CANS newsletter

Message from the President

Praveen Mummaneni, MD, President

Dear CANS members,

In this issue of the CANS newsletter, I wanted to bring three issues to your attention.

The first issue is that there is a proposal to eliminate the 90-day global period for all neurosurgical procedures. A survey was sent to all of you from Katie Orrico JD (AANS/CNS Washington Committee) to provide input on this proposal. If it goes through it would result in a 20% cut in the global surgical payment in January 2017. It would restrict patient access to surgical care for sure as such a cut would, in many cases, create a situation where a surgeon would do a case and not be able to cover the associated practice costs. Please check your email for that survey from Katie Orrico and respond appropriately. If the AANS/CNS Washington Committee has a large percentage of responses from practicing neurosurgeons in opposition to this proposal then they will have a greater chance to oppose this measure.

Secondly, I want to bring your attention to AB 72 which is now being considered in the state legislature and was authored by Assemblyman Rob Bonta (D, Oakland). It attempts to "protect" patients from "surprise billing" for non-emergency services by out of network providers. While the CANS board members do understand that balance billing the patient for out of network care can create financial difficulties for the patients, the way this bill is written is quite problematic. It requires payment for out of network care at a rate set solely by the insurers. This removes any incentive for an insurer to work with a practicing neurosurgeon to negotiate a rate to bring the surgeon into their network. Instead, the insurer can simply keep everyone out of network and chose what to pay

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them for their services. This detail makes the bill unworkable in its current form. The CANS board is opposed to the bill as are several other physician groups.

Finally, I want to bring to your attention Proposition 61 which attempts to peg drug costs paid by the state to prices paid by the VA system. This could help 12% of the population, but it excludes 88% of the population or our state. The proposition creates an unworkable contracting system which will likely increase drug costs for the other 88%. The CANS board is opposed to the measure.

In closing, I invite all of you to attend ***our next annual meeting on January 13-15, 2017 at the Mark Hopkins Intercontinental Hotel in San Francisco***. We will cover topics of great interest to practicing California neurosurgeons and highlighted session topics include: **"How Far Can We Stretch Ourselves On Call and In the OR", "Finding My First and Second Job in Neurosurgery", "Neurosurgery on the Legislative Hot Seat", and "The Future of Neurosurgical Training in California".**

We have superb invited speakers from the leadership of the AANS, CNS, and Washington Committee as well as the NREF.

It is a **MUST ATTEND** meeting. I look forward to seeing all of you in San Francisco!

Sincerely,

Praveen V. Mummaneni MD
Joan O'Reilly Endowed Professor
Vice Chairman
UCSF Neurosurgery
CANS President

CANS Board adds resident Board members; supports NREF

Randall W. Smith, MD, Editor

The autumn Board of Directors meeting was held August 27th at the Sheraton Gateway hotel near LAX. It was attended by officers Mummaneni, Holly, Linskey, Rhoten (by phone), Rosario, Kissel, and Henry; directors Asgarzadie, Chen, Panchal, and Siddiqi; consultants Bonner, Colohan, Smith, Wade (by phone) and Kaczmar; residents Wang and Hariri.

President Mummaneni welcomed Doris Wang, MD from UCSF and Omid Hariri, DO from Arrowhead to the recently created resident positions on the Board.

Considerable discussion occurred regarding the program for the annual meeting in January. It is proving difficult to provide continuing education credits required by the state regarding fluoroscopy licenses. It was decided to conduct a member survey to gauge the interest in having 4 hours of the 10 required educational hours provided on the afternoon of the last day of the meeting vs. how most educational hours are obtained, which is on-line. The cost of providing the standard AMA Category I CME credits for the meeting via the AANS is $2900.

The Board voted to award active membership to **Abbas Bahari**, MD of Pomona; **Scott Berta**, MD, from UCSF; **Amer Khalil,** MD from UCI; **Esther Kim**, MD from Loma Linda; **Ramachandran Kumar**, MD from Loma Linda and **Lisa Mulligan**, MD from Naval Hospital Camp Pendleton. **Farr Ajir**, MD was moved to Senior status at his request. A moment of silence was observed because of the death of **Justin Renaudin**, MD of San Diego, a CANS member since 1978.

The treasurer's report noted a positive bottom line for the last fiscal year with dues and advertising income falling $5000 short of covering routine expenses but income from the 2016 annual meeting more than making up the difference. The Board voted to contribute $2000 to the Neurosurgical Research and Education Foundation every year we experience a positive bottom line up to a total contribution of $20,000. It further decided to add an optional $20 contribution to NREF as part of the annual dues statement.

The Board chose to accept the recommendation of the Awards Committee in which it recommended **Mitchel Berger**, MD from UCSF for the Pevehouse Award for 2017. The Board also chose **Joe Montana** to receive the Public Service Award for his philanthropic work with children.

President Mummaneni announced his delegate appointments for the CSNS meeting in San Diego on September 23-24: Ken Blumenfeld, Joseph Chen, Pat Wade, Mark Linskey, Marc Vanefsky, Omid Hariri and Moose Abou-Samra with Deb Henry and Randy Smith as alternate delegates. Finally, the Board discussed each resolution to be considered and voted its position on each as indicated. Any CANS member wishing to express an opinion should contact Dr. Blumenfeld at kennethblumenfeld@mac.com.

RESOLUTION I (CANS position: Opposed)
Title: **A Neurosurgical Call for Mandatory Automobile Ignition-Seatbelt Interlock**
Submitted by: Gary Simonds, MD
WHEREAS, the combination of seatbelt use and airbags has greatly reduced the morbidity and mortality of moderate and high speed automobile accidents; and
WHEREAS, a sizable proportion of severely injured automobile accident patients did not engage their seatbelts; and

WHEREAS, severe multiple trauma patients, severe closed head injury patients, and spinal cord injury patients are often tragically young; and
WHEREAS, severe multiple trauma patients, severe closed head injury patients, and spinal cord injury patients create a substantial socioeconomic burden on their families, their medical institutions and society in general; and
WHEREAS, an ignition- seatbelt interlock prevents automobile ignition until driver/passenger seatbelts are engaged; and
WHEREAS, mandatory ignition-seatbelt interlocks would potentially save thousands of young Americans from decades of misery and total dependence; therefore
BE IT RESOLVED, that the CSNS requests of its parent bodies the generation of a formal letter addressed to federal governmental officials recommending mandatory Automobile Ignition-Seatbelt Interlocks on all new cars produced and sold in the United States; and
BE IT FURTHER RESOLVED, that the CSNS discusses mounting a campaign through its parent bodies and other advocacy organizations such as the AMA and ACS to bring to public attention this relatively simple and inexpensive method of significantly reducing the tragic morbidity and mortality of automobile accidents

RESOLUTION II (CANS position: Opposed)
Title: **A Ban on Personal Electronic Device Engagement in CSNS Plenary Sessions**
Submitted by: Gary Simonds, MD
WHEREAS, the CSNS plenary session is a rare opportunity to gather leaders in the socioeconomic sphere of neurosurgery; and
WHEREAS, most attendees of the CSNS national meetings are acting in a representative role for either their state societies or their professional organizations (AANS, CNS); and
WHEREAS, the Plenary session of the CSNS national meeting represents a consolidated and concentrated effort to address concerns of individual neurosurgeons, state societies, and professional organizations and to present updates on important socioeconomic studies, activities, and interventions; and
WHEREAS, the socioeconomic issues facing today's American society are hyper-complex and potentially grave in their implications and ramifications and thus bear close attention and consideration; and
WHEREAS, there is a proliferation of CSNS member engagement with various personal electronic devices (personal computers, tablets, smart phones, etc.) during CSNS National meeting plenary sessions; and
WHEREAS, member engagement with personal electronic devices during the CSNS National Meeting Plenary session is distracting to the members using the devices as well as other members in proximity, and is disheartening to those who have organized the sessions and those who present in them; therefore
BE IT RESOLVED, that the CSNS bans member engagement with personal electronic devices in the Plenary Session Hall during National Meeting Plenary Sessions (with the exception of urgent and emergent communications).

RESOLUTION III (CANS position: Support)
Title: **CAST Certification in Spinal Surgery for Graduating Neurosurgical Residents**
Submitted by: Gary Simonds, MD
WHEREAS, the CAST Committee of the Society of Neurological Surgeons "is responsible for accreditation of subspecialty training fellowships and subspecialty certification of fellows in neurosurgery and for development and updating of subspecialty training requirements"; and

WHEREAS, there is increasing juxtaposition of orthopedic fellowship trained spine surgeons and neurosurgery residency trained spine surgeons in communities and medical systems; and
WHEREAS, instances occur where spinal surgery training via an orthopedic spine fellowship is purported to be superior to that incurred in a neurosurgery residency; and
WHEREAS, CAST Certification in Spinal Surgery would obviate the spurious supposition that fellowship training, as acquired by spinal orthopedic surgeons, is necessary for competency and even expertise in spinal surgery; and
WHEREAS, it is the contention of the ABNS and the AANS/CNS Joint Section on Disorders of the Spine and Peripheral Nerves that neurosurgical residency training affords the graduating resident with competency in spinal surgery; and
WHEREAS, the CAST Committee does offer certification to graduating residents (without post-graduate fellowship training) in selected subspecialty fields; and
WHEREAS, many graduating neurosurgical residents have accrued extensive, hands-on, multi-year experience in hundreds of general and complex spinal procedures; and
WHEREAS, the CAST Committee could consider offering certification of orthopedic spine fellowships and/or its trainees, thus evening the spinal surgery "playing field"; therefore
BE IT RESOLVED, that the CSNS requests that its parent bodies recommend that the CAST Committee of the Society of Neurological Surgery offers Spinal Surgery certification to all surgeons graduating from neurosurgical residencies with the requisite experience in the appropriate procedures.

RESOLUTION IV (CANS position: Support)
Title: Corps of Retired Neurological Surgeons (CORNS)
Submitted by: Randy Smith, MD, Ken Blumenfeld, MD and CANS
WHEREAS, retired neurosurgeons carry with them a trove of information, experience and possessions which could prove valuable to the neurosurgical community; and
WHEREAS, retired neurosurgeons may wish to assist their colleagues still in active practice; and
WHEREAS, actively practicing neurosurgeons may wish to engage the retired neurosurgeon, with or without compensation, to assist in handling issues already solved or managed by the retiree; therefore
BE IT RESOLVED, that the CSNS create a Web site forum entitled "CORNS" on which retired neurosurgeons may register indicating their willingness to review requests by active neurosurgeons for assistance or information and respond to the requests that interest them; and
BE IT FURTHER RESOLVED, that the CORNS forum harbor an area in which the retired neurosurgeon can list professional possessions available for purchase or donation; and
BE IT FURTHER RESOLVED, that the CSNS request that the AANS and CNS assist in publicizing the existence of CORNS through their various publications.

RESOLUTION V (CANS position: Support)
Title: Evaluation of Workplace Violence in Neurosurgery Practices
Submitted by: Jeremy Phelps, Josh Rosenow, and Darlene Lobel, on behalf of the CNS Caucus, and Greg Smith
WHEREAS, episodes of workplace violence against medical providers are a daily occurrence across the country, and, while the majority of these events are verbal, an increasing proportion of the events constitute assault, battery, stalking, and sexual harassment1; and
WHEREAS, neurosurgeons often deal with complex, difficult, and life altering conditions and face additional pressures from outside forces potentially limit time spent with patients and patient access to procedures and treatments, which can ultimately lead increased patient frustration, dissatisfaction, and anger, all acknowledged risk factors for violence2; therefore

BE IT RESOLVED, that the CSNS study the prevalence and potential impact of workplace violence within neurosurgery as well as strategies to decrease and mitigate such events; and
BE IT FURTHER RESOLVED that the CSNS develop educational materials addressing these issues for dissemination to neurosurgeons and their practices under the direction of the parent organizations.

RESOLUTION VI (CANS position: Support)
Title: Barriers to access to neurosurgical care as consequence of narrow insurance network development
Submitted by: Brett Youngerman, Rimal Dossani, Steven Tenny, Cara Sedney, Lou Tumialan, Darlene A. Lobel, Clemens M. Schirmer, on behalf of the Medical Practices Committee and the Coding and Reimbursement Committee
WHEREAS, a 2015 JAMA study assessing access to outpatient nonsurgical subspecialist care in federal marketplace plans under the Affordable Care Act demonstrated significant lack of in network specialty coverage resulting in high out-of-network costs to the patient; and
WHEREAS, "narrow networks" are commercial insurance provider networks that excessively restrict patient choice or access to quality care in terms of participating physicians or hospitals in a geographic area;1 and
WHEREAS, there is overwhelming evidence that insurance policies sold in the Affordable Care Act healthcare exchanges are narrower than comparable plans sold outside the exchanges;2 and
WHEREAS, patients may have less than a 30 percent chance of securing an appointment with any particular chosen provider in a network; 4and
WHEREAS, many states have no standards for network adequacy and those that do have likely overestimated access in their exchanges;4 and
WHEREAS, insurers often do not maintain accurate lists of providers, including whether a provider is accepting new patients;3 and
WHEREAS, inaccurate provider directories are challenging for patients attempting to access providers and they make it difficult for regulators to assess network adequacy;3therefore
BE IT RESOLVED, that the CSNS study possible barriers to patient access that may arise as a consequence of health insurance provider networks that limit which physicians may participate in such networks (also referred to as "narrow" or "select" networks) and communicate the results to the membership; and
BE IT FURTHER RESOLVED, that the Council of State Neurosurgical Societies ask the AANS and CNS to direct the Washington Committee to advocate for and support existing efforts for federal regulations requiring all insurance providers and exchanges to: (i) establish and publish quantitative standards for network adequacy including provision for what each exchange considers adequate access to specialty physicians; (ii) mandate that insurance carriers in the exchanges maintain electronic provider directories; (iii) have a minimum frequency with which insurance carriers must update their provider directories including contact information for hospitals and physicians by specialty; (iv) establish oversight procedures and penalties for noncompliance with updating provider directories.

RESOLUTION VII (CANS position: Support)
Title: Healthcare system negotiated vendor contracts
Submitted by: Pratik Rohatgi MD, Sherry Taylor MD PhD, on behalf of the Medical Director's Committee
WHEREAS, healthcare systems are now seeking to reduce operating costs by selecting vendors through competitive bidding; and
WHEREAS, neurosurgeons may be faced with having to use equipment negotiated by the healthcare system against their preferences; therefore

BE IT RESOLVED, that the CSNS survey neurosurgeons to understand if such pricing is performed in their practice environment, in what areas of practice are competitive bidding used, if they have been involved in the vendor selection process, and if their preferred vendor was not selected what was the recourse; and
BE IT FURTHER RESOLVED, that the Medical Director's committee work with the Medical Legal committee to develop a set of questions each neurosurgeon should ask of their hospital administration during the negotiation process to understand their liability when using mandated vendor equipment.

RESOLUTION VIII (CANS position: Neutral—await debate)
Title: Collaboration Among Comprehensive Stroke Centers
Submitted by: Sabih Effendi MD, Peter Kan MD, Ian McCutcheon MD COMMITTEES: Neurotrauma and Emergency Neurosurgery Committee
WHEREAS, emergent neuro-endovascular procedures for stroke (ie intra-arterial thrombolysis and thrombectomy) have become the standard of care; and
WHEREAS, a multitude of comprehensive stroke centers have become established throughout the nation; and
WHEREAS, there is no collaborative effort between comprehensive stroke centers to analyze the socioeconomic burden on physicians/hospitals/medicine, evaluate acute stroke care, coordinate patient care and logistics, collectively gather outcome data, and collectively perform research on existing and new devices and treatment algorithms; and
WHEREAS, this lack of collaboration results in inefficiencies that could be avoided, increased costs throughout a given state or region due to duplication of efforts, and less-than-ideal patient outcomes when clinical pitfalls are not readily shared, especially with ever-expanding arsenal of new medicines, devices, and techniques; therefore
BE IT RESOLVED, that the CSNS, through appropriate committees, work to create an initial model for this type of collaborative system in a single state, to serve as proof of principle and to document obstacles and ways of expediting the process so that other states may more efficiently establish these same systems in other parts of the country; and
BE IT FURTHER RESOLVED, that the CSNS utilize its state advocacy and educational mechanisms to encourage state neurosurgical societies to develop these collaborative systems; and
BE IT FURTHER RESOLVED, that the CSNS support the use of the knowledge and tools gained from the single state collaborative system, to help develop collaborative systems among comprehensive stroke centers throughout the entire USA.

RESOLUTION IX (CANS position: Neutral—await debate)
Title: Staggering Fellowship Cycle to Improve Integration and Continuity
Submitted by: Nitin Agarwal, Jeffrey Mullin, Anand Veeravagu, Justin Singer, Lola Chambless, Clemens M. Schirmer, on behalf of the Young Neurosurgeons Representative Section
WHEREAS, the CSNS Socioeconomic Fellowship offers an active avenue for residents to gain competence in and understanding on the full spectrum of socioeconomic issues relevant to the practice of neurosurgery; and
WHEREAS, significant time and experience is required for new fellows to understand the architecture of the CSNS and its respective committees in order to contribute to and benefit from their fellowship experience; and
WHEREAS, uniform feedback from outgoing fellows suggest that the on-boarding time is significant, protracted, and not rigorous; and
WHEREAS, ongoing mentorship is vital to the success and integration of new fellows but the lack of institutional memory within the fellowship class is problematic; and

WHEREAS, the transition from one fellow to another would benefit greatly from continuity, experience, and organization; therefore
BE IT RESOLVED, that the CSNS explore options how to divide the fellowship class in two halves with staggered start dates but consider two quadrants beginning in the spring and two quadrants beginning in the fall, each continuing to run for a full year; and
BE IT FURTHER RESOLVED, that the CSNS modify the timeline of the resident fellowship to achieve a staggered start-date with half of the fellowship class starting in the spring and half in the fall of each year; and
BE IT FURTHER RESOLVED, that the application and selection process stay unchanged in order to avoid any increased administrative burden on the CSNS.

RESOLUTION X (CANS position: Opposed)
Title: Patient Satisfaction with Neurosurgical Care and Health Care Resource Utilization.
Submitted by: Owoicho Adogwa MD. M.P.H, Joseph Cheng MD. M.S, Karin Swartz MD
WHEREAS, patient satisfaction is increasing being used as a proxy for healthcare quality (Improved outcomes, reduced healthcare resource utilization and costs); and
WHEREAS, patient satisfaction is linked to physician and hospital reimbursement; therefore
BE IT RESOLVED, that the CSNS study the issues regarding patient satisfaction and healthcare resource utilization and a report of these findings will be made to the CSNS membership; and
BE IT FURTHER RESOLVED, that the CSNS collaborates with N2QOD to determine if the relevant data points are available to aid the CSNS and our parent organizations accurately assess the relationship between patient satisfaction and healthcare resource utilization.

RESOLUTION XI (CANS position: Support)
Title: Recognizing the importance of "co-surgeons" in neurosurgery
Submitted by: Cati Miller, Ann Parr, Cara Sedney, Darlene Lobel
WHEREAS, an association between longer surgical duration and patient morbidity has been demonstrated; and
WHEREAS, multiple studies in several surgical fields, including neurosurgery, have shown that a "cosurgeon" or "two surgeon" approach in which two attending physicians work simultaneously has improved patient outcomes by decreasing operative time, blood loss, and infection; and
WHEREAS, there are no standard or accepted neurosurgical recommendations regarding the "cosurgeon" or "two surgeon" approach; and
WHEREAS, the term "co-surgeon" currently defines two or more surgeons, where the skills of both surgeons are necessary to perform distinct parts of a specific operative procedure and is coded as a modifier to allow for partial payment to each surgeon; and
WHEREAS, insurance companies are increasingly reluctant to accept co-surgery claims without exhaustive and repetitive documentation; therefore
BE IT RESOLVED, that the CSNS study current neurosurgical practices for frequency of "cosurgeons", additional outcomes for those who participate in this "co-surgeon" approach, barriers or limitations for implementation of "co-surgeon" approach, and current insurance company policies on "cosurgeons"; and
BE IT FURTHER RESOLVED, that the CSNS develop, publish, and distribute a white paper recognizing the importance of "co-surgeons" to provide more information on this issue, and that could also be utilized to facilitate insurance claims. ❖

CANS MISSION STATEMENT

'To Advocate for the Practice of California Neurosurgery Benefitting our Patients and Profession'

Brain Waves

Deborah C. Henry, MD, Associate Editor

On the American Airlines flight home from Europe this month, I watched "Miracles from Heaven". It is the dramatization of a true story about a young girl, Annabel, diagnosed with chronic intestinal pseudo-obstruction, a motility disorder where either the enteric nervous system or the muscles of the gut just do not move food forward. Patients with this condition present with vomiting, bloating, and severe abdominal pain. Because there is no obstruction, this condition may take awhile to diagnose. There is limited treatment and no cure, and patients may die from malnutrition. If you want to see the movie and don't like spoilers, read no further. Annabel suffers with this disorder for four years until, at the age of nine, she falls 30 feet into hollowed out tree and loses consciousness. She has a near-death experience where she is told she must return, but it will be without pain. When she is rescued by firefighters five hours later, CT scans show no intracranial injury or broken bones. And miraculously, her pseudo-obstruction is cured.

What was most moving for me in this dramatization was the part faith played in sustaining the family. I saw this first hand early in my practice. Around the same time, I treated two teenage girls, one with a medulloblastoma and the other with a spinal cord ependymoma. My medulloblastoma patient complained for months of early morning headaches with nausea and vomiting. Like Annabel in the movie, diagnosis was delayed as doctors for my patient worked her up for gastrointestinal problems. A week before she presented in the emergency room, she was seen in a clinic where she even commented to the doctor that she wondered if she had a brain tumor. Unable to tolerate her condition, she showed up in the emergency room and received the mandatory CT that revealed the culprit of her symptoms, obstructive hydrocephalus. If someone had looked into her eyes during the course of her work-up, they would have seen the florid papilledema.

My patient with the spinal cord ependymoma presented to a clinic with back pain on Monday, weakness on Wednesday, and total paraplegia by Friday morning. Her oncologist did her complete staging first with a myriad of scans and tests, then called me Friday evening to do her emergency surgery to remove the thoracic tumor after radiation oncology declined

to treat her. She was fortunate to make a complete recovery of her paralysis, though months later she presented with a temporal lobe ependymoma.

What was unique about these parallel conditions was the degree family and faith buoyed both patient and parents. My medulloblastoma patient's parents were divorced and because of the delay in diagnosis, were skeptical of all treatments. They had lost faith in each other and in the medical team. We had to work through the despair at each corner of her treatment. My ependymoma parents surrounded their daughter with support, and faith carried them though the surgery and chemotherapy with optimism and hope. The message of the movie shines though in these families, that when you have lost all, including hope, it is often faith that is left to sustain you. ❖

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!

Transitions in Neurosurgery

John Bonner, MD, Associate Editor

Recently, I came across an article written for the Chicago Medical Society by Jerrold B. Leikin, M.D., a clinical physician and professor from Illinois. In the article, Dr. Leikin opines that physician employees and executives should follow what he calls some "basic principles." While the piece was originally written for clinical physicians in Illinois, I think that the principles Dr. Leikin offers are equally applicable to clinical physicians in California. With Dr. Leikin's permission, I have reprinted the article below. It was entitled "Employed Physicians' Bill of Rights".

"Over the past several years, we have witnessed a gradual evolution of the physician's scope of practice. Physicians have been transformed from decision-makers to salaried technicians with a job description that includes data entry, coding/billing, transcribing, medical guideline implementation, and patient care coordination with the overall goal of revenue enhancement. In short, physicians have become mid-level employees (revenue generators) under the direction of corporate executives (expense and revenue managers).

This evolving relationship is modeled on the hotel/hospitality management industry from which the fundamental principles of hospital administration originate (short-term occupancy rates, centralized decision-making, customer relations and structured pricing system). With over a 3000% rise in the number of hospital executives since 1970, corresponding to a 2300% increase in health care spending per capita (as opposed to doubling of the physician workforce over this period), perhaps this shift was inevitable. Further, with ongoing consolidation in health care, which already has led to a majority of physicians becoming employees, practice management uncertainty and disputes are likely to grow while physician career options narrow. As a result, individual contract negotiations have become quite one-sided and problematic. The framework of community-level patient care integration requires a degree of physician independence not usually encountered in the traditional employer-employee relationship.

It is clear that if an employed physician must adapt to the corporate mentality, then the corporate mentality must have to adapt to a career physician's scope of work. Towards this end, the relationship of the executive to the employed physician clinician would benefit from specific fundamental guidelines. The adoption of basic principles form a basis of mutual professional respect and continued quality of patient care. These principles can serve as a "Bill of Rights" for employed physicians.

Rights and Responsibilities

- *Physicians' compensation should be based on the totality of their activities for the organization. This should include educational endeavors (including preparation), committee participation, student/resident activities, and*

administrative responsibilities. Physician compensation should not be tied directly to outcomes of strategic revenue initiatives by the corporation.

- *Physicians should have academic freedom, an essential foundation for clinical research. There must be no censorship by any organization.*
- *Physicians should not be solely responsible for data entry and management (including coding) within complex EMR systems. If the term "user error" is constantly used, it is an organizational issue not a medical issue.*
- *Evaluation of clinical activity requires the peer review process and should be judged only by clinicians, not corporate executives. Only clinicians in a peer review context can judge a colleague's decision-making and documentation approach.*
- *Physician activities performed outside of defined employment boundaries are the sole prerogative of the individual physician and are not to be interfered with unless they directly conflict with or increase the risk of the organization.*
- *Physician conflict of interest disclosures should be limited to physician activities that directly affect the organization and should be disclosed only to entities that directly reimburse physicians during their time of employment.*
- *Restrictive covenants should be limited to only physicians with partnership stakes in the organization and should not apply to salary-based physicians.*
- *Resources should be appropriately allocated by the organization for CME, as defined by state licensure guidelines.*
- *Employed physicians have the right to collective bargaining as outlined in the National Labor Relations Act of 1935 (also known as the Wagner Act).*
- *Acknowledgement that the patient-physician relationship is a sacred trust that cannot be quantified through nebulous metrics such as time, relative value units and simple quality measures. It is the physician who takes the Hippocratic Oath, and no employment scenario should conflict with that oath. The AMA's Fundamental Elements of the Patient Physician Relationship should guide all organizations.*

Good Medicine is Good Business

An environment of mutual respect must exist among all physicians and executives. Currently, the physician as employee model contradicts the accepted doctrine in the business setting: higher degrees of education are commensurate with greater responsibilities. Physician employee rights are limited in an industry when employment decisions are often made for seemingly non-medical reasons. Local, state, and national medical societies should take the lead by adopting these principles."

Postscript: This opinion piece is based on a resolution introduced to the Illinois State Medical Society House of Delegates in April, 2016. ❖

Tidbits from the Editor

Neurosurgery needs your help

Katie Orrico, of the AANS/CNS Washington Committee, recently sent out this request:
As you know, the Open Payments (Physician Sunshine Act) program requires manufacturers of drugs, medical devices and biologicals to report certain payments and items of value given to physicians and teaching hospitals. Each year, physicians have an opportunity to review data reported about them during a 45-day review and dispute period. Following this review period, the Centers for Medicare & Medicaid Services (CMS) make this information available to the public.

On July 15, 2016, CMS released the CY 2017 Medicare Physician Fee Schedule proposed rule. In that document, CMS asked for feedback from stakeholders about the Open Payments program because the agency is considering whether or not to make changes to these rules in the future. So we may respond appropriately, the AANS and CNS would like to gain insight into neurosurgeons' experience with the program.

To that end, the Washington Committee is conducting a brief survey. Please help by **clicking here** to complete this brief survey.

Click here for more information on the Open Payments program. To look up Open Payments data by physician name, click here.

Technology is killing docs

Jessica Davis of *Healthcare IT News* has penned the following regarding a Medical Group Management Association Cost and Revenue report:

MGMA President and CEO Halee Fischer-Wright is concerned that "far too much of a practice's IT investment is tied directly to complying with the ever-increasing number of federal requirements."

Physician-owned multi-specialty practices spent over $32,5000 per each full-time physician on IT equipment, staff, maintenance and other similar expenses in 2015, according to data from the 2016 Medical Group Management Association Cost and Revenue Report.

Technology costs for these practices have increased 40 percent from 2009 to 2015, with the largest IT expense increase occurring in 2010 and 2011, according to the report. This may reflect the 2009 HITECH Act that incentivized providers to use certified electronic health records.

But the incentives considerably waned in 2011, which placed the burden of maintaining EHRs on providers.

"While technology plays a crucial role in helping healthcare organizations evolve to provide higher-quality, value-based care, this transition is becoming increasingly expensive," said MGMA President and CEO Halee Fischer-Wright in a statement.

"We remain concerned that far too much of a practice's IT investment is tied directly to complying with the ever-increasing number of federal requirements, rather than to providing better patient care," she added.

IT expenses have increased about 47 percent per full-time physician, with a steady year-over-year uptick, which suggests larger IT investments haven't significantly improved practice efficiency, according to the report. Other IT trends, like online patient portals have contributed to the excessive costs.

Operating expenses for physician-owned multi-specialty practices have increased by about 15 percent per full-time physician in 2015, compared to the more than 10 percent increase in revenue for practices during the same time period, the report found.

"Unless we see significant changes in the final MIPS/APM rule, practice IT costs will continue to rise without a corresponding improvement in the care delivery process," said Fischer-Wright.

MBC looking for neurosurgical reviewers

The Medical Board of California is seeking physicians to serve as Expert Reviewers in disciplinary cases. As of July 2016, expert reviewers are needed in **Neurological Surgery.**

Neurosurgeons interested in serving as expert reviewers for their specialty can find out more information and apply at the Medical Board website (http://www.mbc.ca.gov/Enforcement/Expert_Reviewer/).

Participating physicians are reimbursed $150 per hour for conducting case reviews and oral competency exams, $200 an hour for providing expert testimony, and usual and customary fees for physical or psychiatric exams. Reviewers have to have a valid CA medical license and be in active practice.

Work Comp shift to RBRVS cuts specialist fees

The California Workers' Compensation Institute has released a study they say demonstrates that the use of the Resource-Based Relative Value Scale medical fee schedule has had the intended effect of shifting medical dollars toward primary care doctors and away from specialists. The CWCI study also found a 14.3% decrease in payments for all services covered by the Official Medical Fee Schedule from 2013 to 2015. The RBRVS fee schedule took effect in 2014.

CWCI further analyzed medical payments by category of service. Payments were up 8.3% for evaluation and management services, and by 12.7% for physical medicine, which includes physical therapy, chiropractic, osteopathic and acupuncture services.

But in six other categories, medical payments dropped from 2013 to 2015. The greatest decrease in spending, 44.9%, was seen in the medicine category, which includes treatment of cardiovascular conditions, nerve and muscle testing, psychiatric testing and psychotherapy, ophthalmology, and physician-administered drugs and biologicals.

Spending was down 34.7% for radiology, 29% for anesthesia, 21.6% for pathology, and 18.4% for surgery.

CA Work Comp pain and opioid treatment guidelines now in effect

The California State Division of Workers' Compensation's (DWC) new guidelines on the treatment of chronic pain and opioid prescribing for injured workers are now in effect. The guidelines include best practices and universal precautions for safe and effective prescribing of opioids for pain due to a work related injury.
According to DWC, the new guidelines encourage safer prescribing of opioid pain relievers with the primary goal of significantly reducing the rate of opioid-related adverse events and substance misuse and abuse.

The Guidelines can be found at http://www.dir.ca.gov/dwc/MTUS/MTUS.html ❖

Thought for the Month:

The easiest way to find something lost around the house is to buy a replacement.

Meetings of Interest for the next 12 months:

Western Neurosurgical Society: Annual Meeting, September 9-12, 2016, Carlsbad, CA
CSNS Meeting, September 23-24, 2016, San Diego, CA
Congress of Neurological Surgeons: Annual Meeting, September 24-28, 2016, San Diego, CA
North American Spine Society: Annual Meeting, October 26-29, 2016, Boston, MA
California Neurology Society: Annual Meeting, November 11-13, 2016, Santa Barbara, CA
Cervical Spine Research Society: Annual Meeting, Dec 1-3, 2016, Toronto, Ontario, Canada
AANS/CNS Joint Pediatric NS Section: December 5-8, 2016, Orlando, Florida.

CANS, Annual Meeting, January 13-15, 2017; Mark Hopkins Hotel, San Francisco, CA

North American Neuromodulation Society: Ann. Meet., January 19-22, 2017, Las Vegas, NV
AANS/CNS Joint Cerebrovascular Section: Ann. Meet., February 20-21, 2017, Houston, TX
Southern Neurosurgical Society: Annual Meeting, February 22-25, 2017, Orlando, FL
AANS/CNS Joint Spine Section: Annual Meeting, March 8-11, 2017, Las Vegas, NV
AANS/CNS Joint Pain Section Bi-Annual Meeting, 2017 TBA
CSNS Meeting, April 21-22, 2017, Los Angeles, CA
AANS: Annual Meeting, April 22-26, 2017, Los Angeles, CA
Neurosurgical Society of America: Annual Meeting, 2017, TBA
Rocky Mountain Neurosurgical Society: Ann. Meeting, 2017, TBA
New England Neurosurgical Society: Annual Meeting, 2017, 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. Praveen Mummaneni 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