



NEWSLETTER SPONSOR

Cooperative of American Physicians, Inc.

- Providing medical malpractice coverage to private practice neurosurgeons through its Mutual Protection Trust since 1977
• Covering nearly 12,000 select California physicians; Group coverage available
• Consistently low rates; Mutual Protection Trust A.M. Best A+ (Superior) rating
• Physician owned and governed
• Local support offices in Los Angeles, San Diego, Palo Alto, Sacramento and Orange County

Attention Neurosurgeons-Message from the President

Praveen Mummaneni, MD, President

The California Association of Neurological Surgeons Annual Meeting is scheduled for January 13th-15th, 2017 at the Intercontinental Mark Hopkins in San Francisco, CA! Our President, Dr. Praveen Mummaneni from UCSF, has put together an engaging program!

PLEASE SAVE THE DATE!

We have secured a fabulous rate of \$219 for the hotel and you can start booking now! Visit www.cans1.org and click on the CANS annual meeting bullet in the calendar!

Draft Agenda is below:

The Evolution of California Neurosurgery Training and Practice

SCHEDULE of EVENTS January 13-15, 2017

FRIDAY

1-4pm CANS Board Meeting (open to all members-buffet lunch before)

6:30 - 8:30 Opening Night Reception

SATURDAY

6:30-7:30 Continental Breakfast- Please visit

EXHIBITS

7:30-7:35 Praveen Mummaneni, M.D. President's Report

7:35-7:40 Mark Linskey, M.D. Secretary's Report Voting:

BOD/Nominating Committee

7:40-7:45 Marshall Rosario, M.D. Treasurer's Report

Session 1: How far can we stretch ourselves?

8:00-8:20 Dr. Michael Lawton - overlapping intracranial surgery, safety and efficacy

INSIDE THIS ISSUE:

ATTN Neurosurgeons-President's Message- pgs 1- 3

CSNS Mtg w/a G-String - pages 4-6

Brain Waves - page 7

Short Cakes - pages 8-9

Hospital Ownership- page 9

Overhead is killing docs - pages 9-10

Safety in Bigger Numbers - page 10

Work Comp shift... -pages 14-15

CANS President Quoted-page 10-11

CMA Webinar- page 11

Feds Allow a Pick- page 11-12

Another of a Thousand Cuts - page 12-13

Thought of the Month - page 13

EXHIBITORS- page 13

Calendar - page 14

CANS Director - page 15

8:20-8:40 Dr. Michael Wang - overlapping spinal surgery, how to work in urgent cases  
 8:40-9:00 Dr. Bill Caton-How to cover multiple hospitals/ER on call  
 9:00-9:20 Dr. Alan Scarrow - a medical-legal perspective on overlapping surgery  
 9:20-9:40 Dr. Neil Martin – Integrating risk management data in quality improvement initiatives

9:40-10:20 Q&A, Panel Discussion

**10:20-10:50 Break - Please visit exhibits**

**Session 2: Finding My First Job in Neurosurgery**

10:50-11:10 Deborah Henry: career choices in neurosurgery  
 11:10-12:00 Panel Discussion - What I Wish I Knew When I Looked for My First Job - Marc Vanefsky, Ken Blumenfeld, Moustapha Abou-Samra, Langston Holly, Javed Siddiqi, Michael Virk, Omid Hariri, Doris Wang

**12:15 – 1:30 Lunch with Exhibitors at the TOP of the MARK**

**Session 3: Neurosurgery on the hot seat**

1:30-1:50 Dr. Shelly Timmons, Washington CMTE Update  
 1:50-2:10 Dr. Jack Knightly: Building quality into a neurosurgery practice  
 2:10-2:30 Katie Orrico, New Regulations and Planning for the Future  
 2:30-2:50 Dr. Richard Pan (California Legislator): Update on medical practice in California, Legislator's Perspective  
 2:50-3:10 Dr, Dev Gnanadev- Medical ethics-How NOT to lose your California medical license  
 3:10-3:30 Dr. Ann Stroink- CSNS update  
 3:30-3:45 Q/A  
 3:45-4:15 Panel discussion  
 4:15-4:30 Praveen Mummaneni, M.D. Closing Remarks

**SATURDAY BANQUET - Must purchase ticket**

**6:30 PM Public service/Award presentations**

**SUNDAY**

**7:00-7:40 Breakfast/Please visit Exhibits-Sponsored by**

**Session 1 The future of neurosurgical training in California: sponsored by the NREF**

8:00-8:20 Dr. Mitchel Berger – Updates on state of neurosurgery training  
 8:20-8:40 Dr. Nicholas Barbaro – Updates from the RRC on residency training  
 8:40-9:00 Dr. Rick Boop – CAST Updates on fellowship training certification  
 9:00-9:20 Dr. Marvin Bergsneider – CV misrepresentation among neurosurgery resident applicants  
 9:20-9:40 Panel Discussion: Dr. Michael McDermott, Dr. Gary Steinberg  
 Dr. Frank Hsu, Dr. Alex Zouros, Dr. Bob Carter, Dr. Javed Siddiqi

**Session 2: Keynote Lecture**

9:40-10:15 Strategic Planning for Healthcare Reform: Dr. Robert Harbaugh

**10:15 BREAK-PLEASE VISIT EXHIBITS**

10:30-12:00

**Resident/Fellow Presentations Socioeconomic or quality improvement program**

Loma Linda Regional Medical Center  
 University of California, San Diego  
 University of California, San Francisco  
 Cedars-Sinai Medical Center: Lindsay Ross  
 Riverside University Health System  
 University of Southern California  
 University of California, Los Angeles  
 Stanford University

University of California, Davis  
University of California, Irvine  
Desert Regional Medical Center  
**12:00 Award for Resident Presentation**

Sincerely,



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



**EXHIBITORS:** CONTACT Emily for more information!  
[emily@cans1.org](mailto:emily@cans1.org) or 916.457.2267 or [click here!](#)

## Council of State Neurosurgical Societies meeting in San Diego—with a G-string

Randall W. Smith, MD, Editor

CANS fielded a full complement of delegates for the CSNS meeting which is more than most states in the Southwest Quadrant could boast, particularly the large Texas society which only had one delegate show up. The anxiety *du jour* was the plan by CMS to implement a study on G-codes which are a set of post op codes for hospital visits after surgery as well as office visits after surgery. These experimental codes are listed in 10 minute increments so a 15 minute post op visit in hospital would get two Gxxx1 codes. Family conferences would get a G-code as well. The MACRA legislation ordered CMS to run a study using the G-codes on a "representative sample" of docs which CMS has decided includes everyone. Organized medicine, including the AANS/CNS Washington Committee, is striving to get the study limited to a true sample of docs rather than us all and has lined up 112 national legislators demanding CMS follow the "representative sample" concept. One can potentially imagine the howling from those chosen to be a true "representative sample" and CMS apparently decided that since there will be howling, it might as well come from everyone.

Of course the ultimate CMS goal is to cut our fees since they think that the money we get for the global 90-day follow-up fee, currently included in the RVU's for a surgery, is too generous and we really aren't doing enough to earn that money. Although that might be true for the follow-up necessary for a single-level ACD&F done as an outpatient, home the same day and 3 routine office follow-up visits within 90 days, it certainly would not be true for the intense follow-up required for a SAH, aneurysm clipping or coiling followed by vasospasm and blood induced hydrocephalus requiring shunting, a 10-day ICU stay plus a week on the ward and so on.

There is no carrot in this game but in the CMS's usual pejorative style, they will cut 5% off your surgical fee if you don't file the G-codes. Since they can't know what you will do on a 90-day global surgery until 90 days after the surgery, that must mean you won't get paid for three months.

This writer continues to suspect that smart neurosurgeons in their 50's will simply decline to play the MIPS game and the G-code game, take the % hits and get out of Medicare ASAP. Since the MBA types running academic medical care and Kaiser can't afford not to play the Feds game, that only leaves private practice neurosurgeons to carry any defiant banner.

Below are the results of the deliberations of the CSNS on the 11 resolutions they considered:

### **RESOLUTION I (CSNS action: Referred to Executive Committee for further study)**

Title: **A Neurosurgical Call for Mandatory Automobile Ignition-Seatbelt Interlock**

**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 (CSNS action: Rejected)**

Title: **A Ban on Personal Electronic Device Engagement in CSNS Plenary Sessions**

**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 (Rejected)**

Title: **CAST Certification in Spinal Surgery for Graduating Neurosurgical Residents**

**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 (Adopted)**

Title: **Corps of Retired Neurological Surgeons**

**BE IT RESOLVED**, that the CSNS create a Web site forum 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 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 this forum through their various publications.

**RESOLUTION V (Adopted)**

Title: **Evaluation of Workplace Violence in Neurosurgery Practices**

**BE IT RESOLVED**, that the CSNS study the prevalence and potential impact of workplace violence towards practitioners 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 (Adopted)**

Title: **Barriers to access to neurosurgical care as consequence of narrow insurance network development**

**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 (Adopted)**

Title: **Healthcare system negotiated vendor contracts**

**BE IT RESOLVED**, that the CSNS survey neurosurgeons to understand if restricted vendor contracting is performed in their practice environment, in what areas of practice are competitive bidding used, if the



physicians have been involved in the vendor selection process, and if there was any recourse if the physicians' preferred vendor was not selected; and

**BE IT FURTHER RESOLVED**, that the Medical Director's Representational Section work with the Medical Legal committee understand the liability implications when using mandated vendor equipment.

**RESOLUTION VIII (Referred to EC for further study)**

**Title: Collaboration Among Comprehensive Stroke Centers**

**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 (Adopted)**

**Title: Staggering Fellowship Cycle to Improve Integration and Continuity**

**BE IT RESOLVED**, that the CSNS explore the implications of CSNS modifying 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 as well as any other options for improving continuity between fellowship classes.

**RESOLUTION X (Referred to EC for further study)**

**Title: Patient Satisfaction with Neurosurgical Care and Health Care Resource Utilization.**

**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 (Referred to EC for further study)**

**Title: Recognizing the importance of "co-surgeons" in neurosurgery**

**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

A few months ago, I read an editorial in the LA Times on eggs. It turns out that eggs in the United States need to be washed and scrubbed clean before being packaged and delivered to markets for purchase. The scrubbed eggs have their outer shells removed and hence are more susceptible to disease. In Europe, the eggs are packaged without these sanitary attempts and often with the hay they were plucked from still hanging from the shell. The outer coating remains intact, the eggs are cheaper, and infections are less. We've been taught that the culprit to avoid is Salmonella. It turns out that most of the chickens in the United States are inoculated against Salmonella, making the disease a rarity. Interestingly, the use of antimicrobial soaps on our own skin disrupts the epidermal protection similar to what happens to the eggs. About half of our skin's epidermal barrier that is removed with surgical scrubbing will repopulate in 6 hours, but it takes 6 days for the epidermis to completely heal (MMWR 2002).

A few weeks ago, the FDA banned 19 active ingredients of hand soap including triclosan and triclocarban in the hopes of reducing drug resistant bacteria. The Centers for Disease Control website states that they are aware of this ban, yet also states on their website that alcohol based hand sanitizers "kill germs quickly", and "there is no chance for the germs to adapt or develop resistance."  
(<http://www.cdc.gov/handhygiene/science/index.html>).

In 2002 in its publication Morbidity and Mortality Weekly Report, the CDC reviews the history of hand washing and its current guideline for the healthcare worker. Using an antiseptic for hand washing probably began in the early 1800s with the decrease of puerperal fever when healthcare workers washed their hands with chlorine solutions prior to the delivery of babies. In 1961, the US Public Health Service felt that hand washing with soap and water for 1-2 minutes was superior to any antiseptic solutions. In 1995, the Healthcare Infection Control Practices Advisory Committee (HICPAC) advocated either antiseptic soap or a waterless antiseptic for workers travelling between infected patients.

Alcohol cleansers, applied in sufficient amounts, are more germicidal than soap and water and maybe more so than either chlorhexidine or povidone-iodine. They are however flammable with a flashpoint between 21-24°C. Chlorhexidine is slower to action than alcohols, is ototoxic when used in ear surgery, and it should not come in contact with the brain or meninges. Its germicidal effects last longer than does alcohol. The old standard, iodophors, may be more effective in dilute concentrations as this increases the amount of free iodine; however, the more diluted the iodophor, the more of a skin irritant it becomes. Triclosan, the substance just banned in hand soaps by the FDA, was developed in the 1960s and is often bacteriostatic and not bactericidal.

How about surgical hand washing? US guidelines are that the antimicrobial product should substantially reduce bacteria on the skin, be non-irritating, have a broad spectrum, and be quick and long-lasting. Alcohol products combined with a second agent are most effective followed by chlorhexidine, iodophors, triclosan, and soap.

The first time I scrubbed my hands as a third year medical student, I was partaking in a ritual that I thought would never change. I carefully unwrapped the scrub brush with dry hands, cleaned under my nails with the red pick, applied the orange-brown Betadine soap and scrubbed by the clock for 10 minutes. The surgery Chief was adamant that the scrub be timed and not short-changed. Today, studies have shown that a 2-3 minute scrub reduces bacteria by the same concentration as that 10-minute scrub. If one applies an alcohol-based product instead, even the scrub brush becomes obsolete. The surgical prep is a work in progress in its effects to control bacteria and save the skin of the health care worker. Perhaps some day, the eggs will be as fortunate. ❖



**DO YOU KNOW A NEUROSURGEON NEW TO CALIFORNIA?  
TELL THEM ABOUT CANS AND DIRECT THEM TO THE CANS WEBSITE:  
[WWW.CANS1.ORG](http://www.cans1.org)! THERE IS A MEMBERSHIP APPLICATION ON THE SITE!**

## Tidbits from the Editor

### SHORT-TAKES

#### **1. HHS' ONC releases updated guide on buying EHR systems**

The HHS' Office of the National Coordinator for Health Information Technology has released an updated [guide](#) for hospitals and physicians seeking to buy new EHR systems entitled, "EHR Contracts Untangled: Selecting Wisely, Negotiating Terms and Understanding the Fine Print." Elise Anthony, the policy director of the office, said, "The one we did in 2013 was indicative of the time that we're at. There's a need for providers to have more information about contracts. You'll see this (version) is much more detailed."

#### **2. Brain Trauma Foundation's Guidelines for the Management of Severe Traumatic Brain Injury**

On September 20th, Neurosurgery published ahead of print [Brain Trauma Foundation's Guidelines for the Management of Severe Traumatic Brain Injury, Fourth Edition executive summary](#). The summary contains links to the comprehensive guideline document which can be located at <https://www.braintrauma.org/coma/guidelines>. The summary will appear in the January 2017 issue of Neurosurgery but is available online now and is free to all readers.



### 3. The Gov strikes twice.

California Governor Jerry Brown has signed two bills affecting we docs still reeling from MACRA and MIPS. The first bill, AB72 by Assemblyman Rob Bonta of Alameda, prohibits billing patients at usual and customary rates for services provided by a doc not in the patient's provider network, the so-called "surprise bill". From now on, the out of network doc can only bill at the insurer's contracted rate or 125% of the Medicare rate, whichever is higher. The second signed bill mandates that all docs consult the CURES database before prescribing opioids.

The new law, SB482 by Sen. Ricardo Lara, D-Bell Gardens, requires doctors and nurses to check the database for signs of abuse when initially prescribing narcotic painkillers like OxyContin, Vicodin and Percocet, as well as steroids, sleep aids and psychiatric medications. They then have to revisit the database every four months for as long as the drug regimen is continued. The requirement will take effect six months after the California Department of Justice certifies it is prepared to handle increased use of the program according to the CMA but other information suggests the requirement will commence on January 1<sup>st</sup>, 2017.

SB 482 contains several exemptions that will allow doctors in a hospital emergency department to prescribe up to seven days of a controlled substances without consulting with CURES. Similarly, doctors would not have to check with CURES before prescribing a five-day supply of drugs that cannot be refilled. Providers would not have to check the database for controlled substances provided to patients receiving hospice care, or who have been admitted to a licensed clinic or hospital.

### Hospital ownership of medical practices balloons

Maria Castellucci of *Modern Healthcare* notes that hospital ownership of physician practices has increased by 86% in the last three years. The analysis, conducted by healthcare consulting firm Avalere Health and the not-for-profit Physicians Advocacy Institute, found that from 2012 to 2015, hospitals acquired 31,000 physician practices in the U.S. In 2012, about one in seven physician practices were owned by a hospital. In mid-2015, one in four medical practices, or 67,000 practices, were owned by hospitals.

The Physicians Advocacy Group describes its mission as advancing "fair and transparent payment policies and contractual practices by payers." Its board is largely composed of current and former leaders of state medical societies, and its recent causes include opposing the proposed mega-deals among health insurers and Medicare's plans to overhaul the way Part B pays providers for administering drugs.

The report also found that in the same three-year period, physicians employed by hospitals increased by 50%. In 2015, about 140,000 physicians were employed by hospitals or systems, a rise from the 95,000 physicians who were employed by hospitals in 2012. Overall, about 38% of physicians in the U.S. are employed by a hospital or system, according to the report.

### Overhead is killing docs

Jessica Davis of *Healthcare IT News* has penned the following:

The 2016 MGMA Cost and Revenue Report found technology costs have increased 40 percent from 2009 to 2015, corresponding with the 2009 HITECH Act.

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.

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.

MGMA President and CEO Halee Fischer-Wright said 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.

## Safety in bigger numbers

Jeff Lagasse, Associate Editor of *Healthcare Finance*, writes that a new analysis by Health Affairs shows that physicians continue to shift from working at smaller to larger group practices, with primary care physicians leading this trend. Using information from Medicare's Physician Compare data set, authors David Muhlestein and Nathan Smith examined the rate of U.S. physician consolidation from smaller to larger group practices from June 2013 to December 2015.

The number of physicians in groups of nine or fewer dropped from 40.1 percent in 2013 to 35.3 percent in 2015, while those in groups of 100 or more increased from 29.6 percent to 35.1 percent during that time.

The greatest changes occurred in the smallest and largest group sizes. For example, in June 2013, 22.5 percent of physicians were in the smallest group size (one to two physicians), and 17.6 percent were in the next smallest group size (three to nine). In December 2015 the number of physicians in each group size had dropped to 19.8 percent and 15.5 percent respectively.

By contrast, in June 2013, 12.6 percent of physicians were in the largest group size (500 or more physicians), and 17 percent were in the next largest group (100-499). Those numbers had grown to 15.4 percent and 19.7 percent, respectively, by December 2015.

### **CANS President quoted in No on Prop 61 news**

The No on Prop 61 campaign announced today that [more than 130 groups](#) have come out in strong opposition to the measure. New groups opposing Prop 61 include influential physicians and patient advocacy organizations such as the California Association of Neurological Surgeons, California Academy of Eye Physicians and Surgeons, California Urological Association and the Medical Oncology Association of Southern California.

“We treat Californians with extremely grave neurological conditions and patients who cannot afford to wait for needed medications,” said **Dr. Praveen Mummaneni, President, California Association of Neurological Surgeons**. “We oppose Prop 61 because it imposes new bureaucratic hurdles that will interfere with some patients getting the medicines they need.”

These groups join the Veterans of Foreign Wars, Department of California; Vietnam Veterans of America, California State Council; California Medical Association; California Taxpayers Association; State Building & Construction Trades Council of California and other veterans, patient advocacy, labor, business, taxpayer, civil rights and seniors groups also opposed.

The measure would impose unworkable contracting requirements for some state prescription drug purchases based on prices paid by the U.S. Department of Veterans Affairs (VA). Independent experts warn the measure could increase state prescription drug costs, while reducing patient access to medicines.

The controversial author and promoter of Prop 61 - who is president of an organization that brought in more than \$1 billion last year selling prescription drugs and operating HMOs - exempted his own organization from having to comply with the measure.

The California Public Employee Retirement System (CalPERS), the nonpartisan Legislative Analyst's Office (LAO), and HIV and hepatitis C advocacy groups have raised significant concerns about this flawed initiative.

### **CMA Webinar on pain**

**Phil Lippe**, the CANS consultant and resident pain guru, recommends that physicians seeing patients with pain &/or prescribing controlled substances view the CMA webinar on pain.

The Webinar, which includes CME, is available for viewing in the CMA resource library [here](#).

The Webinar is free to CMA members but will cost non-members \$100.

Phil thinks the \$100 is worth the info.

### **Feds allow a pick-your-poison option**

CMS has announced the agency's plan to provide physicians with a flexible start date for the initial Quality Payment Program performance year. According to the proposed regulation implementing the Medicare Access and CHIP Reauthorization Act's (MACRA) new payment program, physicians would

be required to report under the Merit-based Incentive Payment System (MIPS) or the advanced alternative payment model (APM) beginning on Jan. 1, 2017. The AANS and CNS, along with nearly all physician organizations, opposed this aggressive timeline, suggesting instead that CMS begin the program no sooner than July 1, 2017. Following multiple meetings, written comments and Congressional pressure, CMS unveiled the "Pick Your Pace" program.

Under the "Pick Your Pace" program, CMS announced that the final MACRA regulation would **exempt** physicians from any **penalties** if they choose one of three MIPS reporting options in 2017, or participate in an advanced APM. While details won't be released until CMS issues the final rule, the options are as follows:

- **First Option: Test the Quality Payment Program.** With this option, as long as physicians submit *some* data under MIPS, physicians will avoid any payment penalties. This first option is designed to ensure that physician systems are working, and that clinicians are prepared for broader participation in 2018 and 2019.
- **Second Option: Participate for part of the calendar year.** Physicians may choose to submit MIPS information for a reduced number of days. This means the initial performance period could begin later than Jan. 1, 2017. Neurosurgeons submitting information on quality measures, electronic health record (EHR) use and clinical practice improvement activities for part of the calendar year could qualify for a small bonus payment.
- **Third Option: Participate for the full calendar year.** Practices ready to fully participate in MIPS on Jan. 1, 2017 can participate for a full calendar year. Neurosurgeons submitting data on quality measures, electronic health record (EHR) use and clinical practice improvement activities will qualify for a modest bonus payment.
- **Fourth Option: Participate in an Advanced Alternative Payment Model in 2017.** Instead of participating in MIPS, physicians can participate in the Quality Payment Program in 2017 by joining an advanced APM, such as Medicare Shared Savings Track 2 or 3. Neurosurgeons that receive sufficient Medicare payments or see enough Medicare patients through an advanced APM in 2017 will also qualify for an additional 5 percent incentive payment in 2019.

## Another of the thousand cuts—leading to early retirement or quitting Medicare

So you thought that the California requirement that every CA doc has to post a notice in the waiting room that docs in CA are regulated by the Medical Board of California, just in case a patient would like to file a complaint, was the height of bureaucracy? Wrong! The Feds have topped even that irritating silliness.

The U.S. Department of Health and Human Services (HHS) Office of Civil Rights (OCR) recently finalized new nondiscrimination rules intended to advance health equity and reduce health care disparities. The final rule includes new requirements with respect to *nondiscrimination postings and grievance procedures*. Physicians need to be in compliance with the rule by October 19, 2016.

With a few exceptions, physicians are expected to:

- Post a notice of nondiscrimination and taglines in the top 15 languages spoken by individuals with limited English proficiency

- Develop and implement a language access plan
- Designate a compliance coordinator and adopt grievance procedures (applicable to group practices with 15 or more employees)
- Submit an assurance of compliance form to OCR

In addition to administrative enforcement mechanisms, such as loss of federal financial assistance, individuals are permitted to bring individual or class action violation claims in federal court directly against physicians who are not in compliance with these rules.

To assist with implementation, OCR has translated into 64 languages a [sample notice and taglines](#) for use by covered entities. In addition, OCR has published a [summary of the rule](#), [factsheets on key provisions](#) and a list of [frequently asked questions](#).

The California Medical Association (CMA) has sought guidance from the California Department of Health Care Services to determine what languages California physicians must post for the nondiscrimination notice. As additional information becomes available, CMA will provide more detailed instructions about how physicians may comply with this rule.



## Thought for the Month:

When you are dissatisfied and would like to go back to your youth, think of Algebra.

**IT'S THAT TIME OF YEAR AGAIN! DRS., PLEASE TALK TO YOUR LOCAL REPS ABOUT EXHIBITING AT THE CANS ANNUAL MEETING! REFER THEM TO ME: [EMILY@CANS1.ORG](mailto:EMILY@CANS1.ORG) OR 916.457.2267**

## Meetings of Interest for the next 12 months:

3rd World AVM Congress, October 24-26, 2016, Silverado Resort, Napa, California  
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](#)**



CNS Spine Complication Course, January 26-29, 2017, Park City, UT  
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  
Neurosurgical Society of America: Annual Meeting, April 2-5, 2017, Jacksonville, FL  
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  
Rocky Mountain Neurosurgical Society: Ann. Meeting, 2017, TBA  
New England Neurosurgical Society: Annual Meeting, 2017, TBA  
Western Neurosurgical Society: Annual Meeting, September 8-11, 2017, Banff, Alberta, Canada  
CSNS Meeting, October 6-7, 2017, Boston, MA  
Congress of Neurological Surgeons: Annual Meeting, October 7-11, 2017, Boston, MA

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](mailto:emily@cans1.org)) or fax (916-457-8202)—Ed. ❖

**T**he 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](mailto:rws-avopro@sbcglobal.net) or to the CANS office [emily@cans1.org](mailto:emily@cans1.org).
- Past newsletter issues are available on the CANS website at [www.cans1.org](http://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](mailto:emily@cans1.org), 916-457-2267 t, 916-457-8202 f) with the word "unsubscribe" in the subject line.



**CANS Board of Directors**

<b>President</b>	Praveen Mummaneni, MD	San Francisco
<b>President-Elect</b>	Kenneth Blumenfeld, MD	San Jose
<b>1<sup>st</sup> Vice-Pres</b>	Langston Holly, MD	Los Angeles
<b>2<sup>nd</sup> Vice-Pres</b>	Patrick R.L. Rhoten, MD	San Diego
<b>Secretary</b>	Mark Linskey, MD	UCI
<b>Treasurer</b>	Marshal Rosario, MD	Campbell
<b>Immed Past Pres</b>	Phillip Kissel, MD	San Luis Obispo
<b>Past President</b>	Deborah C. Henry, MD	Newport Beach
<b>Directors</b>		
<b>Northern CA</b>	Ripul Panchal, DO	Sacramento
	John K. Ratliff, MD	Stanford
	Mitchel Berger, MD	San Francisco
<b>Southern CA</b>	Joseph Chen , MD	Los Angeles
	Frank Hsu, MD	UCI
	Javed Siddiqi, MD	Colton
	Farbod Asgarzadie, MD	Los Angeles
<b>Resident Board Members</b>		
North	Doris Wang, MD, PhD	UCSF
South	Omid Hariri, DO	Arrowhead
<b>Consultants</b>	Moustapha Abou-Samra, MD	Ventura CSNS
	John T. Bonner, MD	Fresno Newsletter
	Theodore Kaczmar, Jr, MD	Salinas Past President
	Philipp M. Lippe, MD	San Jose CAC
	Lawrence M. Shuer, MD	Stanford Residency Training Programs
	Randall W. Smith, MD	Escondido Newsletter
	Patrick J. Wade, MD	Glendale CMA
	Kenneth Ott, MD	San Diego Past President
	Marc A. Vanefsky, MD	Anaheim Past President
	Austin R. T. Colohan, MD	Loma Linda Past President
<b>Historian</b>	Donald J. Prolo, MD	San Jose
-----		
<b>Executive Secretary</b>	Emily Schile	
	<a href="mailto:emily@cans1.org">emily@cans1.org</a>	

**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](http://www.cans1.org)

**Editorial Committee**

**Editor**  
**Randy Smith, M.D.**

**Associate Editors**  
**John Bonner, M.D.**  
**Deborah Henry, M.D.**