CANS newsletter

Virtual Credit Card payment of docs by health plans not OK

Randall W. Smith, MD, Editor

Andis Robezneiks, writing for the *AMA News,* points out that the Centers for Medicare and Medicaid Services (CMS) has weighed in with definitive guidance saying that health plans cannot require physician practices or other health care organizations to accept payments made using so-called virtual credit cards that are often accompanied by exorbitant service fees.

Ever since the Automated Clearing House (ACH) EFT standard went in effect in 2014, the AMA has advocated that CMS issue guidance spelling out physician rights regarding insurance company electronic payments.
Section 1104 of the Affordable Care Act expanded efforts to standardize health care business practices, EFTs and electronic remittance advice (ERA). The CMS ERA and EFT rule was published in 2012 and took effect in 2014. The standards apply to all insurers, not just Medicare and Medicaid.

But not all private insurers followed the letter or spirit of the regulations. Some insisted on making payments with so-called virtual credit cards (VCCs), a 16-digit number emailed, faxed or mailed to a provider in order to make a one-time payment. For the past three years, the AMA has been alerting physicians to their rights to refuse payments via VCCs and advocating against the coercive tactics used by payers and their vendors to force physicians' acceptance of VCC payments.

Chief among doc complaints were increased administrative burdens and fees as high as 5 percent assessed with each VCC transaction. On the revised FAQ page, **CMS unequivocally asserts that physicians cannot be forced to take VCCs as payment.** "A health plan cannot require a provider to accept virtual credit card payments," the CMS states. "A provider has the right to request that a health plan use the electronic funds transfer (EFT) transaction. If a provider makes the request, the health plan must comply."

The new guidance on the CMS FAQ page states that the only fee that may apply to a HIPAA EFT transaction is the small charge (averaging 34 cents per transaction) applied by the provider's bank. Physicians and other providers are not required to contract for any type of "value-added" service—such as 24-hour hotline numbers—that physicians did not request. ❖

INSIDE THIS ISSUE:

CANS MISSION STATEMENT

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

Brain Waves

Deborah C. Henry, MD, Associate Editor

At our last board meeting this past September, Dr. Smith, our editor, mentioned that this column discusses everything from baseball to…. I don't remember what else he said because my mind became fixated on the baseball. I have written about football and concussions, title IX and women athletes and women neurosurgeons, but never baseball.

This grand old American pastime was my first sport love simply because my dad loved it. He played it through college and into very minor leagues. He was a pitcher and proud of it. When I was a mere tyke of 6 years of age, he received tickets to a Red Sox game at fabled Fenway Park. He took my brother, not me the oldest child. I was hurt. I figured I better learn the game to gain my father's favor. I tried to play it and was relegated often to right field. Somehow, I did not get his athletic gene.

In residency, my dad sent me a list from his Golf Magazine of why golf is harder than neurosurgery. In honor of my dad, who passed away this past Christmas holiday, and the boys of October, lets look at how baseball is like neurosurgery:

1. It takes a lot to become a major league baseball player. There are many years of training, coaching, and traveling. No one can deny that it takes also a lot to become a neurosurgeon.

2. Baseball season is the longest of all the sports. One hundred sixty-two games and then there is the playoffs. Neurosurgery residency is also the longest of all residencies, averaging 7 years or more.

3. In baseball, there is a lot of waiting around. Waiting for the ball to come to you. Waiting to bat. Waiting for the pitch to come. In neurosurgery, there is a lot of waiting around too. Waiting for the OR room to get clean. Waiting for the patient to get in the room. Waiting for the MRI DVD to open correctly.

4. Each baseball team plays with nine players at a time. However, most of the game is just between the pitcher and the catcher. Though the pitcher looks to be the one calling the shots, it really is the catcher. Neurosurgery is the same. The team may be large-front desk, back staff, nurses, aids, but it all comes down to the patient and the doctor.

5. If you are batting .400, you are awesome. You might be awesome too if you are batting .400 operating on chronic back pain.

6. The pitcher requires precision to paint the corners of the strike zone with a 97-mph fastball. The neurosurgeon, well, let's just say, requires precision, period.

7. In the end, only two things matter in baseball: how you played the game and if you won. In the end only two things matter in neurosurgery: how you play the game, and if you helped your patients.

Tonight is game five, and the series between the Astros and the Dodgers is tied 2 apiece. My dad lived through the days of Bob Feller and the Indians, Carl Yastrzemski and the Red Sox, and Mike Hargrove and the Texas Rangers. But he was a Houstonian from 1977 until he passed away 10 months ago. I know that I will make some Dodgers fans mad, but Dad, if you are watching the World Series, I hope the Astros win for 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

Retirement and the Value of having a Schedule

Moustapha Abou-Samra, MD, Associate Editor

I retired on July 1, 2017.

Since then, this became the preferred topic of conversation with many of my friends, acquaintances and even patients.

"Congratulations!" "Well deserved!" These are typically the first comments, in response to my announcement, followed immediately by, "what are your plans?" And as time passes, by another question: "what do you miss the most about your work?"

In this short essay, I only plan to address the former question, leaving the latter for another time.

I plan to travel, is my response … and then comes my attempt to explain my idea of travel …

"But what will you do when you're not traveling?", a trusted colleague and dear friend asked me.

I must say that as I was preparing to retire, the notion of not having to get up at 5 AM anymore and of having some free time in my days seemed very attractive. I was really looking forward to "slow-down".

Soon I realized that slowing down was not in my DNA. I still wake up, at 5 Am, without an alarm, clock ready to tackle/enjoy the day. But every morning I am faced with two questions: what will I do today? Actually, what should I do today? I find these questions not only stressful and frustrating but also time consuming.

I am fortunate to have five adult children and seven grandchildren who seem to like me, and I love spending time with them. Traveling to visit them, since they live some distance away, has given some structure to my early retirement. Being able to spend more time with my wife as well as my daughter who

lives in Ventura, her husband and her 5 months old daughter has been very special. But the reality that my days need to be more, or at least better structured, is starting to sink in.

Should I devise a real strict schedule, filling my day to the minute? Or should I leave room for some flexibility? How much free time should I factor in my schedule?

Not surprisingly, quite a bit of research has been done regarding this subject.

A team of Taiwanese researchers from I-Shou University and the National Pingtung University of Science and Technology reached the conclusion that retirees with more free time, were not happier than those with less free time on their schedule. And those retirees who manage their free time well enjoy a higher quality of life. *Some free time in my day seems good. A lot of free time- not so good.*

There are significant advantages to having a structure in our daily routine:

- Helps us stay productive
- Increases our feeling of happiness and well being
- Saves time and energy
- Reduces stress

Having a defined schedule for each day is the way to go, for me.

By the same token, I am also realizing that having a rigid schedule is counter productive. Leaving some time to do some of the chores that I was always "too busy" to do, taking an impromptu walk, being available to have breakfast or lunch with a friend, trying new things that I had never done before or spending an unscheduled hour or two reading something that all of a sudden strikes my fancy, are some of the things that make retirement special.
Retirement is a work in progress. I plan to enjoy it and make it work. ❖

Tidbits from the Editor

Patient referrals all depend on who or what makes them

Reuters Health notes that Timothy J. Daskivich, MD, of Cedars-Sinai in LA and co-authors have published a study in the September 2017 issue of the *Journal of the American Medical Informatics Association* entitled "Online physician ratings fail to predict actual performance on measures of quality, value, and peer review". The article purports to show that patient online platforms bear little relationship to scientific data about a doc's quality of care.

Using the five most popular online platforms - Healthgrades, Vitals, Yelp, RateMDs and UCompareHealth – the authors looked at consumer ratings for 78 medical and surgical specialists. They then compared those patient ratings to the doctors' specialty-specific performance scores, which were based on how closely the doctors adhered to medical guidelines, certain outcomes of their patients' hospital stay and the cost of the care they provided.

Since a 2013 survey noted that over 80% of patients indicated they would visit a doc based on positive patient reviews and almost the same percent said they would not visit a doc with negative reviews, the power of patient reviews can't be ignored but since the online reviews don't tell the entire story of how

good a doc is, the authors feel there needs to be a way to pair consumer ratings with quality and performance measures.

Interestingly, the patients' ratings tended to be consistent across the five platforms as related to each doc but there was no significant association between what the patients' thought and the more objective measures of performance. The authors found that less than a third of the doctors with the lowest performance scores had consumer ratings in the lowest category. For some specialties, the disparity between consumer ratings and actual performance was even greater.

Daskivich admits that consumer ratings do, however, seem to explain some service-related aspects, such as staff friendliness, time spent with patients, empathy and ability to answer questions but that there needs to be a way to pair consumer ratings with quality and performance measures. the study authors say.

Dr. Vagelis Hristidis of the University of California, Riverside, who researches online ratings and health insurance ratings and how those relate to a doctor's performance scores, is working on an automatic classification tool that extracts the factors rated by each text-based patient review," he told Reuters Health by email. "For example, does a review talk about wait time or about medical skills?"

Finally, Reuters Health reports that the study authors recommend that patients ask their primary care doctors for referrals to specialists. "Another doctor knows who they trust, and if it's local, they likely personally know the doctor and quality of care provided," Daskivich said.

Playing ball with the Feds

If you are inclined to try to avoid a payment cut from Medicare, the American College of Surgeons points out the following:

The Centers for Medicare & Medicaid Services (CMS) Quality Payment Program (QPP) requires eligible clinicians to submit data for the 2017 performance year. Although two options are available to providers who want to participate in the QPP—Alternative Payment Models or the Merit-based Incentive Payment System (MIPS)—most will participate through MIPS. MIPS is composed of four components: Quality, Advancing Care Information, Improvement Activities, and Cost.

This is the first year of the program, and providers have the following "Pick Your Pace" options, detailed below, to choose their participation level:

- ***Test the MIPS program**. Submit a minimum amount of 2017 data to Medicare to avoid a 4 percent Medicare Part B penalty in 2019.*
- ***Partially participate in MIPS**. Submit data to Medicare for a continuous 90-day period in 2017 to avoid the penalty and possibly earn a small incentive payment. Providers who choose to partially participate in MIPS will need to report 90 consecutive days of patient data for the Quality component between January 1 and December 31. To ensure 90 consecutive days of data are reported, providers had to begin data collection no later than October 2. However, providers can still begin participating with this option as data may be reported retrospectively for many of the Quality component submission mechanisms. The Improvement Activities component requires providers simply to attest to implementing the improvement activity for at least 90 days of the performance year (January 1 to December 31).*
- ***Fully participate in MIPS**. Submit up to a full year of data to Medicare in 2017 to be eligible for a **positive payment adjustment in 2019.***

You're not a doctor - you're a meal

Of course, its not true.

But that's how some lawyers see doctors – as things waiting to be eaten. Doctors are healers; not fighters. But to a plaintiff's lawyers, it's just business. If a lawyer is poised to take a bite out of you, don't make it easy. Arm yourself with knowledge.

Register for our webinar, **How to Keep Lawyers from Circling Your Practice.** In 30 minutes, we'll teach you techniques you can use every day to protect your practice from lawyers on the hunt.

TWO CHOICES: Webinar begins **Tuesday, Nov. 14 at 11 AM, EST** and **Wednesday, Nov. 15 at 2 PM, EST**.
Click to register.

Regards,
The Medical Justice Team

CSNS—Alive and Poor

The Council of State Neurosurgical Societies met in Boston in early October just prior to the CNS meeting. The primary reason to hold a meeting was to debate and vote on 11 resolutions submitted by state delegates or CSNS committees. The results of actions on those resolutions are listed below.

Of some concern was the waning funding by medical manufacturing corporations of the CSNS fellowship program. That program allows for awarding 13 annual fellowships to residents training in the 4 regional quadrants that make up the CSNS plus one fellow from the military training program. The goal of the fellowship program is to involve neurosurgeons in training in socioeconomic issues associated with being a neurosurgeon and to create a cadre of past fellows who hopefully will become involved in their respective state societies, return to the CSNS as full state delegates and eventually assume leadership roles in the CSNS.

The cost of the program, about 24K/year, comes from paying for travel and lodging for the fellows as they attend two twice-a-year meetings of the CSNS. Medtronic and a few other companies had basically underwritten the program for many years, but that funding has dried up without replacements being found.

Although the CSNS functions like a Joint Section of the AANS/CNS, its meetings do not generate income as there is no exhibitor support from industry and there is no registration fee. The general operating budget of about 300K is underwritten by the AANS and CNS which pays for meeting rooms, A/V, administrative personnel and a limited amount of food but neither parent organization has been inclined to underwrite the fellowship program.

Each year many state societies voluntarily donate to a CSNS fund to pay for studies and actions on items or issues that arise at meetings or are part of adopted resolutions so as not to go begging to the parent organizations every time the Council wants to do something. CANS has been a regular donor to the

voluntary fund generally giving $2250 a year with the total amount raised annually from all the states of about 30K.

This year's fellowship costs had to be paid for in part by the voluntary fund and some funds borrowed from another account, but the CSNS feels that funding for the fellowship program should be separate from the voluntary fund if possible.

So now what?

A CSNS ad hoc committee appointed to address this funding issue appeared to recommend a drive to appeal to individual neurosurgeons to make contributions to a CSNS fund that would garner enough money to endow the fellowship program as it now is. Although such an approach is worth trying, it probably would be wise to have a plan B. Much like the NIH, who approves many research protocols but can and does only fund a certain percentage based upon available funds, the CSNS could annually identify 13 worthy recipients of annual fellowships but only actually award the number they can pay for. After a good fund-raising year, maybe with a sugar daddy or two chiming in, all 13 fellowships could be awarded but after a lean year, maybe fewer could be awarded determined by how much voluntary fund money is available to supplement individual donations. Thus, the program stays alive but lives within its means.

As to the predominant business of the CSNS, the delegates took the following actions on each of the 11 resolutions submitted:

RESOLUTION I Action: Resolution Rejected
Title: A Single Neurosurgical Board Certification System
Submitted by: Gary Simonds MD MHCDS FAANS
BE IT RESOLVED, that the CSNS calls for the AANS and CNS to petition the ABNS and AOBNS to seek an agreement on a single neurosurgical board certification system, under a single certifying body.

RESOLUTION II Action: Amended Resolution Adopted
Title: A Single Neurosurgical Maintenance of Certification System
Submitted By: Gary Simonds MD MHCDS FAANS
BE IT RESOLVED, that the CSNS studies the ramification of a unified neurosurgical board certification and maintenance of certification process, under a single certifying entity, and be it further resolved that the results of this study be presented at a future plenary session.

RESOLUTION III Action: Amended Resolution Adopted
Title: Realistic Analysis of Value versus Detriment of Neurophysiological Monitoring in Spinal Surgeries
Submitted By: Gary Simonds MD MHCDS FAANS
BE IT RESOLVED, that the CSNS seeks to better understand the impact of use of neurophysiological monitoring in spinal surgery through study and survey (to include: depth of penetrance, justifications for its use in procedures prevalence of false positive and false negative results, changes in length of surgery, associated patient and health care worker complications, perceived change in procedural difficulty, blood loss in surgery, associated surgeon stress, impact on cost of care, related litigation, etc.); and
BE IT FURTHER RESOLVED, that entities of the CSNS generate a white paper on the current status of use neurophysiological monitoring in spinal surgery in the United States

RESOLUTION IV Action: Amended Resolution Adopted
Exploring the Role and Limits of Palliative Care in the Management of Neurosurgical Patients
Submitted By: Gary Simonds, MD MHCDS FAANS

BE IT RESOLVED, that the CSNS develops a survey of practicing neurosurgeons and residents to explore their experience with, and attitudes and concerns about, the role of palliative care in neurosurgical patients

RESOLUTION V Action: Amended Resolution Adopted

Title: Evaluation of the practice of balanced billing in neurosurgery

Submitted by: Vincent Y. Wang on behalf of the Medical Practice Committee

BE IT RESOLVED, that CSNS define and study the issue of balance billing and develop a white paper to help practicing neurosurgeons understand this issue including the most updated state regulations

RESOLUTION VI Action: Amended Resolution Adopted

Title: Evaluation of Resident Attitudes and Perceptions of Research in Neurosurgery

Submitted by: Michael Karsy, Steven Tenny, Fraser Henderson, Jeremy Amps

BE IT RESOLVED, that the CSNS utilize an existing survey of neurosurgical resident attitudes and perception towards research in residency to identify limitations factors for residents and report the findings at an upcoming CSNS Meeting.

RESOLUTION VII Action: Adopted

Title: Survey of Neurosurgeons to Access for Factors Affecting Attrition

Submitted By: Steven Tenny, Karin Swartz, Michael Karsy, Jessica Stark, Workforce Committee

BE IT RESOLVED, that the CSNS conduct an online survey of a large sample of currently practicing neurosurgeons to identify common factors, and their importance, on the attrition of practicing neurosurgeons in order to help guide future efforts of organized neurosurgery to address issues practicing neurosurgeons find increasing the likelihood of their own attrition.

RESOLUTION VIII Action: Adopted

Title: Current Practice Patterns in Preoperative Patient Education

Submitted by: Cara Marie Rogers and Jeremy Phelps, on behalf of the Medical Practices Committee

BE IT RESOLVED, that the CSNS seek study the current practice patterns among neurosurgeons regarding preoperative patient education through creation of a survey to inquire about materials and methods utilized, delegated educators, and opinions regarding potential value of formalized materials; and

BE IT FURTHER RESOLVED, that the CSNS generate a white paper using the data from this survey to highlight current practice patterns and comparison to current best practices in the literature.

RESOLUTION IX Action: Adopted

A position statement on network adequacy for access to neurosurgical care

Submitted by: L.M. Tumialán, C.M. Schirmer, C. Mulholland, B.A. McCutcheon, R.H. Dossani, C.A. Miller, P.V. Mummaneni and the Coding and Reimbursement Committee.

BE IT RESOLVED, that the CSNS petition the AANS and CNS to produce a statement that acknowledges the inequity of narrow networks regarding access to neurosurgical care; and

BE IT FURTHER RESOLVED, that the CSNS request that the AANS and CNS produce a statement regarding network adequacy.

RESOLUTION X Action: Amended Resolution Adopted

Title: Establishing a fellowship match for all neurosurgical subspecialties

Submitted by: Rimal H. Dossani, MD, Richard Menger, MD, Catherine Mazzola, MD, Lawrence Shuer, MD, & Bharat Guthikonda, MD

BE IT RESOLVED, that the CSNS survey residents and recent graduates about their experiences with the fellowship selection process, and

BE IT FURTHER RESOLVED, that the CSNS survey neurosurgery fellowship directors about their experiences with fellow selection processes.
BE IT FURTHER RESOLVED: The CSNS write a letter to the SNS asking to investigate potential concerns with the fellowship selection process, including timing of interviews and the contractual process.

RESOLUTION XI Action: Adopted
Title: A Call to Protect Patient Safety Data from Legal Discovery
Submitted by: Tyler Schmidt, Kristopher T. Kimmell, G.E. Vates, and the Patient Safety Committee
BE IT RESOLVED, that the CSNS study the impact of this legal decision on neurosurgeons and their participation in patient safety and quality improvement reporting at their local facilities; and
BE IT FURTHER RESOLVED, that the CSNS work with the Washington Committee to raise awareness among neurosurgeons that their participation in PSOs should generate patient safety data exclusive to federally mandated safety reporting thus rendering it protected from legal discovery due to PSQIA federal confidentiality provisions ❖

Quote for the Month:

You only live once, but if you do it right, once is enough ~ Mae West

ATTENTION EXHIBITORS:

The CANS Annual Meeting is fast approaching and we want to see your company there! We have **redesigned our website** and our top sponsors will be featured prominently on the home page! Check it out at www.cans1.org

Please contact emily@cans1.org for more information!

The meeting will be at the historic U.S. Grant hotel downtown San Diego, CA

Meetings of Interest for the next 12 months:

AANS/CNS Joint Pediatric NS Section: Ann. Meeting, Nov. 28-Dec. 1, 2017, Houston, TX.
Cervical Spine Research Society: Annual Meeting, Nov. 30 – Dec. 2, 2017, Hollywood, FL
CANS, Annual Meeting, January 12-14, 2018; US Grant Hotel, San Diego, CA
North American Neuromodulation Society: Ann. Meet., January. 11-14, 2018, Las Vegas, NV
AANS/CNS Joint Cerebrovascular Section: Ann. Meeting, Jan. 22-23, 2018, Los Angeles, CA
Southern Neurosurgical Society: Ann. Meeting, Feb. 28-March 3, 2018, San Juan, Puerto Rico
AANS/CNS Joint Spine Section: Annual Meeting, March 14-17, 2018, Orlando, FL
Neurosurgical Society of America: Annual Meeting, June 10 - 13, 2018 Jackson Hole, Wyoming
CSNS Meeting, April 27-28, 2018, New Orleans, LA
NERVES Annual meeting, New Orleans, LA, April, 2018, Date TBA
AANS: Annual Meeting, April 28-May 2, 2018, New Orleans, LA
California Neurology Society: Ann. Meeting, 2018, TBA
AANS/CNS Joint Pain Section Bi-Annual Meeting, 2018, TBA.
Rocky Mountain Neurosurgical Society: Ann. Meeting, 2018, TBA
New England Neurosurgical Society: Annual Meeting, 2018, TBA
Western Neurosurgical Society: Annual Meeting, September 14-17, 2018, Kona Coast, Hawaii, HI
CSNS Meeting, October 5-6, 2018, Houston, Texas
Congress of Neurological Surgeons: Annual Meeting, October 6-10, 2018, Houston, Texas
International Society for Pediatric Neurosurgery: Annual meeting, October 7-11, 2018,Tel Aviv, Israel
North American Spine Society: Annual Meeting, October 26-29, 2018, Los Angeles, CA

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. Kenneth Blumenfeld 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.

CANS Board of Directors

President	Kenneth Blumenfeld, MD	San Jose
President-Elect	Langston Holly, MD	Los Angeles
1st Vice-Pres	Patrick R.L. Rhoten, MD	San Diego
2nd Vice-Pres	John K. Ratliff, MD	Stanford
Secretary	Mark Linskey, MD	UCI
Treasurer	Theodore Kaczmar Jr, MD	Salinas
Immed Past Pres	Praveen Mummaneni, MD	San Francisco
Past President	Phillip Kissel, MD	San Luis Obispo
Directors		
Northern CA	Gregory Helbig, MD	Modesto
	Mitchel Berger, MD	San Francisco
	Ciara Harraher, MD	Santa Cruz
Southern CA	Joseph Chen , MD	Los Angeles
	Frank Hsu, MD	UCI
	Javed Siddiqi, MD	Colton
	Farbod Asgarzadie, MD	Los Angeles
Resident Board Members		
North	Linda Xu, MD	Stanford
South	Joel Beckett, MD	UCLA

Consultants	Moustapha Abou-Samra, MD	Ventura	CSNS
	John T. Bonner, MD	Fresno	Newsletter
	Deborah C. Henry, MD	Newport Beach	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	San Diego	Newsletter
	Patrick J. Wade, MD	Glendale	CMA
	Marc A. Vanefsky, MD	Anaheim	Past President
	Austin R. T. Colohan, MD	Loma Linda	Past President
Historian	Donald J. Prolo, MD	San Jose	

Executive Secretary Emily Schile
emily@cans1.org

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