CALIFORNIA ASSOCIATION OF NEUROLOGICAL SURGEONS, INC. NEWSLETTER

MARCH 1982 VOL. IX, NO. 1

PRESIDENT'S MESSAGE

I would like to take this opportunity to express my appreciation for your having allowed me the honor of serving as the President of CANS in the past year.

As I prepared to turn the reins over to Dr. Enoch, I deliberated about the meaning of that appointment. Just what is the Presidency of CANS? First, it is not necessarily awarded by default, but rather seems to be a measure of the degree of involvement. When I was asked almost eight years ago to become involved with CANS activities, I must confess I was somewhat naive about the time considerations. The evolution of this involvement through committee appointments, then to nomination to the Board, then to Chairmanship of committees, eventually leading to deliberations with AANS and CNS, seemed natural and pyramidal. The tremendous amount of time required for reading and attempting to assimilate the reams of material from CMA, AANS, CNS, JSEC, Journals, Newspapers, Legal Newsletters, etc., is only now appreciated. Then, with trepidation, accepting the request to provide a year's worth of leadership—of holding the reins of a well-organized and efficient association created by the foresight of prior leaders through the necessity of invention was a humbling event.

Certainly this acceptance cannot be considered an ego trip. I wonder how many of you know the names of past-presidents of this organization. In presenting testimony at compensation meetings and Department of Health Services forums, the invariable statement was, "Who is this guy?" When presenting arguments and recommendations to AANS and CNS, the question of, "Does this person really represent California neurosurgery?" presents a humbling, not an ego-sustaining, picture.

What have I presided over this year? Probably most important is the recognition of CANS as spokesman organization, not only for member neurosurgeons, but for all neurosurgeons in California. Four hundred ninety-five doctors call themselves neurosurgeons in California. Over 300 of them that are neurosurgeons belong to or are applicants of CANS. CANS was set up as a socio-economic organization and exists not only for economic decisions, but also for "social" inter-relationships between neurosurgeons and other medical groups, including hospitals and other peer review organizations. More frequently now, issues affecting Quality of Care are being presented to the Board.

Other issues this year included the representation of California neurosurgery in workman's compensation in which testimony as to the relative value of services was presented. Problems with Blue Shield and other third-party carriers involving the "medical necessity program", such as the resolved problem with pneumoencephalography, occurred. This year it was the question as to whether myelography is an out-moded procedure in the advent of CT scanning, whether spinothalamic tractotomy via laminectomy is still an accepted procedure, and of course, the issues of micro-diskectomy and the use of Chymopapain remain under discussion.

Strong presentation was made to JSEC with reference to the manpower issues.

Possibly the most important single impact this year has been the direction of categorization through emergency medical services. CANS was active in attempting to communicate with Senators with regard to the Chiropractic bill and has presented a strong front in issues involving liability of third-party carriers.

It is imperative that CANS represent the thinking of the majority of California Neurosurgeons and not that of an inbred group of selectmen. The problems involved in this are well-illustrated by the nomination procedures currently in AANS.

At present, the President of CANS must establish a position that what is good for a practicing neurosurgeon President is also good for the California Neurosurgical Community. I can fully recognize the weakness and strength of that position.

The CANS Newsletter must express views, but those views, without feedback, could eventually be harmful. The strength of this organization will be directly proportional to the desire of the new blood to participate and to make errors and correct them. That is my definition of experience.

The immediate future of CANS includes the economic impacts of third-party cost-containment and cost shifts. There will be increased participation of non-medical entities in the practice of medicine, such as INA, Prudential, HMO groups, etc. Moreso, the impact of third-party containment practices as being tantamount to issuing standards of care, for example, not paying for one-to-one nursing in an indicated circumstance, not paying for certain procedures unless a second opinion or even third opinion is obtained, and not paying for necessary equipment in the care of patients.

The liability arena will become more active as patient-doctor stress is increased by the effect of third-party disability determiners, payors of medical care, forcing physicians to compromise in their care of individual patients.

There will be continued Peer Review and attempts to become involved as Amicus Curiae in court actions. EMS and categorization and manpower will be ongoing issues requiring careful scrutiny.

There will be new procedures presented for evaluation and for recommendations. One might say that the President of CANS is you. The Board is your eyes, ears, arms and legs. It is your anger and your pleasure and unless you direct it, it is going to select courses you do not like or might not be able to live with. CANS is stronger this year and getting even stronger. Be proud of the activity of some very tireless workers on your behalf and hopefully, recognize the improvement of the quality of care as a result of their efforts.

Neurosurgery is still the most respected and envied specialty in the practice of medicine. CANS will help to keep it that way.

SIDNEY TOLCHIN, M.D.

REPORT ON SURVEY OF THE EMERGENCY MEDICAL SERVICES COMMITTEE

During the past year the Emergency Medical Services Committee (EMSC) has concerned itself with the gathering of information from the membership of CANS regarding delivery of emergency Neurosurgical trauma care. In order to obtain this information a survey letter was sent to the membership asking two questions:

1. In which hospital or hospitals do you currently render emergency neurosurgical trauma care?
2. In which hospital or hospitals would you prefer to render emergency neurosurgical trauma care?

In charging the EMSC with the responsibility of obtaining this information it was the thesis of the President and Board of Directors of CANS that Emergency Neurosurgical Trauma Care should be rendered where the Neurosurgeons are. This constitutes a more rational approach to the rendering of such care than, in some cases, trying to bring Neurosurgeons to any hospital which might wish to care for such neurologically traumatized patients.

The fact that neurosurgeons might designate certain hospitals within their practice areas or preferred hospitals for delivery of trauma care would seem to speak for itself. Such a preferred designation would seem to imply that such an institution had the necessary equipment and facilities and was staffed with their medical specialists and ancillary personnel sufficient to make such care not only possible but desirable. Those hospitals not suitably equipped and staffed for the stated emergency neurosurgical trauma care would not be expected (in most cases) to be named as preferred hospitals.

The results of this survey have been very informative. To date, with nearly 250 CANS members responding, certain hospitals in the various counties are clearly preferred for emergency neurosurgical trauma care delivery and certain hospitals are not. In some counties virtually all of the hospitals in which such care is currently being delivered were listed as preferred. In other (usually larger metropolitan) areas a seemingly ample number of hospitals were preferred hospitals and a number of hospitals were not.

It is not, and never has been, the intention of the Board of Directors of CANS to involve itself with the designation of any hospital as a "Trauma Center," nor has CANS had any intention of "working alone" or pursuing the problem of emergency trauma care independently.

Now that meaningful information has been obtained from many of the neurosurgeons who are members of CANS, it is the recommendation of the EMSC that this data be forwarded to those bodies that function in a policy-making capacity. Included should be the American College of Surgeons Trauma Committee, The Trauma Committee of the CMA, and perhaps the various County Medical Societies. After review of the information it is hoped these bodies will communicate further with the Board of Directors of CANS regarding ways in which we may help to improve the quality of emergency neurosurgical trauma care, and at the same time do our best to preserve the fundamentals inherent in the practice of Neurological Surgery.

Melvin L. Cheatham, M.D.

BOARD OF DIRECTORS MEETING NOTICE

The next meeting of the Board of Directors will be held on Saturday, May 22, 1982, at the San Francisco Airport Hilton, beginning at 10:00 a.m. All Standing and Special Committee Chairmen are urged to attend.

COMPLIMENTARY NEWSLETTER

Complimentary Newsletters are being mailed to non-members of the California Association of Neurological Surgeons, Inc. Those interested in becoming a member of the Association may send a request for an application form to: Executive Office, California Association of Neurological Surgeons, Inc., P.O. Box 41761, Sacramento, CA 95841, or telephone (916) 966-9760.

REVIEW OF ANNUAL MEETING OF CANS

SAN DIEGO — FEBRUARY 27, 1982

In conjunction with the Annual Meeting of the Federation of Western Societies of Neurological Science, the California Association of Neurological Surgeons convened at the Hotel del Coronado in San Diego, February 27, 1982. The sessions opened at 8:00 a.m. with a presentation by Attorney William M. Shernoff, Immediate Past President of the California Trial Lawyers Association, in which he expounded the potential for patients' recovery from "bad faith" actions of health insurance companies. This was followed by a four-part workshop on "The Economics of Manpower Excess." The distillate of each section of the workshop was presented to the entire group, provoking interesting questions and answers.

At the luncheon, the guest speaker was Mr. Edward Hamilton, Executive Director of the Association for California Tort Reform. He gave a most impressive resume of activities in Sacramento that work on behalf of practicing physicians, and he paid tribute to the most essential financial support provided by CMA.

The afternoon was occupied with the "Business Meeting" which included subjects pertinent to the practice of neurological surgery in the State of California. The lengthy agenda cannot be reported in full, but the minutes will be available to those who might wish to write to CANS office in Sacramento.

Elections are reported as follows:

Officers:

President-Elect .....William H. Wright, M.D.
1st Vice-President .....DeWitt B. Gifford, M.D.
2nd Vice-President .....Robert E. Florin, M.D.
Secretary .....Frank P. Smith, M.D.
Director .....Paul H. Chodroff, M.D.
Director .....Gail A. Magid, M.D.
Director .....Ulrich Batzdorf, M.D.

Delegates:

CSNS Delegates	Alternate Delegates
David G. Scheetz, M.D.	Melvin L. Cheatham, M.D.
William H. Wright, M.D.	Paul H. Chodroff, M.D.
DeWitt B. Gifford, M.D.	Jan Belza, M.D.
	Randall W. Smith, M.D.

CMA Delegate	Alternate Delegate
George Ablin, M.D.	Sidney Tolchin, M.D.

New Active Members:

~~Zivko Z. Gajic, M.D.~~	Santa Cruz, CA
Frank S. Harris, M.D.	Bakersfield, CA
William M. Klemme, M.D.	Kentfield, CA
Jerome S. Litvinoff, M.D.	Chula Vista, CA

New Associate Members

Moustapha Abou-Samra, M.D.	Ventura, CA
Henry M. Bartkowski, M.D.	San Francisco, CA
William L. Caton, III, M.D.	Arcadia, CA
Brian R. Copeland, M.D.	Bakersfield, CA
Gary C. Dennis, M.D.	Bakersfield, CA
Theodore D. Johnson, M.D.	Los Angeles, CA
Pablo M. Lawner, M.D.	Torrance, CA
Fauzy Mahomar, M.D.	Pasadena, CA
Stephen L. Nutik, M.D.	Redwood City, CA
Stanley A. Shatsky, M.D.	Los Gatos, CA
James D. Tate, M.D.	Redding, CA

Change from Associate to Active Status:

John A. Carr, M.D.	Walnut Creek, CA
James N. St. John, M.D.	Martinez, CA

BYLAW AMENDMENTS — Approved

1. AMENDMENT TO ARTICLE II (page 5) ADDING:
"THIS ASSOCIATION IS REPRESENTATIVE OF THE NEUROSURGEONS OF CALIFORNIA AND SERVES AS THE SPOKESMAN FOR THE PRACTICE AND SCIENCE OF NEUROLOGICAL SURGERY IN THE STATE OF CALIFORNIA."

2. AMENDMENT TO ARTICLE IX (page 21) ADDING:
"NON-MEMBERS
SECTION 9.09. AS THE REPRESENTATIVE ORGANIZATION AND SPOKESMAN FOR THE PRACTICE AND SCIENCE OF NEUROLOGICAL SURGERY IN THE STATE OF CALIFORNIA, THE ASSOCIATION RECOGNIZES AND ACCEPTS CERTAIN RESPONSIBILITIES IN ORDER TO ENSURE THE QUALITY OF NEUROSURGICAL CARE FOR THE PEOPLE OF THE STATE OF CALIFORNIA AND ELSEWHERE. THESE RESPONSIBILITIES SHALL INCLUDE EVALUATIONS AND RECOMMENDATIONS CONCERNING ACTIVITIES CONDUCTED BY NON-MEMBERS OR OTHER AGENCIES WHICH PERTAIN TO THE PRACTICE OR SCIENCE OF NEUROLOGICAL SURGERY IN THIS STATE."

3. SECOND ADDITION TO ARTICLE IX:
"SECTION 9.09-1. EVALUATION AND RECOMMENDATIONS MADE UNDER SECTION 9.09 SHALL BE AT THE DISCRETION OF THE BOARD OF DIRECTORS, WHO SHALL BE RELIEVED OF LIABILITY IN THIS ACTION ACCORDING TO SECTION 9.08, AS IF THE NON-MEMBERS WERE MEMBERS."

LETTERS TO THE EDITOR

Over the past several years we have from time to time received letters which are quite pertinent and feel that this information should be disseminated throughout the membership. Members are invited to participate in this portion of the newsletter. These letters will not necessarily represent the opinions of the editorial staff or of the CANS Board, but will reflect opinions of the membership on pertinent issues. Send your comments to Frank P. Smith, M.D., Editor, 880 Cass Street, No. 101, Monterey, CA 93940.

CALIFORNIA ASSOCIATION OF NEUROLOGICAL SURGEONS, INC.

Budget Statement - September 1, 1980 through August 31, 1981 (Fiscal Year)

INCOME	1980-1981 BUDGET	ACTUAL	VARIANCE	1981-1982 NEW BUDGET
Dues	$36,791.67	$35,281.67	$ 1,510.00-	$36,666.67
Application Fees	500.00	400.00	100.00-	500.00
Rental Fees	1,200.00	550.00	650.00-	1,200.00
Advertising Fees	100.00		100.00	100.00
Sponsorship Fees	50.00		50.00	50.00
Registrations	1,750.00	1,252.75	497.25-	1,600.00
Interest	500.00	1,983.41	1,483.41+	2,000.00
Services		15.00	15.00+	
Miscellaneous	8.33		8.33	
Total Income	$40,900.00	$39,482.83	$ 1,417.17-	$42,116.67
EXPENSES				
Salaries	$ 8,000.00	$10,306.50	$ 2,306.50-	$10,000.00
FICA	532.00	651.65	119.65-	665.00
Workers Compensation	150.00	37.91	112.09+	150.00
Unemployment Tax	300.00	385.63	85.63-	420.00
Equipment Purchase	500.00	453.68	46.32+	60.00
Equipment Repair/Maint.	100.00	84.64	15.36+	100.00
Equipment Lease/Rental	150.00	297.86	147.86-	200.00
Supplies	1,000.00	894.41	105.59+	1,000.00
Duplication	300.00	159.67	140.33+	200.00
Postage/Shipping	1,200.00	1,004.17	195.83+	1,300.00
Telephone	1,000.00	783.69	216.31+	900.00
Rent/Office, P.O. Box	1,250.00	1,328.00	78.00-	1,250.00
Printing/Composition	3,000.00	3,302.10	302.10-	4,000.00
Travel and Expenses	7,000.00	6,529.55	470.45+	7,000.00
Meeting Space	200.00	210.00	10.00-	200.00
Legal Fees	5,000.00		5,000.00	2,500.00
Insurance	200.00	340.00	140.00-	350.00
Taxes	20.00	18.64	1.36+	30.00
Bonding				300.00
Services		27.72	27.72-	
Consultants	500.00	2,249.91	1,749.91-	750.00
Outside Services	800.00	1,028.97	228.97-	1,600.00
Refunds		105.00	105.00-	
Reserve	8,900.00		8,900.00	8,541.67
Miscellaneous	798.00	261.99	536.01+	600.00
Total Expenses	$40,900.00	$30,461.69	$10,438.31+	$42,116.67

SECURING THIRD PARTY CARRIER PAYMENT

The outline of steps detailed below is intended to offer a guide to help your patients receive satisfactory reimbursement from their insurance carriers, for their health insurance claims. Delay in patient reimbursement appears to be a major problem which is increasing in magnitude, and various techniques that can be utilized on behalf of one's patients in securing prompt and full reimbursement for their health insurance expenses is in the best interest of both patients and the medical community.

WHEN to help patients receive satisfactory reimbursement from their third party carriers for health insurance claims:

1. Delayed payment of claim (usually over 90 to 120 days)
2. Non-payment of claims, either all or in part
3. Revision of fees to reduced amounts or with different RVS numbers with reduced values.
4. Rejection of claims as unnecessary or unwarranted.

WHO are the third party carriers involved:

1. Private insurance carriers
2. Medicare
3. Medi-Cal
4. Workmen's compensation carriers
5. HMOS and IPAS
6. Other pre-paid plans such as Kaiser, Ross Loos
7. Champus
8. Blue Shield
9. Others

HOW to improve the patients' prospects of satisfactory reimbursement from the third party carriers for such expenses incurred:

A. Preventive

1. Careful use of RVS and descriptive nomenclature of the services and procedures rendered to the patient.

    a. Anticipate delay caused by review of claims and try to reduce delay by supplying a copy of the operative report and discharge summary early. Problems may relate to the following:

        1) When RVS code listed as BR or RNE
        2) When no adequate descriptor exists in the RVS.
        3) Use of -22 modifier, indicating extra difficulty.
        4) Use of more than one major procedure code for the same operation.
        5) Charges for items usually included in the global surgery fee such as a final pre-op visit, family conference or the post-operative visits during the stipulated follow-up time.

2. Workmen's Compensation: Elective procedures or hospitalization require <u>prior</u> authorization from the carrier to avoid the usual denial or delay for payment that occurs when such contact is omitted. Discussion of the anticipated and desired fee for services at the time authorization is secured generally is followed by prompt and full payment for such services.

3. Kaiser and other pre-paid plans: They have no legal obligation to pay outside physicians or hospitals for services to their members. However, in an emergency, prompt telephone contact with the nearest branch facility of that third party carrier to whom the patient subscribes to secure <u>authorization for care and payment</u> is usually helpful in reducing the delay in reimbursement for such services at a later date. The name and position of the person authorizing such emergency care and payment should be carefully recorded for future reference.

B. Corrective

1. Private insurance carriers

    a. Initial contact in the event of delay should be directed to the claims office representative handling the patient's claim.

        1) Advise patient to call or write the insurance company for their reasons for delay or reduction in the reimbursement.

        2) Assist patient with information needed to allow claims representative or reviewer to reconsider the request for improved reimbursement.

    b. Second step is a request for "Medical Review" of the claim, usually with explanatory letter from the doctor's office.

    c. Third step is referral to the Insurance Review Committee of the local County Medical Society.

    d. Fourth step is the possibility of appeal to and review by the State Insurance Commissioner.

    e. The final step is an appeal to the Attorney General of the state which is the last appeal available.

2. Medicare

    a. Northern California
    The Medicare billing should be directed to:

        California Blue Shield
        P.O. Box 7968
        San Francisco, California 94120

1) If the claim is not paid in approximately 90 days, the claim should be resubmitted with "rebilling" written in red on the new bill and sent to the same address as listed above.

2) If the above is unsatisfactory, then request an Administrative Review of the claim by one of the medical advisors, or appeal to:

Mr. Richard Payne
Medicare Appeals
Blue Shield of California
P.O. Box 7968
San Francisco, California 94120

3) Review of the claim under the Fair Hearings provision of the California Medicare program; this may occur in two phases and the request should be directed to the:

Fair Hearing Section
Medicare Liaison
Blue Shield
P.O. Box 7968
San Francisco, California 94120

4) A subsequent review may be requested by the Insurance Review Committee of the local County Medical Society, a final appeal may be submitted to the: CMA Appeals Committee.

b. For Southern California address:

Occidental Life Insurance Company
P.O. Box 54095
Los Angeles, California 90054

1) If the claim is not paid within approximately 90 days, resubmit a new claim with the word "rebilling" written in red to the same address.

2) A subsequent review by a different examiner and consultant may be requested by subsequent letter request to Occidental at the above address within four to five weeks.

3) A local Medical Society Insurance Review Committee review is available.

4) A request for Fair Hearing with Occidental similar to that in the northern part of the state should be directed to:

Mr. Jack Byrne
Associate Medicare
Administrator
Occidental
P.O. Box 54905
Los Angeles, California 90054
(213) 742-2563

3. Medi-Cal

a. For complaints that have not been resolved by processing through their Medi-Cal inquiry form 60-1, submit to:

CSC
P.O. Box 15300
Sacramento, California 95813

b. Then contact:

Mr. Jim Perry
Director, Provider Relations
(916) 920-5000, Ext. 5092

c. If further appeal is desired, contact:

Mr. Reynolds Wagnon
Director of Provider Relations
P.O. Box 15000
Sacramento, California 95813

d. The last appeal is a formal grievance that must be filed with the State Department of Health.

4. Workmen's Comp: The authorization and any variation from the minimum fees provided in their schedules which is based on the 1974 RVS must be negotiated in advance, or be prepared to accept the minimum fees specified.

5. HMOS and IPAS: Suggest that in the event of difficulty in reimbursement of patient expenses, which were rendered under emergency circumstances by subscribers to HMO or IPA, that the Administrator or Director of the program be contacted as soon as possible for aid and resolution of the difficulty. With this group as well as the other pre-paid plans, such as Kaiser or Ross Loos, it is feasible to use legal means such as small claims court or municipal court to press claims against the patient, while simultaneously offering the patient help as an advocate in a counter suit for recovery of their costs and damages against their covering third party.

6. Kaiser: The best technique with Kaiser or Ross Loos is contact as soon as possible after the emergency situation is controlled to secure authorization from a responsible administrator or physician at the parent institution. In situations in which continuing problems exist, there are two names worth contacting regarding Kaiser:

Dr. John Flaningam
280 W. MacArthur
Oakland, California 94611
(415) 428-6903

and:

Richmond Prescott, M.D.
Permanente Medical Group
1924 Broadway
Oakland, California 94612
(415) 645-6267

7. Champus: In the event of a problem with Champus, send a copy of the statement and an explanatory letter to:

   Champus Provider Services
   Box 85024
   San Diego, California 92138

8. Blue Shield: Three levels of appeal are available:

   a. The first: Includes neurosurgeon reviewers which should be directed to:

      Jeanette Gentile
      Professional Relations Division
      California Blue Shield
      (415) 445-5211

   b. The second: A Director of Professional Relations will represent Blue Shield in hearing before the Board of your County Medical Society and can often provide assistance needed:

      Mr. John Walsh, Manager
      Professional Relations Division
      Northern California Blue Shield
      (415) 445-5188

   The last resource is:

      Ralph Schaffarzick, M.D.
      Medical Director
      California Blue Shield
      (415) 445-5420

C. Punitive

1. A recourse to consider is the use of public opinion generated via press or media contact in regard to individual patient situations that are particularly distressing. This has obvious disadvantages which may be legally dangerous, time consuming and evoke undesirable publicity.

2. Legal recourses:

   a. Consideration of a class action suit by the individual or a group against a third party payor.

   b. Bad faith lawsuit

      1) Must confer with the patient regarding the situation and the possibility of assisting the patient in pressing his claim against the third party by legal means.

      2) If patient agrees, the physician should then send a letter to the insurance company advising them that the patient's claim is indeed valid and that unless paid within a specified amount of time, the case will be referred to legal counsel and the physician will be prepared to act on behalf of the patient in court.

      3) The case may then be referred to a selected attorney's office for review and evaluation and of its possible merits for such action.

      4) If accepted, then the attorney's office will press claim in regard to costs and damages in the suit against the third party payor.

Robert E. Florin, M.D.

CANS, CMA & YOU

Join the CMA? Why? Well, let's look at some possible reasons.

The CMA provides a number of member services such as a broad range of insurance programs and retirement plans. The CMA provides numerous continuing medical education programs and publishes the Western Journal of Medicine. The CMA maintains an active role in such areas as quality assurance, health planning, physician manpower, and professional liability.

The CMA holds a justifiably enviable record of legislative advocacy. Last year, 575 health-related legislative bills were monitored. The CMA took a position on more than 100 of these bills. Eighteen CMA-sponsored bills were enacted into legislation. Not a single bill opposed by the CMA was enacted.

California neurosurgeons play an active role in the CMA. Three neurosurgeons are members of the CMA Council, the governing body. Many more neurosurgeons sit in the House of Delegates and participate on numerous committees and commissions.

The California Association of Neurological Surgeons maintains an official linkage with the CMA through its selected delegate and alternate to the House of Delegates, the policy-making body of the CMA. In order to maintain this most important representation, it is necessary that at least 80% of CANS members are also members of the CMA. At the present time, we are in danger of falling below this threshold and losing our representation. Hence, it is imperative that each and every one of us mount an effective recruitment campaign. Our goal should be that all CANS members are also members of the CMA.

Why join the CMA? Because the CMA needs the input of organized neurosurgery, and CANS needs the strength of organized medicine. That's why!

Philipp M. Lippe, M.D., FACS

EDITORIAL - "IN PERSPECTIVE"

There is a simmering series of problems that relates to neurological surgeons in the United States of America, requiring a long-term perspective. In the 1980's there will be more need than ever for organized support by doctors in the preservation of medical care as deemed necessary for the best interests of patients.

The cost of medical care has become accelerated through the high cost of labor, nurses' salaries, and multiple diagnostic studies forced by malpractice issues. All supporting agencies such as employers, labor unions, insurance companies and government at all levels, have been willing to compromise on service, as long as they could keep the cost down. A package of total health care can be offered at a "reasonable rate" as long as the actual services are minimal. This is the success formula of HMO's, with which specialty surgeons will be faced if the program continues, such as that being launched in Riverside County of California by Health Force Management. This is a for-profit corporation owned 51% by Blue Cross, which puts together physicians' groups to serve as health net providers. There are many alleged incentives, but the underlying basis for cost effectiveness seems to be less care for less money.

This leads us to the major problem of support for health care programs, and we should start by recognizing that good, total health care requires an expensive program. Corporate fringe benefits have often been touted as providing good health care. The popular thing now is to allow each employee a given sum, such as $70 per month, to invest in any type of health care program that he might elect. This has produced a vicious cycle that could be expected. The lower-level wage earner takes his $70 per month and feeds his family, with some of the money reserved for an inadequate health care program. For him or his family, any health problem is a disaster, since the services provided are inadequate, and payments for care are minimal.

It is appropriate to survey the perspective for those surgeons who are aligned with a health care program, those in full-time medical center employment, and those who are in practice in the community, as well as those who are in academia. The HMO surgeons will continue to be paid less than their worth, as the cost of the programs increases. The surgeons in private practice in the community will face increasing pressure to join HMO's, as they try to give care at a reasonable fee schedule. The university surgeons now enjoying private practice while serving at the medical school level, will have increasing problems as the medical schools learn how to absorb surgical income in order to balance the budget. The new appointees to professorships will be offered fixed income levels that will appear to be acceptable to those who are at a beginning status. This will be far different from the private income levels of most surgeons operating at most university medical centers today.

Thus, before long, all surgeons may be faced with the same socio-economic problems, and the future would not seem to be very satisfactory as one reviews the experiences of Canadian surgeons. This is the compelling reason that the AANS should take an active and forthright stand in socio-economic matters, rather than decide that "those matters relating to social or economic issues should be left to the committee structure," as outlined in the recent AANS Newsletter. We should remember that the changing of its name from the Harvey Cushing Society to the American Association of Neurological Surgeons was done in the concept of representing all neurosurgeons, in Congress or anywhere necessary. Certainly the programs for scientific enrichment and education must be maintained, but the real clout necessary to protect the status of neurosurgeons can only come from the very active effort of the central core of the AANS. A time will come when town and gown will have the same perspective in the matters outlined above.

Frank P. Smith, M.D.
Editor

CHYMOPAPAIN FOR DISCOLYSIS

The F.D.A. may authorize the use of chymopapain for disc chemolysis in mid-1982, under carefully controlled circumstances. Prospectively, anyone performing the procedure may need to be certified as having had approved training.

CANS is actively studying the process for providing an approved training course, after the exact details are released by the F.D.A.

In the meantime, the Board of Directors of CANS provides the following concepts:

1. When chymopapain becomes legally available, a decision for or against its use in individual patients will rest with the attending neurosurgeon, since the effectiveness of the procedure has not as yet been unequivocally proven.

2. The procedure of percutaneous, x-ray monitored disc injection, is well within the field of expertise and practice of the qualified neurosurgeon who cares for discogenic disorders of the spine.

SITE SELECTION AND FORMAT OF ANNUAL MEETING OF CANS

The origin of the California Association of Neurological Surgeons in 1973, was stimulated by the malpractice insurance crisis, and a number of other socio-economic issues.

Attendance at annual meetings was high while the crises existed. As things levelled off, attendance slipped. Your Board of Directors experimented with having the Annual Meeting in 1979 in conjunction with CMA! That was not a great success. Then came a "resort" experiment in 1980, in Monterey. This was well attended by comparative analysis. In the following year, the annual meeting was held in Palm Springs, along the same lines of "resort" exposure, but absentia was too prominent. This year, we have had an outstanding program in conjunction with the Federation of Western Societies of Neurological Science in San Diego, and still have not attracted the numbers of neurosurgeons that should participate.

There is a feeling of fellowship that develops over a period of a few years among those California neurosurgeons who have been coming to the annual meetings. This has been enhanced at some of the "resort" meetings where the wives have attended in a manner that helps all of our families get to know each other a little better. No doubt this meeting format will reappear in the future. Now, in prospect of better attendance by the busy neurosurgeons who indicate the need to fly in and out for a one-day meeting, the site for the 1983 meeting is set for a hotel at the San Francisco Airport, on a Saturday to be announced. Let's hope that there will be a large attendance to meet the issues that never go away, but just lurk out there.

CHANGE OF ADDRESS

Please notify the Executive Office of any change of address, including county, or telephone number, so that we might keep our membership records current.

PEER REVIEW AND PROFESSIONAL LIABILITY INSURANCE

ARE YOU COVERED?

Several months ago, I learned that a number of professional activities were not specifically covered by current professional liability insurance contracts. Of the eleven insurance carriers in the State of California, four or five did not extend coverage for peer review activities conducted in connection with specialty organizations, such as CANS. Most, but not all, provided coverage for peer review activities in connection with hospitals and county medical societies.

In my role as CMA Councilor, representing specialty organizations, I was appointed by the Council to chair an ad hoc committee to look into this situation. After an initial meeting with several insurance carriers, it became apparent that there were a number of areas of activity for which physicians could find themselves without adequate coverage. The situation could be serious and I plan to pursue the matter through CMA channels. In the meantime, I would strongly urge that all CANS members write to their respective professional liability insurance carriers and ascertain specifically whether or not coverage is provided for peer review activities in conjunction with specialty organizations and county medical societies.

Philipp M. Lippe, M.D., FACS

P.S. As of March 9, 1982, I was informed that the Board of Directors of NORCAL took action to extend professional liability insurance coverage for peer review activities by specialty organizations. Several other major carriers to date have not taken similar action.

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