

Quantifying Case Volumes in Neurosurgery Survey Takes Brief Look at Perennially Elusive Data

By Bonnie Darves

One of the most common questions asked about practice opportunities they're considering is what kind of case volume they'll be expected to maintain on an annual basis—and how that compares to what similarly trained neurosurgeons in other practices are tallying. Unfortunately, it's also a question that's particularly difficult to answer because of the many factors that affect not only volumes—from sub-specialty area to patient population, to patient acuity and comorbidities, to name a few.

Further, that information isn't collected and reported regularly in any generally accessible format, outside of individual practices that use their neurosurgeons' procedure volumes to plan staffing levels, calculate productivity and ascertain OR utilization and efficiency—among other metrics. And that detail doesn't make it into the neurosurgeon compensation surveys, with the exception of measuring and reporting on work Relative Value Units (wRVUs). The annual wRVU totals can identify how hard neurosurgeons work, but they don't translate readily into case volumes because such surveys don't provide case-type breakdowns.

A study in April 2019 issue of *Neurosurgery* based on a 2016 survey of 193 neurosurgeons, conducted as part of a global neurosurgeon mapping initiative facilitated by the World Federation of Neurological Societies and the World Health Organization, provided a narrow view on the numbers. The survey, which included 176 neurosurgeon respondents representing 57 countries, found a mean of 245 cases annually, across 11 common neurological disorders that frequently warrant surgical intervention.

Data on case-volume trends is also in short supply; however, one study did track shifts in the types of neurosurgical cases that are

either rising or declining from a proportional standpoint. A study published in the *Journal of Clinical Neuroscience* in May 2016, based on findings from the National Surgical Quality Improvement Program (NSQIP) database reported that neurosurgeons' percentage of spinal procedures relative to cranial and peripheral nerve cases increased from 68.8% to 76.8% over a seven-year period, while cranial cases as a proportion of total cases dropped from 29.7% to 21.6%.

To try to get some sense of what's going on in case volumes in this country, *Neurosurgery Market Watch* conducted a brief survey in February 2020, with the intention of reporting the findings. Of the 1,573 neurosurgeons who opened the survey, 167 provided complete responses to the following four questions:

1. How many years have you been in practice post-training?
2. What is your neurosurgery specialty or sub-specialty?
3. What is your employment model (academic, hospital employed, private practice or other)?
4. How many neurosurgery cases did you do last year? If you perform cases across neurosurgery sub-specialty areas, such as spine, cranial and pediatric, please specify by approximate percentage.

The case-volume range, across all respondents who provided breakdowns, was 80 to 450 annually, for an average of 277 cases per neurosurgeon. (Two outliers, in the 600-case and higher range, were excluded.) The neurosurgeons with the highest case volumes, 300 and above, all reported a high percentage (80% or more) of spine cases as a portion of their total cases. On the low end, pediatric neurosurgeons, who accounted for 13% (22) of respondents, generally reported

IN THIS ISSUE...

Quantifying Case Volumes in
Neurosurgery
PAGE 1

Perfecting the Privademic Model at
Premier Health
PAGE 4

Coding Corner
PAGE 6

Perspectives
PAGE 7

Legal Corner
PAGE 8

How to Use Your Recruiter More
Efficiently: Make Sure to Keep the
Lines of Communication Open
PAGE 10

Featured Opportunity
PAGE 10

Neurosurgery Positions
PAGE 11

Upcoming Events/CMEs
PAGE 12

Neurosurgery Market Watch is published quarterly by Harlequin Recruiting in Denver, Colorado, as a service for neurosurgeons and candidates seeking new opportunities.

Submissions of articles and perspectives on the neurosurgery job market that may be of interest to practicing neurosurgeons are welcomed. Please contact the publisher or editor for more information and guidelines.

PUBLISHER

Katie Cole
303.832.1866 | katie.cole@harlequinna.com

EDITOR

Bonnie Darves
425.822.7409 | bonnie@darves.net

ART DIRECTOR

Annie Harmon, Harmony Design
720.580.3555 | annie@harmonyd.com

Neurosurgery Market Watch,
Harlequin Recruiting
P.O. Box 102166, Denver CO 80250
www.harlequinna.com

continued on page 2

Quantifying Case Volumes

(continued from Page 1)

annual case volumes of 200 or fewer, although two pediatrics-only neurosurgeons reported volumes of more than 250.

Following are some breakdowns provided by high-case-volume respondents:

- 500 cases: 50% cranial, 50% spine
- 475 cases: 75% spine, 25% cranial
- 460 cases: 99% spine
- 450 cases: 50% endovascular and 50% vascular, skull base and microsurgical
- 450 cases: 70% vascular/endovascular, 20% spine and 10% general neurosurgery

Total Cases by Neurosurgery Specialty Area for All Respondents

Category	Cases	%
Spine	17,358	37.69%
Not Specified	16,365	35.53%
Cranial	5,114	11.10%
Pediatrics	2,150	4.67%
Endovascular	1,614	3.50%
General	592	1.29%
Cervical	500	1.09%
Vascular	484	1.05%
Lumbar	466	1.01%
Functional	321	0.70%
Oncology/Tumor	245	0.53%
Pain	242	0.52%
Skull	215	0.47%
Peripheral Nerve	164	0.35%
Trauma	132	0.29%
Intracranial	98	0.21%
Total	46,060	100.00%

- 420 cases: 40% endovascular, 30% cranial and 30% spine
- 400 cases: 70% spine, 20% pain, 5% cranial and 5% peripheral nerve
- 400 cases: 91% vascular/endovascular, 5% trauma, 2% general and 1% each spine and tumor
- 375 cases: 80% spine, 20% cranial and peripheral nerve

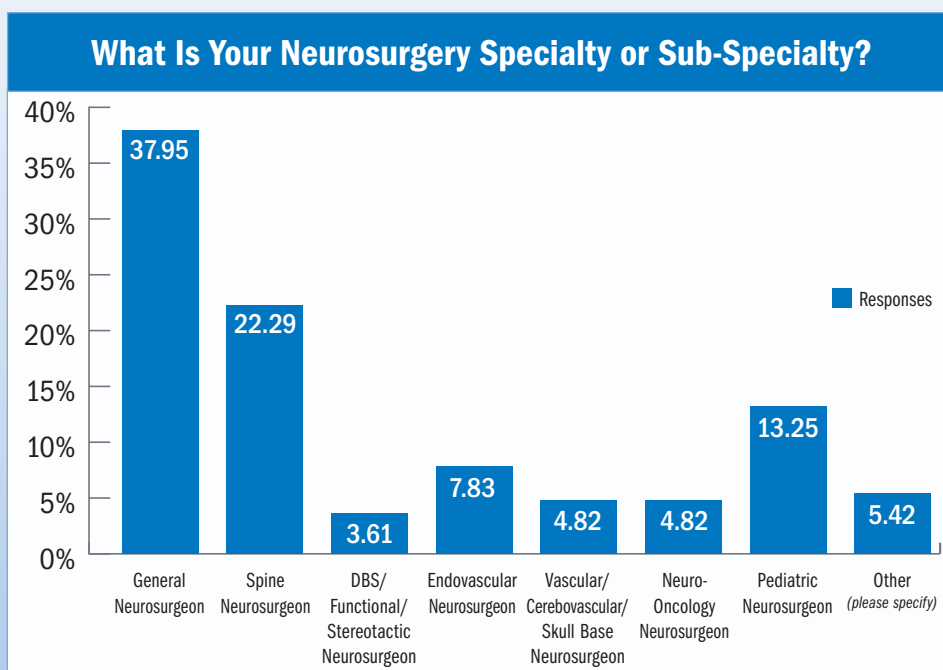
Among respondents who elected a primary sub-specialty or clinical focus, 37.9% (63) chose general surgery, 22.2% (37) chose spine, 13.25% (22) pediatrics and 7.8% (13) reported endovascular. Vascular/cerebrovascular and neuro-oncology each accounted for 4.8% (8) of respondents, and functional neurosurgeons represented 3.6% (6) respondents. All other respondents did not specify or cited "other" as their clinical focus.

The respondent distribution across years in practice was relatively even and unremarkable. Approximately 35% of neurosurgeons who completed the question reported being in practice 10 years or fewer, and 33% between 11 and 20 years.

Approximately 31% of respondents have practiced 21 years or longer. The following chart shows the full breakdown.

Years in Practice		
Years	Respondents	Distribution
0-5	24	15.89%
6-10	30	19.87%
11-15	26	17.22%
16-20	24	15.89%
21 +	47	31.13%
	151	100.00%

In terms of annual case volumes over neurosurgeons' career spectrum, without accounting for case type, it appears that volume levels are highest in between years six and 15. As the chart below illustrates, neurosurgeons in practice between six and 10 years averaged 301 cases annually, and those in practice between 11 and 15 years average 319.



Average Case Volumes by Years in Practice

Years in Practice	Average Annual Cases
0-5	293
6-10	301
11-15	319
16-20	263
21 +	227

Neurosurgery residents' post high spine volumes

For neurosurgeons who are still in training or fellowship, it might be helpful to know that they'll likely emerge well positioned to handle busy OR schedules based on their spine volumes during training—at least compared to their counterparts in orthopedic surgery. A study in the August 2019 issue of *Neurosurgery* found that neurosurgery residents, over a 10-year period ending in 2018, performed an average of 433 procedures, compared to 119

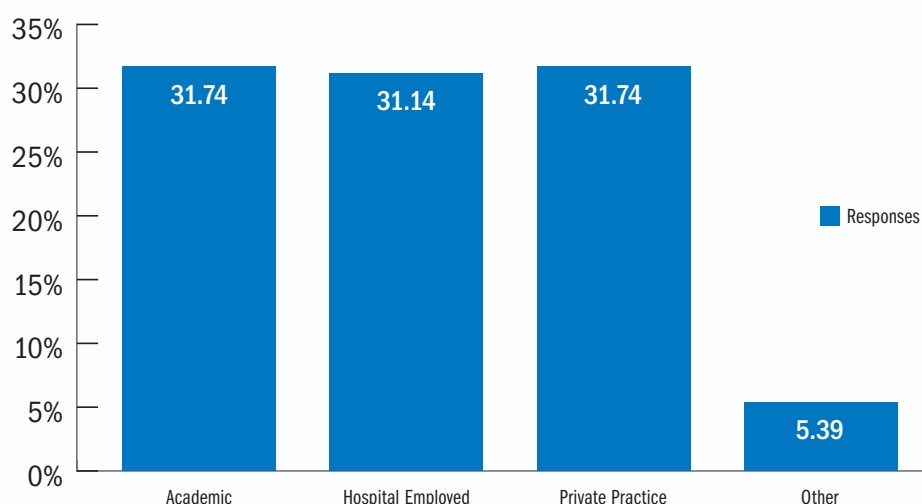
for orthopedics residents. Overall, neurosurgery residents' average spine case volumes were 3.6 times greater than those performed by orthopedics residents.

The study didn't look specifically at the quality of training and did not equate higher volumes with better quality. Nonetheless, its authors (Pham et al) suggested that the results

might uncover opportunities to determine what constitutes optimal spine training in terms of volumes and exposure, and the role of spine fellowships in both specialties going forward.

Ms. Darves, editor of Neurosurgery Market Watch, is an independent medical writer and editor based in the Seattle area.

Neurosurgeon Employment Model



LAHEY HOSPITAL & MEDICAL CENTER SPINE FELLOWSHIP

The Lahey Spine Fellowship is a SNS/CAST approved program. Fellows will be able to master a wide variety of surgical techniques, including minimally invasive surgery, image guided surgery, and deformity correction in a large volume practice that spans a breadth of degenerative, traumatic, and oncologic disorders.

For the first 6 months, the fellow will work under the direct supervision of our four dedicated spine attendings. Depending upon the fellow's demonstrated skills, the opportunity to function as a supervised junior attending during the latter 6 months will be given.

The fellow will learn the fundamentals of clinical trial design, cost-effectiveness research, and comparative effectiveness research. Research is sponsored by a multi-million dollar PCORI award, NIH award, over one million dollars in philanthropic funding, and is a key component of the Lahey Comparative Effectiveness Research Institute (CERI).

Applications for one-year fellowship positions beginning July 2021 are now being accepted. Applicants must have successfully completed orthopedic or neurosurgery residency training program and be eligible for a Massachusetts medical license.

- ▶ Applicants should send letter of interest and CV to:

Subu Magge, M.D.

Fellowship Director, Lahey Spine Fellowship
41 Mall Road, Burlington, MA 01805

Subu.N.Magge@lahey.org

Beth Israel Lahey Health 
Lahey Hospital & Medical Center

Perfecting the Privademic Model at Premier Health

Focus on Innovation, Collaborative Culture Spell Success for Ohio Neurosciences Group

By Bonnie Darves

Privademic models—hybrids of private practice and academia—have proliferated in neurosurgery and in other specialties over the last decade, but relatively few have moved beyond loose affiliations, limited academic appointments and referral mechanisms to achieve the tight integration that might benefit both entities. Premier Health's neurosurgery and neurology group in Dayton, Ohio, has managed to pull it off, in spades.

The spirit of collaboration is at the core of the Premier Health philosophy and extends to its partnership with Wright State University (WSU), through the Wright State University and Premier Health Neuroscience Institute. The Dayton region's strongest biomedical research institution joined forces with the clinical resources of the region's leading health system to create a centerpiece for neuroscience research unmatched in the area. The institute is an employed practice of the Premier Health system.

It's this collaboration and hard work that has positioned the organization for the success it enjoys today, according to Daniel Gaudin, MD, PhD, who joined Premier Health in 2017 and serves as chief of neurosurgery and director of functional neurosurgery. "We've focused on a coordinated approach, bringing together spine, neurotrauma, stroke, neuro-oncology, physical medicine, epilepsy, and movement and memory disorders in a single setting for both patient care and research," he said. "The fact that all of our specialists are in close proximity—we can reach out to each other easily to refer patients or coordinate on cases—really helps us deliver streamlined care and good continuity."

Essentially, Premier Health brings the clinical expertise—with its team of neurosurgeons, neurologists, neuro-intervention surgeons, physical medicine specialists, and specialty trained advanced practice provider (APPs)—



Neurosurgeon Ania Pollack, MD, left, division lead for neuro-oncology, and Dr. Fadi Tayim, neuropsychologist and division chief of the Clinical Neuroscience Institute's Brain Mapping Center, review tumor imaging.

and Wright State University provides the research infrastructure and expertise. "We've had some obstacles to surmount, in recruiting and logistics, but it's become a very solid partnership," Dr. Gaudin added.

Research spans broad range

Miami Valley Hospital, Premier Health's Level I trauma center in Dayton, is the flagship for neuro-trauma and neurosurgery services, and the institute also operates a vast network of outpatient clinics throughout Southwestern Ohio. The research component, which has an intensive focus on stroke, cognitive medicine and movement disorders, operates out of both the hospital and on the Wright State University campus.

"Premier Health has had a long history and great relationship with Wright State, including developing several residency programs, and that foundation has helped us in building and expanding the neuroscience institute," said Jason Merritt MSN, RN, vice president

of operations for the Premier Physician Network. Premier Health collaborates with WSU's Boonshoft School of Medicine to train neurology residents and has created several other physician and advanced practice provider training programs.

In recent developments, Premier Health now provides diagnostic and treatment services in neurovascular intervention, brain mapping and functional MRI, and also offers robust neuropsychology services. In addition, they've substantially broadened neuro-oncology services through weekly tumor boards and close consult arrangements between the surgeon, brain mapping, medical and radiation oncologists. The organization also hosts an annual Neuroscience Institute Symposium, which welcomes a wide array of researchers and clinicians to focus on selected topics in translational neuroscience.

What's also impressive is that Premier Health has built an enviable market position despite the competitive environment in which



it operates. Both Cincinnati and Columbus have well-established, large-scale academic neurosurgery and neuroscience programs, and there are several successful private groups in the region.

Robust team approach, solid culture underpin success

One measure of success for any physician practice is the high regard of the referring community, and Premier Health neurosurgeons

expands its capabilities in brain mapping and MR-guided diagnoses and treatment. Annual encounter volume across all neuroscience services exceeds 50,000.

“Our referring physicians tell us that they appreciate the access that their patients have to our services—neurosurgery, generally, isn’t known for its accessibility—and the frequent communication they receive from us,” Dr. Gaudin said. “And in the current environment, we know that patients increasingly research

The clinical team’s structures and group culture are also major contributors to the program’s success. The organization employs 30 advanced APPs, including nurse practitioners and physician assistants, who are specialty certified. Those APPs are trained and supported to work at the top of their licenses in trauma, the OR, the ICU and clinics. “This is one of the pieces that we’ve done well,” Mr. Merritt said, adding that the APPs are crucial to helping the organization deliver high-quality, streamlined and responsive care across the continuum.

The team approach is also embedded in the neuroscience institute’s culture. Staff at all levels of the organization are invited—and even expected—to contribute to decisions about operations, initiatives and strategic direction. In addition, the management team includes several relatively young administrators, which keeps the dynamic lively. Twice weekly meetings ensure frequent communication about what’s working and what isn’t, and clinical and support staff’s input is both valued and acted upon.

“We wouldn’t think about making a decision that affects the physicians or the APPs without their direct involvement, for example. We all sit together and discuss the options and then agree on a direction,” Dr. Gaudin said. “A lot of organizations make mistakes in that regard, in my experience.”

“Our referring physicians tell us that they appreciate the access that their patients have to our services—neurosurgery, generally, isn’t known for its accessibility—and the frequent communication they receive from us.”

— Daniel Gaudin, MD, PhD

have certainly garnered that. The group meets regularly with local primary care physicians and educates them about its services and approach to collaborative care. Most important, the group ensures that patients have easy access and highly coordinated care—and that referring or other primary physicians are kept in the loop. Neurosurgeons perform approximately 250 cases annually, and procedural and services volume is expected to grow as Premier Health

their options for care—and shop—so the patient experience is important. It really matters now.”

By design, Premier Health’s -neurosurgery services are fast-tracked so that patients move quickly through assessment, imaging and diagnosis to ensure that procedures, when warranted, can be performed as soon as possible. “We’ve worked to make it easy for both patients and primary care physicians to navigate our world,” Dr. Gaudin said.

CONTRIBUTORS WANTED!

Neurosurgery Market Watch welcomes submissions of articles of potential interest to practicing neurosurgeons. We are particularly interested in opinion articles about how trends occurring in the neurosurgery marketplace or in the health policy arena might affect the practice environment.

To discuss a potential idea, please contact Bonnie Darves at **425-822-7409** or **bonnie@darves.net**

CODING CORNER

Coronavirus Effects on Billing: Preparing to Use the New ICD-10 COVID-19 Codes

By Barbara Young



As the novel coronavirus continues to take hold throughout the country and healthcare facilities attempt to quickly reconfigure care delivery for patients and consumers who

are being advised to stay home and not seek nonemergent care at hospitals and other facilities, appointments are being cancelled nationwide. Some care organizations and practices already have telehealth systems in place, while others are scrambling to develop or increase that capacity.

In turn, providers are facing new challenges in preparing to bill for telehealth services when patients can't make in-facility appointments due to precaution, self-quarantine, containment, and even potential regional quarantines. The Centers for Disease Control and Prevention (CDC), effective immediately, has released new ICD-10 diagnosis codes for billing associated with COVID-19.

Following is an update on and guidance for preparing to use the new codes when delivering services directly or via telehealth technology to patients whose care or care-seeking activities are affected by the coronavirus:

- Remember that when billing for telehealth patient phone calls, providers can use the same office visit and diagnosis codes they would regularly use for an office visit but need an additional modifier to bill. They also must use the place of service as 02 to designate that the place of service was telehealth.
- Always check with local insurance carriers to verify coverage of telehealth, even though most insurance companies now offer coverage. Some states are mandating

the coverage so that patients won't have to go without treatment, and the availability of telehealth billing can help practices mitigate cash-flow interruptions in these uncertain times.

- Exposure to COVID-19. For cases where there is a concern about a possible exposure to COVID-19, but this is ruled out after evaluation, it is appropriate to assign the code Z03.818, "Encounter for observation for suspected exposure," with other biological agents ruled out.
- For cases where there is an actual exposure to someone who is confirmed to have COVID-19, it is appropriate to

respiratory in nature, so the site would not be "unspecified."

- If the provider documents "suspected," "possible" or "probable" COVID-19, do not assign code B97.29. Assign a code(s) explaining the reason for encounter (such as fever, or Z20.828).

This coding guidance has been developed by CDC and approved by the four organizations that make up the Cooperating Parties: the National Center for Health Statistics, the American Health Information Management Association, the American Hospital Association, and the Centers for Medicare & Medicaid Services.

"Providers are facing new challenges in preparing to bill for telehealth services when patients can't make in-facility appointments due to precaution, self-quarantine, containment and even potential regional quarantines."

assign the code Z20.828, "Contact with and (suspected) exposure to other viral communicable diseases."

- Signs and symptoms. For patients presenting with any signs/symptoms (such as fever, cough or respiratory symptoms) and where a definitive diagnosis has not been established, assign the appropriate code(s) for each of the presenting signs and symptoms such as: R05 Cough, R06.02 Shortness of breath, R50.9 Fever or unspecified.
- Note: Diagnosis code B34.2, "Coronavirus infection, unspecified," would generally not be appropriate for the COVID-19, because the cases have universally been

For more information on providing healthcare services during in light of growing coronavirus cases, refer to the CDC's COVID-19 clinical presentation: <https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html>. Stay up to date on developments by regularly visiting the CDC's website at <https://www.cdc.gov/coronavirus/2019-ncov/summary.html>.

Ms. Young is head of Barbara Young Medical Billing Services, a full-service medical billing, coding and collections company on Staten Island, New York, which has been in operation since 2003.

PERSPECTIVES

Advocating for Neurosurgery and Patients: An Interview with John A. Wilson, MD, FAANS

By Bonnie Darves



In February, Neurosurgery Market Watch spoke with John A. Wilson, MD, FAANS, president-elect of the American Association of Neurological Surgeons (AANS), about big-picture issues in neurosurgery at

the confluence of policy and practice, and about avenues for young neurosurgeons to get involved in initiatives that the specialty is pursuing. Dr. Wilson is vice chair of neurosurgery and co-director of neuroscience services at Wake Forest Health in Winston-Salem, N.C.

Q: In term of AANS policy and legislative priorities for 2020 and beyond, what's on the front burner right now nationally for the specialty?

A: There's a lot going on, but we're focusing on key areas on issues that affect patient access to care. One is the ongoing increase in prior authorization (PA) requirements for much of the care that neurosurgeons provide. Those insurer-imposed requirements—for imaging tests and surgical procedures, particularly in spine care—are not only bothersome for neurosurgeons; they're also proving a significant barrier to providing timely care. In our recent survey, 82% of respondents reported that PA always (34%) or often (49%) delays access to necessary care—and PA wait times can range from two days at best to 31 days at worst.

We're likewise concerned about implications of the Protecting Access to Medicare Act (PAMA) program that requires physicians to consult appropriate use criteria (AUC) before ordering advanced imaging services. This affects clinicians across almost every medical

specialty, from primary care to neurosurgery. Like prior authorization, the AUC program will be administratively burdensome and may delay patient access to vital diagnostic tests.

The AANS and Congress of Neurological Surgeons (CNS), as leaders of the Regulatory Relief Coalition, is collaborating with Congressional members to introduce H.R. 3107, the "Improving Seniors' Timely Access to Care Act." This bill would help protect patients from unnecessary delays in care by streamlining and standardizing prior authorization under the Medicare Advantage program.

We're also working to maintain the strides that we've gained in this country with the Affordable Care Act's (ACA) insurance market reforms—such as coverage for pre-existing conditions and guaranteed [policy] issue. The AANS recognizes that millions of Americans have no health insurance, and we fully support health insurance coverage for all Americans. To that end, we recently joined the Partnership for America's Healthcare Future.

Q: What is AANS doing to address some of the more topical issues we've seen in the last year—regarding narrow insurance networks and improper billing practices that garnered headlines nationally?

A: The narrow insurance networks that restrict patient access to the neurosurgeon of their choice and leave patients potentially vulnerable to unanticipated medical bills are key concerns for us. AANS is advocating for legislation to protect patients from unanticipated medical bills, and in our view, H.R. 5826, the "Consumer Protections Against Surprise Medical Bills Act," is moving in the right direction.

Whatever legislation emerges, it should hold patients harmless and ensure that they are only responsible for in-network cost-sharing amounts when out-of-network providers take care of them. Patients should be kept out of the middle of payment disputes between health plans and providers. At the same time, we need a process that fairly reimburses neurosurgeons for their services.

Right now, we're working with our state and national medical organization partners, including through the Out of the Middle coalition. We're advocating for final legislation that adopts network-adequacy standards, enables neurosurgeons to participate in health plan networks, and increases transparency for patients regarding what transpires behind the scenes that affects their access to high-quality care.

Q: I know that there's been considerable concern about Medicare reimbursement issues and coming changes in Evaluation and Management (E&M) codes. In a nutshell, what should practicing neurosurgeons understand about this?

A: It's really about championing and ensuring fair reimbursement. Medicare (CMS) currently pays neurosurgeons a single fee (global payment) when they perform major or minor procedures. This single fee covers the procedure and related care before and after the procedure, within a 10- or 90-day timeframe.

The pre- and post-op services are the same as standalone E&M office and outpatient visits. Although final 2020 Medicare Physician Fee Schedule rule increased the values for these E&M codes, effective Jan. 1, 2021, the

continued on page 11

LEGAL CORNER

Making Sense of Post-Termination Income Payment and Employment Contract Indemnification Clauses

By Bonnie Darves



Benjamin Mayer, JD, MBA

In this regular column, Neurosurgery Market Watch speaks with health lawyers about contract issues and other trends related to neurosurgery compensation and performance. For this article, attorney and contract specialist

Benjamin Mayer, JD, MBA, of Mayer Law Firm, LLC, in Denver, Colo., talked about provisions that could deprive neurosurgeons of compensation due them, or put neurosurgeons at significant legal and financial risk.

Q: Many young neurosurgeons are so focused on their starting salaries and earning potential that they're not inclined to think about what might happen to their income should they leave a job after a few years.

However, as compensation models become increasingly complex, some physicians have discovered that in walking out the door they might also potentially be walking away from money that's due them—in the form of bonuses, quality payments or other distributions that might lag their departure from the practice. What should neurosurgeons look for in contracts to ensure they'll get any monies that they're entitled to receive?

A: Of course, the more specific the contract is regarding the handling of income to be paid post-termination, the better off the neurosurgeon will be. For example, there might be situations in which a physician leaves a practice in November and bonuses aren't paid out until Dec. 31.

If the contract doesn't specify that the surgeon will be paid for all bonus money accrued by the date of departure, regardless of the specified distribution date, there might be money left on the table.

In the same vein, if a portion of the neurosurgeon's compensation is based on collections, and the practice doesn't receive those revenues until three to six months after the physician leaves, it could be difficult to obtain that money—unless the contract specifically provides for that. I've seen contracts, for example, that essentially "cut off" all compensation on the physician's departure date. That may be okay if the neurosurgeon's compensation is salary-based only, but it could be problematic if there's a bonus or collections component.

To counter this, the neurosurgeon should ensure that the contract provides for post-departure receipt of all sums due through bonuses or from collections for services provided and billed during employment. As such, it might be reasonable to request a provision stating, "Following the end of employment, any as-yet unpaid compensation based on collections and/or bonuses earned while employed will be paid post-termination, by when normally scheduled."

Q: It's been reported that employer-indemnification clauses are becoming increasingly common in physician employment contracts. What should neurosurgeons understand about such clauses, and when should they be negotiated?

A: On a basic level, employer-indemnification clauses require that the physician reimburse

the employer for any losses the employer sustains as a result of a physician's actions, and that aren't covered by existing malpractice or liability coverage. Here's, in part, what that clause might look like: "Employee agrees to defend, indemnify and hold harmless the [employer] from any and all damages, liability and expenses ... in any way related to the physician's provision of medical care." Another might include a section that reads: "Employee is liable for any ... amount above the liability coverage limits."

Such broadly worded clauses are not only unreasonable but also too open-ended, potentially leaving the physician with a large amount of personal liability. It means that the physician could be liable for what a hospital pays out in a judgment or settlement if the hospital is also named in a malpractice suit (which is common). It's important for neurosurgeons to understand that it shouldn't be assumed that the physician's malpractice coverage would cover any amounts owed to an employer through an indemnification provision. In fact, most times, it doesn't. The neurosurgeon would have to fully read the fine print of the policy.

It's recommended to either remove such clauses (ideally) or substantially revise them so that they're limited to specific narrow circumstances—such as to only intentional wrongdoing, or to other limited circumstances not involving a physician's negligent acts or omissions.

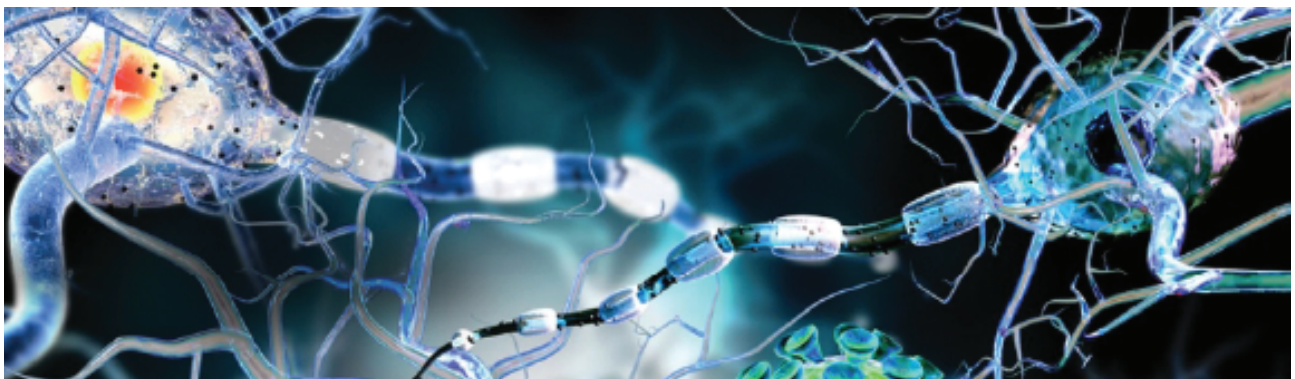
REVOLUTIONIZING THE PRACTICE OF NEUROSURGERY

- A team of world-renowned, nationally-ranked experts in stroke, brain and skullbase tumors, spinal cord and traumatic brain injuries, movement and peripheral nerve disorders, cerebrovascular and pediatric neurosurgery
- Producing future leaders with the highest rate of graduates entering academic careers in the country
- Continuing to drive for diversity through unique initiatives to improve access for women and other underrepresented minorities
- Addressing burnout and investing in physician wellness with programs for faculty and residents
- Access to state-of-the-art adult and children's hospitals using some of the world's most technologically advanced equipment

- #2 in NIH funding nationally
- 10 top 100 NIH-funded PIs in Neurosurgery
- Ranked #9 Neurology & Neurosurgery program in the country by U.S. News & World Report
- 30 active laboratories
- 4700+ neurosurgical operations annually
- 33% of faculty are women and underrepresented minorities
- Leaders in advanced imaging, including VR and tractography
- 1st in the U.S. to appoint a Chief Wellness Officer to address physician burnout

Upcoming Neurosurgery Events

- **2020 Neuroscience Symposium in Hong Kong**, May 9, 2020
- **Stanford Brain Tumor Center Symposium: Breakthroughs in Brain Tumor Treatment**, June 26, 2020
- **2nd Rhoton Society Meeting and 8th International Symposium on Microneurosurgical Anatomy**, August 4-8, 2020



Stanford
MEDICINE | Neurosurgery

med.stanford.edu/neurosurgery

How to Use Your Recruiter More Efficiently: Make Sure to Keep the Lines of Communication Open

By Katie Cole



One of the most significant holdups to a successful neurosurgeon search is communication. After the organization has hired a recruiter to fill the position, the best way to effectively utilize that recruiter is by ensuring that you keep the lines of communication open and freely flowing. In my many years of experience recruiting neurosurgeons, I can honestly say that poor communication really is the biggest obstruction to filling the open position.

Once candidates are submitted for your review, it's important to respond timely to that submission. Even if you don't have time to review the CV that day, or if you've sent the CV to the department chair for approval, at least send an acknowledgement to the recruiter that the candidate has been received and is under review.

If the candidate misses the mark in some way, communicate this with the recruiter, too. This will allow the recruiter to refocus on candidates who might be more in alignment with your search criteria. If you decide to

pass on a candidate for any reason, do let the recruiter know. That way, she or he can pass the information along to the candidate—and continue searching for other candidates who would be a better fit for your organization.

Nothing stalls a search more than active candidates who receive no feedback. The candidates get restless and lose the initial interest they had in the position if they are not communicated with timely. For example, I recently had a candidate whose CV and qualifications I had submitted last fall. He was very specialized and exactly what the client's group was looking for, they acknowledged. The department initially set up interviews with the wrong physician leader and then re-set them—a process that took another few weeks. The candidate had even encountered one of the group's surgeons at a conference and enjoyed the conversation. The practice wanted to bring in the neurosurgeon for an interview a few weeks later, but by the time the invitation was extended, the candidate had other offers.

The moral of the story is this: If candidates aren't communicated with timely and regularly, they lose interest in the opportunity and, worse, might no longer be available when you are

actually ready to reach out to them. Similarly, if questions aren't answered timely about the specifics of the position, candidates might also lose interest in the opportunity. If the candidate doesn't think there is priority or urgency, she or he might move on from the opportunity solely because they don't feel prioritized enough.

Understandably, the group's COO, CEO, practice managers and lead neurosurgeon—whoever is responsible for or involved in hiring—have many other duties to focus on besides recruitment. So, although it makes sense that they can't prioritize the search even if there is an urgent clinical need, they might need to adjust their calendars (or reach out to resources who can assist) to avoid missing out altogether.

Finally, even if there is a hold on the position or details waiting on approval, a recruiter can keep the candidates interested in the opportunity by giving the candidate updates regularly. This ensures that everyone is in kept in the loop with developments and feedback.

Ms. Cole, a Denver resident, is publisher of Neurosurgery Market Watch and Surgery PA Market Watch.

FEATURED OPPORTUNITY

Academic Spine Opportunity: New York City Region

An academic neurosurgery program in New York is seeking a BE/BC spine neurosurgeon to join the department on the program's main campus. The department prefers a candidate who has completed a spine fellowship or who has equivalent experience.

The position is open due to expansion, and the department is seeking a candidate to start this year. This department is the academic practice that provides neurosurgery services to the hospital system. The department's

surgeons perform procedures at the main hospital campus, and the department also operates other campuses and outpatient offices in locations throughout the area. Combined, the facilities and clinics serve a substantial regional catchment area in Suffolk County.

The incoming neurosurgeon's spine call will overlap with general neurosurgery call; spine call is also shared with orthopedics spine. Call is 1:5. The department also

has backup call that follows the week after primary call. Backup call services are paid on top of salary.

Neurosurgeons who join the program are hired as faculty members and have academic appointments.

The department will provide a competitive compensation package, and neurosurgeons receive a combined salary from both the state and the practice plan. The benefits program is excellent through the state.

Advocating for Neurosurgery and Patients Q&A

(continued from Page 7)

adjustments don't apply to the E&M portion of the global surgery codes. In addition, CMS continues to examine all global surgery code values. That creates differential payments that potentially favor some specialties over others—and the net effect could be a cut to neurosurgical reimbursement by as much as 25%.

What we're also concerned about is the new add-on code (GPC1X) that allows for additional payments for complex services, in some specialties outside surgery such as primary care specialties. We're saying that this code should either be eliminated or apply across the board.

Because of the budget neutrality environment, our analysis indicates that both these E&M payment policies could result in a potential 6% payment cut for neurosurgeons.

Q: There are clearly a lot of challenges facing the specialty—and healthcare delivery generally—in our country. If there's a bright spot to report, what might that be?

A: I'd point to the recent implementation of the "21st Century Cures Act," which was first passed

in 2016. The funding will significantly beef up research to benefit patients, by accelerating medical product development and moving innovations and advances into patient care faster and more efficiently. And it's the result of a true concerted bipartisan effort on Congress' part, which makes it a real win for all of us.

Q: Let's talk about how young neurosurgeons can get involved in some of the AANS policy and advocacy initiatives you've discussed. What are some areas where their input and voices would be especially welcomed?

A: We look at our young neurosurgeons as the lifeblood and intellectual power that drives our organization, and through our active Young Neurosurgeons Committee, we encourage their involvement in all policy, advocacy and political action activities. Many of our policy-related committees actively recruit neurosurgical residents and those neurosurgeons new to practice.

The AANS/CNS Washington Committee also has a two-year (competitive) fellowship

that embeds several neurosurgeons into the Washington Committee and its subcommittees—including the Coding and Reimbursement Committee, the Communications and Public Relations Committee, the Drugs and Devices Committee, and the Neurosurgery Quality Council.

In addition, the AANS/CNS Council of State Neurosurgical Societies (CSNS) is a training ground for neurosurgical residents to gain experience and knowledge in organized neurosurgery's health policy and socioeconomic activities. CSNS runs a robust resident fellowship program that sponsors dozens of residents each year, and many go on to serve on AANS advocacy-related committees. Finally, the AANS political action committee, NeurosurgeryPAC, has slotted seats for young neurosurgeons to help expose them to the political side of advocacy.

NEUROSURGERY POSITIONS

GENERAL NEUROSURGERY

Tucson, AZ: *Hospital Employed*

Macon, GA: *Private Practice*

Richland, WA: *Hospital Employed*

Cincinnati, OH: *Private Practice*

Gastonia, NC: *Hospital Employed*

Fort Wayne, IN: *Hospital Employed*

Brooklyn, NY: *Private Practice, Spine/Cranial Trauma*

Las Vegas, NV: *Private Practice, Cranial*

Dayton, OH: *Hospital Employed/Priva-demic*

ENDOVASCULAR

San Antonio, TX: *Academic*

Union, NJ: *Private Practice*

Macon, GA: *Private Practice*

Reading, PA: *Hospital Employed*

Houston, TX: *Hospital Employed*

CRANIAL

Tucson, AZ: *Hospital Employed*

Phoenix, AZ: *Hospital Employed*

SPINE

Long Island, NY: *Private Practice*

Reading, PA: *Hospital Employed*

Knoxville, TN: *Hospital Employed*

Tucson, AZ: *Hospital Employed*

Union, NJ: *Private Practice*

Rapid City, SD: *Private Practice*

Philadelphia, PA: *Priva-demic*

Greenville, NC: *Academic*

Dayton, OH: *Hospital Employed/Priva-demic*

Long Island, NY: *Academic*

► For more information on these positions, or if you are interested in hiring a neurosurgeon for a permanent position, please contact katie.cole@harlequinna.com or call (303) 832-1866.

Harlequin Recruiting
PO Box 102166
Denver, CO 80250

UPCOMING U.S. NEUROSURGERY EVENTS

Spine Tumor Seminar 2020

☐ April 16
New York, New York

Third Comprehensive World Brain Mapping Course

☐ April 23-24
Boston, Massachusetts

2020 AANS

☐ April 25-29
Boston, Massachusetts

Georgia Neurological Society Spring Meeting 2020

☐ May 21-25
Sea Island, Georgia

Neurotrauma 2020

☐ June 27 - July 1
Atlanta, Georgia

Society of University Neurosurgeons Annual Meeting

☐ August 2-5
Whitefish, Montana

UPCOMING INTERNATIONAL CMES

BritSpine

☐ April 1-3
Glasgow, Scotland

IMAST 2020

☐ April 1-4
Athens, Greece

21st Annual Dubai International Spine Conference

☐ April 11-13
Dubai, UAE

SpineWeek 2020

☐ April 27- May 1
Melbourne, Australia

ESO-WSO: Joint European Stroke Organisation and World Stroke Organisation Conference

☐ May 12-15
Vienna, Austria

Global Spine Congress

☐ May 20-23
Rio de Janeiro, Brazil

36th Annual Meeting Cervical Spine Research Society - Europe

☐ May 27-29
Rome, Italy

6th Endoscopic Skull Base Dissection Course | Hands-on dissection, lectures & mini symposium

☐ September 30 - October 2
Leiden, Netherlands