



SAVE THE DATE

The 43rd CANS ANNUAL MEETING

Friday, January 22nd – Sunday, January 24th

The Cliffs Resort, Pismo Beach, CA

“Regaining Patient Choice and Physician Freedom”

ICD-10 NEWS

Randall W. Smith, MD, Editor

1. ICD-10 will not be delayed.
The deadline to switch to ICD-10 remains Oct.1, although CMS has agreed to flexibilities for Medicare Part B claims that should help make that transition smoother.

2. Medicare claims with a date of service on or after Oct. 1 will be rejected if they do not contain a valid ICD-10 code. ICD-10-CM is composed of codes with between three and seven characters. Codes with three characters act as the heading of a category of codes and can either be further subdivided to provide greater specificity (which would add characters) or stand alone.

For example, C81—Hodgkin's lymphoma—cannot stand alone and is not a valid code. But it can be further subdivided into C81.00 (nodular lymphocyte predominant Hodgkin lymphoma, unspecified site), C81.03 (nodular lymphocyte predominant Hodgkin lymphoma, intra-abdominal lymph nodes) or a few other options.

In this example, using any one of the valid codes for Hodgkin's lymphoma would not be cause for a rejected claim or an audit under the recently announced flexibilities for Medicare Part B claims.

A complete list of valid codes and code titles is on the CMS website and listed in tabular order, the same order in the ICD-10-CM codebook.

3. A “family of codes” is the ICD-10 three-character category. Codes within a category are clinically related and provide differences in capturing specific information on the type of condition. For example, category H25—age-related cataract—contains a number of specific codes that captures information about the type of cataract and information on the eye involved.

With few exceptions (described in more detail below), Medicare Part B claims will not be denied or subject to an audit solely based on the specificity of the diagnosis codes as long as they are from the appropriate family of ICD-10 codes.

4. Certain claims fall outside of the coding flexibility.
In certain circumstances, a claim may be denied because the

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ICD-10 code is not consistent with an applicable policy, such as Local Coverage Determinations or National Coverage Determinations. Check CMS' document for more information.

5. These flexibilities do not extend to prior authorization requests.

The flexibilities only pertain to claims processing and post-payment reviews. ICD-10 codes with the correct level of specificity will be required for prepayment reviews and prior authorization.

6. CMS' changes do not affect Medicaid or commercial payers. The official guidance only applies to Medicare fee-for-service claims from claims by physicians and other practitioners that are billed under the Medicare Fee-For-Service Part B physician fee schedule. It does not apply to claims submitted for beneficiaries with Medicaid coverage. Check CMS' document for more information.

Here are some codes we neurosurgeons are likely to use. They are taken from the CMS website.

Spinal Stenosis of the Lumbar region (ICD-9 724.02)

- M48.06 Spinal stenosis, lumbar region
- M48.07 Spinal stenosis, lumbosacral region
- M99.23 Subluxation stenosis of neural canal of lumbar region
- M99.33 Osseous stenosis of neural canal of lumbar region
- M99.43 Connective tissue stenosis of neural canal of lumbar region
- M99.53 Intervertebral disc stenosis of neural canal of lumbar region
- M99.63 Osseous and subluxation stenosis of intervertebral foramina of lumbar region
- M99.73 Connective tissue and disc stenosis of intervertebral foramina of lumbar region

Thoracic, Thoracolumbar and Lumbosacral Intervertebral Disc Disorders (ICD-9 722.10-.93; 724.4)

- M51.04 Intervertebral disc disorders with myelopathy, thoracic region
- M51.05 Intervertebral disc disorders with myelopathy, thoracolumbar region
- M51.06 Intervertebral disc disorders with myelopathy, lumbar region
- M51.07 Intervertebral disc disorders with myelopathy, lumbosacral region
- M51.14 Intervertebral disc disorders with radiculopathy, thoracic region
- M51.15 Intervertebral disc disorders with radiculopathy, thoracolumbar region
- M51.16 Intervertebral disc disorders with radiculopathy, lumbar region
- M51.17 Intervertebral disc disorders with radiculopathy, lumbosacral region
- M51.24 Other intervertebral disc displacement, thoracic region
- M51.25 Other intervertebral disc displacement, thoracolumbar region
- M51.26 Other intervertebral disc displacement, lumbar region
- M51.27 Other intervertebral disc displacement, lumbosacral region
- M51.34 Other intervertebral disc degeneration, thoracic region
- M51.35 Other intervertebral disc degeneration, thoracolumbar region
- M51.36 Other intervertebral disc degeneration, lumbar region
- M51.37 Other intervertebral disc degeneration, lumbosacral region
- M51.44 Schmorl's nodes, thoracic region
- M51.45 Schmorl's nodes, thoracolumbar region
- M51.46 Schmorl's nodes, lumbar region
- M51.47 Schmorl's nodes, lumbosacral region
- M51.84 Other intervertebral disc disorders, thoracic region
- M51.85 Other intervertebral disc disorders, thoracolumbar region
- M51.86 Other intervertebral disc disorders, lumbar region
- M51.87 Other intervertebral disc disorders, lumbosacral region
- M51.9* Unspecified thoracic, thoracolumbar and lumbosacral intervertebral disc disorder

Neck and Back Pain (ICD-9 723.1, 724.1, 724.2, 724.3, 724.5)

- M54.2 Cervicalgia
- M54.30* Sciatica, unspecified side
- M54.31 Sciatica, right side
- M54.32 Sciatica, left side
- M54.40* Lumbago with sciatica, unspecified side

M54.41 Lumbago with sciatica, right side
 M54.42 Lumbago with sciatica, left side
 M54.5 Low back pain
 M54.6 Pain in thoracic spine
 M54.89 Other dorsalgia
 M54.9* Dorsalgia, unspecified

Radiculopathy (Primary) (ICD-9 723.4, 724.3, 724.2, 724.4, 729.2)

M54.10* Radiculopathy, site unspecified
 M54.11 Radiculopathy, occipito-atlanto-axial region
 M54.12 Radiculopathy, cervical region
 M54.13 Radiculopathy, cervicothoracic region
 M54.14 Radiculopathy, thoracic region
 M54.15 Radiculopathy, thoracolumbar region
 M54.16 Radiculopathy, lumbar region
 M54.17 Radiculopathy, lumbosacral region
 M54.18 Radiculopathy, sacral and sacrococcygeal region
 M54.30* Sciatica, unspecified side
 M54.31 Sciatica, right side
 M54.32 Sciatica, left side

Cervical Spine Disorders and Displacement (ICD-9 722.0, 722.4, 722.71, 722.91, 723.4)

M50.OO Cervical disc disorder with myelopathy, unspecified cervical region
 M50.OI Cervical disc disorder with myelopathy, occipito-atlanto-axial region
 M50.O2 Cervical disc disorder with myelopathy, mid-cervical region
 M50.O3 Cervical disc disorder with myelopathy, cervicothoracic region
 M50.IO* Cervical disc disorder with radiculopathy, unspecified cervical region
 M50.II Cervical disc disorder with radiculopathy, occipito-atlanto-axial region
 M50.12 Cervical disc disorder with radiculopathy, mid-cervical region
 M50.13 Cervical disc disorder with radiculopathy, cervicothoracic region
 M50.20* Other cervical disc displacement, unspecified cervical region
 M50.21 Other cervical disc displacement, occipito-atlanto-axial region
 M50.22 Other cervical disc displacement, mid-cervical region
 M50.23 Other cervical disc displacement, cervicothoracic region
 M50.30* Other cervical disc degeneration, unspecified cervical region
 M50.31 Other cervical disc degeneration, occipito-atlanto-axial region
 M50.32 Other cervical disc degeneration[mid-cervical region
 M50.33 Other cervical disc degeneration, cervicothoracic region
 M50.80* Other cervical disc disorders, unspecified cervical region
 M50.81 Other cervical disc disorders, occipito-atlanto-axial region
 M50.82 Other cervical disc disorders, mid-cervical region
 M50.83 Other cervical disc disorders, cervicothoracic region
 M50.90* Cervical disc disorder, unspecified, unspecified cervical region
 M50.91 Cervical disc disorder, unspecified, occipito-atlanto-axial region
 M50.92 Cervical disc disorder, unspecified, mid-cervical region
 M50.93 Cervical disc disorder, unspecified, cervicothoracic region

Another useful ICD-10 item is the AANS ICD-10 Express Code which eliminates the daily need of a weighty, unwieldy reference by including only the most common diagnoses faced by the practicing neurosurgeon. For optimal ease of use, these codes are condensed to help coders and physicians locate the correct codes in a quick and logical way. The Express Code costs \$39 plus shipping for AANS members at <https://marketplace.aans.org> ❖

CANS MISSION STATEMENT

‘TO ADVOCATE FOR THE PRACTICE OF CALIFORNIA NEUROSURGERY
BENEFITTING OUR PATIENTS AND PROFESSION’

Brain Waves

Deborah Henry, MD, Associate Editor

Traffic is back from its summer vacation as the throng of students head back to school to listen to those Talking Heads. That's who has taught us since the beginning. That's what we see at meetings. Some person standing in front of us, his or her mouth moving, and the audience fading in and out of attention. So I was surprised when I read about the advancements in neurosurgical education in the recent Congress meeting flyer.

Despite my agreeing with most neurosurgeons that it would be beneficial to have one major neurosurgical organization rather than two, both the Congress and AANS have managed to distinguish themselves, occupying different seats in the realm of the neurosurgical practice. The Congress, in my opinion, keeps itself on the cutting edge of neurosurgical education, creating innovative ways to advance the knowledge base of neurological surgeons from residency to retirement.

I remember a Congressional address where the neurosurgeon talked of mechanisms of learning and spoke of paradigm shifts in education. He stressed that early learning works much like an apprenticeship. Initially, we lack the knowledge base, so learning of facts happens quickly. As we mature, our learning takes on an application of knowledge rather than an acquisition of knowledge. In fact it becomes more difficult to learn new material as we become set in the ways that have worked for us in the past. The trying of new ideas requires that paradigm shift-the ability to think outside the box.

A couple of years ago, I discovered the flipped classroom, where reading is done at home and "homework" is done in the classroom. This paradigm shift brought active and engaged learning into the classroom rather than the passivity of learning through a power point presentation. As neurological surgeons, we have sat through our share of presentations from "this is what that is" to "this is how I do it". The Congress has embraced this new learning style and trialed it first in August 2014 in a luncheon seminar on "Hematology and Coagulation for Neurosurgeons: Dangers and Solutions" where a webinar was presented prior to the meeting, and the luncheon was therefore an opportunity for group discussion and interaction. This fall, they will have three flipped classroom luncheons, a repeat of last fall, one on pituitary tumor management, and the third on return to play.

The ways we can learn are changing as fast as social networking. We are in the infancy of a huge shift into active learning. It is wonderful seeing neurosurgery stepping onto the bandwagon. Fare thee well, Talking Heads. ❖

**DO YOU KNOW A NEUROSURGEON NEW TO CALIFORNIA?
TELL THEM ABOUT CANS AND DIRECT THEM TO THE CANS WEBSITE:
WWW.CANS1.ORG! THERE IS A MEMBERSHIP APPLICATION ON THE SITE!**

Tidbits from the Editor

CANS Board of Directors Meeting—8/30/2015

The meeting was held at the Sacramento/Sierra Medical Society and was attended by officers Kissel, Mummaneni, Page, Blumenfeld and Henry; by directors Panchal, Holly, Asgarzadie and Berger; by consultants Abou-Samra, Bonner, Lippe, Shuer, Smith, Wade and Prolo.

William Sheridan, MD, a Kaiser Redwood City neurosurgeon, was admitted to active membership.

CANS delegates to the Council of State Neurosurgical Societies meeting in New Orleans on September 25-26 were appointed and include: Drs. Kissel (Chairman of delegation), Abou-Samra, Henry, Blumenfeld, Linskey, Vanefsky and Wade.

The Board decided to award the Byron Cone Pevehouse Distinguished Service Award for 2016 to **Moustapha Abou-Samra** for his extensive and selfless work on behalf of neurosurgeons everywhere. Moose has served as CANS President (after many years as a director and officer), Western Neurosurgical Society President, President of the Neurosurgical Society of America, Chairman of the AANS Political Action Committee, Chairman of the CSNS SW Quadrant and currently is a Regional Director on the AANS Board.

The Board decided to bestow the George Ablin Distinguished Public Service Award for 2016 to pediatrician **Richard Pan, MD**, California State Senator from Sacramento, for his pivotal role in creating the current CA law requiring all CA school students to be vaccinated with the only exceptions being medical ones. Both the Pevehouse and Ablin awards will be presented at the Saturday evening dinner on January 23rd during the CANS annual Meeting.

The Board discussed each of the 10 resolutions scheduled for debate at the CSNS meeting in September and took various positions as listed elsewhere in this newsletter.

Strategic Planning Meeting results

Fifteen members of the CANS Board of Directors met for a total of 7 hours starting at 7 PM Saturday 8/29 and continuing on Sunday 8/30. The topics were four: Mission/Website, Capital (revenues), Membership and Annual Meeting. The actions taken:

- The Mission statement was changed to "It shall be the mission of the California Association of Neurological Surgeons to advocate for the practice of California neurosurgeons benefiting our patients and profession."
- Non-members who attend the 2016 and 2017 CANS Annual Meeting and complete a CANS membership application on-site will have their annual dues forgiven for one year.
- Provide Resident Fellowships for two residents as consultants to the BOD, one from northern CA, one from the southern CA to attend the appropriate BOD meetings.
- Provide up to \$5,000 to upgrade the CANS Website, provide intractability and new capabilities and attract Website sponsors and advertisers.
- Pursue outreach to attract non-member neurosurgeons in all forms of practice.
- Prepare a standardized Power Point presentation addressing the history of and ongoing importance of CANS to be presented at Grand Rounds at the various California neurosurgery training programs.
- Increase the basic exhibitor fee to \$3,000 and create more enticing tiered exhibitor options.
- Investigate the creation of a CANS Foundation.
- Review and potentially revise the Annual Meeting format.

End-user agreements and EHR vendors

Joseph S. Eastern, M.D., a New Jersey dermatologist, has written an interesting article in *Clinical Neurology News* (<http://www.clinicalneurologynews.com>) that calls attention to the end user licensing agreement (EULA) that Electronic Medical Records vendors want you to sign as part of buying their EHR system.

He actually read the EULA proffered by the company he was choosing to convert his practice to one with EHR's and noticed that the vendor assumed no liability at all in the event of accidental destruction of his records. He also discovered that the vendor would have the unrestricted right to sell his practice data to third parties. He strongly recommends finding a lawyer who understands tech contracts and medical privacy laws before you sign these EULA's.

He also noted that since one EHR installation in three ultimately fails you need to be certain that you do not get locked into a long-term contract should your EHR turn out to be a poor performer.

You need to know exactly what happens to your data if the vendor goes out of business, or if a flood wipes out its servers or anything else that forces you to switch vendors. The EULA should include specific methods by which data will be migrated and be sure to remove any clauses that force you to pay a "ransom" to regain control of your own records.

You will want to know how your data is backed up – and how the backup is backed up – and whether you can maintain a separate backup in-house if necessary.

His article implies that there are some EULA clauses that are still pungent to a doc but that the vendor refuses to change even with the help of an attorney. Maybe that would be the time to shop around since there are a lot of vendors out there who want to make a buck.

RESOLUTION I (CANS position—opposed, nannyism)**Title: INCLUSION OF A PATIENT IMPACT ASSESSMENT ON CSNS RESOLUTIONS**

WHEREAS, the principle charge of the CSNS is to act as a forum for the State Neurosurgical Societies to air and discuss socioeconomic issues and concerns; and

WHEREAS, language regarding the centrality of the patient in CSNS activities permeates the official language of the body, for example:

I. PURPOSE, MISSION & VISION

1. The purpose of the Council of State Neurosurgical Societies is to provide a national forum for the State Neurosurgical Societies of the United States. This forum is primarily for discussion, consideration, and proposals of action regarding socioeconomic issues concerning Neurological Surgery.

2. The Mission Statement for the Council of State Neurosurgical Societies is as follows:

The CSNS is a representative, deliberative and collaborative organization of delegate neurosurgeons in training and practice that exists to:

1. positively influence and affect the socioeconomic policy of organized Neurosurgery for the benefit of Neurosurgical patients and our profession,

2. serve as a resource for socioeconomic knowledge and education for our Neurosurgical colleagues, regulatory and health care officials as well as legislative representatives,

3. provide a conduit for new initiatives, concerns and issues to be brought to the AANS and CNS for response and action, and

4. provide an environment for developing future leaders in healthcare policy and advocacy for Neurosurgery.

We believe that the specialty of Neurosurgery stands for the highest quality of care and that neurosurgeons are their patient's strongest advocates. ; and

WHEREAS, the welfare of the neurosurgical patient should be integral in the discourse surrounding socioeconomic issues in neurosurgery (for the patient may be directly impacted by any such issues and/or action taken with respect to them); therefore

BE IT RESOLVED, that all resolutions submitted to the CSNS carry a "Patient Impact Assessment"; and

BE IT FURTHER RESOLVED, that the Patient Impact Assessment of a CSNS resolution comments upon the anticipated effect the resolution will have on neurosurgical patients if its requested action is seen to fruition; and

BE IT FURTHER RESOLVED, that a CSNS resolution author(s) is prepared to discuss the patient impact of the resolution in open testimony at the CSNS plenary session.

RESOLUTION II (Support)**Title: Making connections between graduating residents and state societies**

WHEREAS, graduating neurosurgical residents often relocate upon residency graduation and may not be aware of existing state neurosurgical society infrastructure; and

WHEREAS, state neurosurgical societies and the CSNS have been working to reinvigorate the membership and involvement for these societies and involve young neurosurgeons; and

WHEREAS, a knowledge of the state society and local/state neurosurgeons may be beneficial to the new graduates; and

WHEREAS, the ABNS currently collects new contact information for graduating residents from their program coordinators as part of the board certification process; therefore

BE IT RESOLVED, that the CSNS petition the ABNS for access to this contact information; and

BE IT FURTHER RESOLVED, that this information be utilized to contact the newly graduated residents to connect them to their new state societies and CSNS quadrants.

RESOLUTION III (Neutral-await debate)

Title: **"Integrated care pathways" for Neurosurgeons in the Era of the Affordable Care Act**

WHEREAS, current health care reform places emphasis on care delivery across the continuum of care and utilizes alternative payment models to promote this; and

WHEREAS, these alternative payment models include concepts such as bundling for disease based practices, value based care, and accountable care organizations for which hospitals and physicians will incur financial penalties for events such as readmissions, patient dissatisfaction, extended length of stay, or hospital acquired infections; and

WHEREAS, as a response to these alternative payment models, many hospitals are requesting their physicians participate in the creation of "Disease Group Care Pathways", also known as "Clinical pathways", "care pathways", "critical pathways", "integrated care pathways", or "care maps" to attempt to standardize a patient's experience and eliminate variations of care, even when there is no evidence based medicine, in order to cut costs and improve quality; and

WHEREAS, it is unclear what impact these "Care Pathways" will have on the practice of Neurosurgery; and

WHEREAS, there are few sources of practical knowledge and tools for neurosurgeons to effectively participate in such efforts; and

WHEREAS, there should be a means to share these pathways among Neurosurgeons; therefore

BE IT RESOLVED, that the CSNS will investigate the extent to which "Integrated Care Pathways" are being implemented in neurosurgical practices, including the impact of these pathways on practice, and will report the findings in a white paper; and

BE IT FURTHER RESOLVED, that the CSNS create content that describes and explains the practical creation, validation and acceptance of an "Integrated Care Pathway" with relevance to clinical neurosurgery geared towards the busy practicing neurosurgeon and make available such content to both the CSNS membership and neurosurgeon members of the AANS and CNS.

RESOLUTION IV (Support)

Title: **CSNS resource to access and dispute Physician Payments Sunshine Act Data**

WHEREAS, the Physician Payments Sunshine Act requires companies participating in United States Federal Health Care Programs to report certain financial relationships with individual physicians and teaching hospitals, including, but not limited to, speakers' fees and honoraria, travel, meals, research funding, educational items; and

WHEREAS, the Centers for Medicare and Medicaid Services (CMS) implements this reporting through the Open Payments Program; and

WHEREAS, neurosurgeons' financial data is available to the public through an open-access website; and

WHEREAS, CMS is not required to alert neurosurgeons about newly reported financial relationships, unless they sign up on the Open Payments website to receive alerts; and

WHEREAS, there exists potential for damage to physician and hospital reputations from inaccuracy in reporting, from misinterpretation of reports by patients or those unfamiliar with the reporting format; and, WHEREAS, neurosurgeons may not know how to access their data, sign up for alerts, or properly dispute or correct a report; therefore

BE IT RESOLVED, that the CSNS will post a link to the Open Payments website on the CSNS website providing neurosurgeons access to their data in order to encourage and accommodate early review and timely disputing; and

BE IT FURTHER RESOLVED, the CSNS will develop and post an informative document on the CSNS website describing how physicians can sign up to receive alerts when new reports are made and learn how to dispute or correct questionable reports.

RESOLUTION V (Neutral—await debate)

Title: **Assessing the impact of ICD-10 on neurosurgical practices and patient access to neurosurgical care**

WHEREAS, the effects of the coding change from ICD-9 to ICD-10 are likely to have an impact on physicians and medical practices; and

WHEREAS, many of the changes may affect the productivity of physicians and the operation of their offices; and

WHEREAS, these changes may have a negative impact on the work flow of clinical operations and outpatient volumes; and

WHEREAS, the collective effect of the implementation of ICD-10-CM may result in decreasing patient access to neurosurgical care; therefore,

BE IT RESOLVED, that the CSNS will measure the impact of ICD-10 implementation by conducting a survey in collaboration with NERVES, that will be administered to the AANS, CNS, and NERVES membership, and that this survey will measure such factors as outpatient clinical volumes, surgical volumes, number of days of account receivables, charge lag, collections, denials, and cash flow; and

BE IT FURTHER RESOLVED, that this survey will be sent out in two phases: the first survey will collect data from three months prior to until three months after ICD-10 implementation, and a second survey will be distributed six months after ICD-10 implementation to measure any changes from the initial survey; and

BE IT FURTHER RESOLVED, that a white paper summarizing the finding of the surveys will be drafted and distributed to AANS and CNS members.

RESOLUTION VI (Support)

Title: **Evaluating the impact of the medical review panel process on neurosurgical malpractice litigation**

WHEREAS, The Medical Review Panel Process is in place in 17-20 states to evaluate medical malpractice litigation claims prior to proceeding to a trial; and

WHEREAS, The Purpose of the Medical Review Panel is to provide, with the assistance of a judge, a consensus opinion as to whether the physician plaintiff acted within or outside the acceptable standard of care; and

WHEREAS, the CSNS is invested in providing support for organized neurosurgery and protecting the neurosurgical community against frivolous litigation; therefore

BE IT RESOLVED, that by the 2016 Spring CSNS meeting, the CSNS will assess the effectiveness of the medical review panel process in preventing frivolous litigation pertaining to neurosurgery only, and

BE IT FURTHER RESOLVED, that if the medical review panel process is found to be helpful in protecting neurosurgeons against frivolous litigation, then the CSNS will formulate a statement of support /recommendation that the medical review panel process should be adopted in all 50 states.

RESOLUTION VII (Support)

Title: **Expansion of Non-delegate, non-appointee participation in CSNS activities**

WHEREAS, a recent change of the CSNS rules and regulations in Spring 2015 (see summary of changes referenced below) has created the category of Non-delegate, non-appointee individuals (NDNA); and

WHEREAS, there exist a current mandate from the chair and EC to expand membership and participation within the Young Neurosurgeons Representative Section (YNRS) from the larger body of eligible neurosurgeons to; and

WHEREAS, the use of the double negative in the NDNA designation could be considered repudiative and a disincentive for engagement of the target group of young neurosurgeons; and

WHEREAS, there is an ongoing lack of recognition of status and academic standing of the CSNS from the perspective of program directors and department chairs when ask to grant leave to attend the CSNS meeting due to the lack of a formal membership that signifies ongoing scholarly interest and engagement in organized neurosurgery; and

WHEREAS, currently there does not exist a membership class or coherent treatment of such individuals that allows access to protected portions of the CSNS website and ongoing participation in committee work that may require such access; therefore

BE IT RESOLVED, that the CSNS move to amend the rules and regulations to modify the description of the NDNA category to the positive descriptor "Affiliate"; and

BE IT FURTHER RESOLVED, that the new class of affiliates (NDNA members) of the CSNS are granted appropriate website access to foster collaboration and work on the committee level; and

BE IT FURTHER RESOLVED, that the CSNS further define and clarify the interpretation of the rules and regulations changes from Spring 2015, which created the status and privileges of Non-delegate, non-appointed individuals (NDNA) pertaining to the internal work of the CSNS with consideration of creation of a "Affiliate" membership class and a administrative framework to apply for and be granted membership similar to other Joint AANS/CNS Sections in order to further attract lasting interest and participation of neurosurgeons in the CSNS.

RESOLUTION VIII (Support)

Title: **Development of new quality reporting measures**

WHEREAS, the Physician Quality Reporting System (PQRS) is a quality reporting system established by the Center for Medicare and Medicaid Services (CMS) for reporting quality of services provided to Medicare; and

WHEREAS, CMS requires individual eligible professionals (EPs) and group practices to report a set of Clinical Quality Measures (CQM) as stipulated in the criteria for meaningful use stage I-III and CMS final rule 77; and

WHEREAS, quality measures were intended to be indicators of the quality of care provided by a specific practitioner or practice; and

WHEREAS, the many of the quality measures established by the CMS are the result of coming up with a lowest common denominator for all physicians and may not be appropriate measures to represent the care provided by neurological surgeons; and

WHEREAS, individual EPs and group practices who do not satisfy report data on quality measures for Medicare Part B Physician Fee Schedule (MPFS) in 2015 will face the 2017 PQRS negative payment adjustment; and

WHEREAS, the importance of satisfactorily reporting on quality measures through PQRS is critical due to CMS making performance data available to the public in 2016; therefore

BE IT RESOLVED, that the CSNS develop a white paper which describes the process of creating a reportable quality measure that is relevant to neurosurgical practice; and

BE IT FURTHER RESOLVED, that the CSNS establish a web base tool accessible to all neurologic surgeons that will aid in the identification of PQRS quality measures applicable to neurologic surgeons; and

BE IT FURTHER RESOLVED, that the CSNS offer to work with the AANS and CNS, and work, in particular, with the Quality Improvement Council to establish a Potential Neurological Surgery Preferred Specialty Measure Set specific to the care of neurosurgical patients.

RESOLUTION IX (Neutral—await debate)

Title: Assessment of the Impact of Mobile Technology in the Neurosurgical Operating Room

WHEREAS, the use of mobile technologies have dramatically increased among healthcare providers over the past decade; and

WHEREAS, use of mobile devices, particularly in the operating room, has been of increasing interest to patients and the general public; and

WHEREAS, such interest has primarily revolved around the balance between mobile technology's ability to improve communication and enhance productivity for surgeons, in contrast to concerns over it's potential role in causing distraction or contamination in the operating room; and

WHEREAS, formal position statements focusing on the use of mobile technologies in the operating room have been issued by the American College of Surgeons (ACS)¹, American Academy of Orthopaedic Surgeons (AAOS)², and the Association of periOperative Registered Nurses (AORN)³; and

WHEREAS, organized neurosurgery has yet to formally address the role of mobile technology within the operating suite; therefore

BE IT RESOLVED, that the CSNS develop a white paper to study the issue of mobile technology use in the neurosurgical operating room; and

BE IT FURTHER RESOLVED, that the CSNS request that the parent organizations develop a position statement on the use of mobile technologies in the neurosurgical operating room.

RESOLUTION X (Neutral—await debate)

Title: **Development of recommendations for appropriate use of personal electronic devices by neurosurgeons**

WHEREAS, neurosurgeons, like other healthcare providers, are increasingly dependent on personal electronic devices (PEDs) to carry out their workflow in caring for patients,

WHEREAS, PED use also carries significant risk secondary to potential security breach of personal health information (PHI) and distraction during patient care,

WHEREAS, these risks are a focus in the media and have resulted in medicolegal action in some instances,

WHEREAS, some organizations have developed guidelines for clinicians to recommend appropriate use of these devices in patient care areas (the operating room particularly),

WHEREAS, the CSNS has recently developed educational material to neurosurgeons regarding appropriate use of PEDs (RESOLUTION VII-2013F),

BE IT RESOLVED that the CSNS petition its parent organizations to develop formal recommendations on the appropriate use of PEDs in healthcare delivery and patient care, and

BE IT FURTHER RESOLVED that the CSNS provide our parent organizations with two work products that can be distributed to members:

- 1) How can neurosurgeons protect PHI when they use PEDs?
- 2) Benefits and pitfalls of PEDs in the OR and clinic: what every neurosurgeon should know.

Docs fight back against SCIF allegations

Last month we reported that the State Compensation Insurance Fund added a number of docs as defendants to its complaint against Michael D. Drobot and his son. The carrier on July 13 filed an amended complaint naming 14 medical providers as additional defendants in its two-year-old civil Racketeering Influenced and Corrupt Organizations Act claim against the Drobots. State Fund alleges the medical providers accepted kickbacks in exchange for referring spinal patients to Pacific Hospital of Long Beach.

Attorneys for Dr. Gerald Alexander, Dr. Ian Armstrong, chiropractor Michael Barri, Dr. Mitchell Cohen, Dr. Timothy Hunt, Dr. Philip Sobol and Dr. Jacob Tauber feel that the court should not countenance SCIF's attempt to bankrupt the medical professionals by forcing them to become entangled in the dispute between SCIF and Drobot. As this writer understands it, the docs want to be left out until the case against Drobot is brought to a conclusion. If Drobot is found innocent, then maybe everyone should just go home. If he is found guilty, then and only then can SCIF file an additional complaint against the docs.

Drobot alleges he paid the docs nearly \$23 million through sublease, collection, option and marketing contracts, including: \$5.17 million to Sobol, \$1.4 million to Hunt, \$713,000 to Tauber, \$570,000 to Ivar, \$515,000 to Alexander, \$445,000 to Cohen and \$381,000 to Armstrong.

A hearing on the providers' motions to be dismissed from State Fund's complaint is scheduled for Sept. 21.



Opinion for the Month:

Even duct tape can't fix stupid ... but it can muffle the sound!

Meetings of Interest for the next 12 months:

Western Neurosurgical Society: Annual Meeting, September 10-13, 2015, Kauai, HI
 CSNS Meeting, September 25-26, 2015, New Orleans, LA
 Congress of Neurological Surgeons: Annual Meeting, September 26-30, 2015, New Orleans, LA
 North American Spine Society: Annual Meeting, October 26-29, **2015**, Boston, MA
 California Neurology Society: Annual Meeting, November 13-15, 2015, San Francisco, CA
 AANS/CNS Joint Pediatric NS Section: Ann. Meeting, December 8-11, 2015, Seattle, WA
 Cervical Spine Research Society: Annual Meeting, December 3-5, 2015, San Diego, CA
 North American Neuromodulation Society: Ann. Meet., December 10-13, 2015, Las Vegas, NV
CANS Annual Meeting, January 22-24, 2016, The Cliffs Resort, Pismo Beach, CA
 AANS/CNS Joint Cerebrovascular Section: Ann. Meet., February 15-16, 2016, Los Angeles, CA
 Southern Neurosurgical Society: Annual Meeting, March 2-5, 2016, San Antonio, TX
 AANS/CNS Joint Spine Section: Annual Meeting, March 16-19, 2016, Orlando, FL
 Neurosurgical Society of America: Annual Meeting, June 19-26, 2016, Dublin, Ireland
 CSNS Meeting, April 29-30, 2016, Chicago, IL
 AANS/CNS Joint Pain Section Bi-Annual Meeting, **April 29, 2016**, Chicago, IL
 AANS: Annual Meeting, April 30-May 4, 2016, Chicago, IL
 Rocky Mountain Neurosurgical Society: 2016 Annual Meeting, TBA
 New England Neurosurgical Society: 2016 Annual Meeting, TBA
 AANS/CNS Joint Neurotrauma and Critical Care Section 2016 Meeting, **TBA**

Any **CANS** member who is looking for a new associate/partner/PA/NP or who is looking for a position (all California neurosurgery residents are CANS members and get this newsletter) is free to submit a 150 word summary of a position available or of one's qualifications for a two month posting in this newsletter. Submit your text to the CANS office by E-mail (emily@cans1.org) or fax (916-457-8202)—Ed. ❖

The assistance of Emily Schile and Dr. Phillip Kissel in the preparation of this newsletter is acknowledged and appreciated.

- To place a newsletter ad, contact the executive office for complete price list and details.
- Comments can be sent to the editor, Randall W. Smith, M.D., at rws-avopro@sbcglobal.net or to the CANS office emily@cans1.org.
- Past newsletter issues are available on the CANS website at www.cans1.org.
- If you do not wish to receive this newsletter in the future, please E-mail, phone or fax Emily Schile (emily@cans1.org, 916-457-2267 t, 916-457-8202 f) with the word "unsubscribe" in the subject line.

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This newsletter is published monthly from the Executive Office:

California Association of Neurological Surgeons
 5380 Elvas Avenue
 Suite 215
 Sacramento, CA 95819
 Tel 916 457-2267
 Fax 916 457-8202
www.cans1.org

Editorial Committee

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