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 following is reprinted from the Honolulu Star Bulletin on November 15, 2000:

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 70's. 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 with the Honolulu Symphony. He is survived by a son Kerry; daughters Karen McGregor of Los Angeles, Calif., and Kathleen Sattler, 12 grandchildren and 5 great grandchildren, and a sister, Ruth Clinger of Salt Lake City.
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 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 one-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.

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
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 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 below 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, MD, PhD, 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. 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 MD, MD Anderson Cancer Center, 1515 Holcombe Blvd., Houston, Texas 77030-4095 (tel. 713-792-2400) or check out our website at 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 disorders. Two awards are available, one for clinical research and one for basic science research. Each award is valued at $500.00.

For further information and submission forms, please contact Keith R. Kuhlengel, MD, 1671 Crooked Oak Dr., P.O. Box 10247, Lancaster, PA 17605-4207, Phone (717) 569-5331, e-mail: kkuhleng@redrose.net, or check out our website at 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 – by 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 hypophysectomy. 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 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 two 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.

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

Comments, Submissions, or Suggestions for the Newsletter?

Please e-mail John Hurlbert at 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