name, which you wish to appear on the Certificate, clearly. Your Society will then forward your name, together with your money to WFNS who will prepare your Certificate and mail it to your Society for forwarding on to you.

With kind regards and very best wishes, I remain,

Yours sincerely,

**Prof. Dr. Madjid Samii**  
President, WFNS