AANS/CNS Joint Section on Disorders of the Spine and Peripheral Nerves
Executive Committee Meeting

Marriott Marquis Hotel, Liberty Ballroom, Salon L, Level M4, Washington, DC
Sunday, May 3, 2015 11:00 am – 1:00 pm

AGENDA

ATTENDEES:

Officers:	Chair: Praveen Mummaneni, MD Past Chair: John Hurlbert. MD Chair-Elect: Jack Knightly, MD Secretary: Marjorie Wang, MD Treasurer: Michael Wang, MD
Voting Members:	Annual Meeting Chair: Zoher Ghogawala, MD Scientific Program Chair: Adam Kanter, MD Exhibits Chair: Daniel Hoh, MD Media Chair: John Ratliff, MD
Non-Voting Members:	Member at Large 1: Eric Potts, MD Member at Large 2: Frank Lamarca, MD, Member at Large 3: Jean-Valery Coumans, MD Ex-Officio: Langston Holly, MD (absent)

Standing Committee Chairs:

Education: Dom Coric, MD (call-in)
Nominating: R. John Hurlbert, MD; Michael Groff, MD; Joseph Cheng, MD (excused)
Annual Meeting Chair: Zo Ghogawala, MD
Media Committee Chair: Ratliff
Research and Awards: John Chi, MD
Rules and Regulations: W. Brad Jacobs, MD

Ad Hoc Committees:

AANS Board Liaison: Deborah Benzil, MD
CPT: Luis Tumialan, MD
D&D, ASTM/FDA: Jake Gologorsky, MD
Exhibits: Dan Hoh, MD
Fellowship: Dan Sciubba, MD
Future Sites: Christopher Wolfla, MD
Guidelines: Sanjay Dhall, MD,
Intersociety Liaison: Michael Rosner, MD
Membership: Kurt Eichholz, MD (call-in); Aruna Ganju, MD, Co-Chair
NeuroPoint Alliance: Praveen Mummaneni, MD,
NREF: Christopher Shaffrey, MD
Outcomes: Paul Park, MD
MOC/spinal deformity: Juan Uribe, MD,
Peripheral Nerve TF: Lynda Yang, MD
Publications: Justin Smith, MD
Public Relations: Michele Johnson, MD
Strategic Planning: Michael Groff, MD
Washington Committee: Jack Knightly, MD
YNC Committee: Laura Snyder, MD

Invited Guests:	James Rutka, MD, Journal of Neurosurgery; Nelson Oyesiku, MD, Neurosurgery; Nathan Selden, MD, CNS President; Regina Shupak, CNS; Dean Chou, MD; Line Jacques, MD; Daniel Lu, MD; Peter Kuhn, AANS; Matthew McGirt, MD
Absent:	Langston Holly, MD, Ex-Officio; Christopher Wolfla, MD, Future Sites; Michael Rosner, MD, Intersociety Liaison
Excused:	Joseph Cheng, MD, Nominating Committee & Payor Response; Khoi Than, MD, YNC Committee

AGENDA TOPICS

	AGENDA ITEM	DISCUSSANT
1	**Call to Order:** The meeting was called to order at 1100 hrs	Dr. Praveen Mummaneni
2	**Approval of Minutes**: Motion moved to approve by Dr. Mummaneni, seconded by Dr. Ghogawala, motion passed by attending members	
3	**Treasurer's Report:** (3. Annual Meeting Report, 3.1 Statement of Activities) Annual meeting costs appear to be increasing by 20% over a five year period despite current financial slump and decreasing meeting attendance. Last year's meeting costs were approximately $783K and if this stays on track as well as including the requested CNS increase, profit margins will be significantly impacted. NREF & Fellowships – there have been numerous meetings to work out plans for funding fellowships internally using NREF. Donations for the C. Kuntz fund have totaled $125K from members and the Mayfield clinic. Monies from the old NREF will be transferred to the new NREF as previously discussed at the annual meeting. Consensus will be needed to approve the mechanisms proposed for financing fellowships as well as sustainability. Long term investments – information available in the agenda book. Members were told of a previous 5% long term $1M annuity that had been established however this has now matured and the interest rate has dropped to 1.3%. A decision needs to be made as to what to do with these funds including putting into another annuity. At the present time, the AANS holds approximately $3M in long term investments for the DSPN - $1.6M are in a general investment fund and just over $1.3M are in the annuity fund. Discussions by members ensued with respect to how to ensure these funds are secure and what the best use would be. Dr. Mummaneni suggested using the interest generated fund research fellowship endeavors as industry funding is dwindling. Dr. Mike Wang thanked Drs. Wolfla, Kuntz and Hurlbert for having the forethought of establishing this annuity. If the funds are to be sustainable, an ideal amount would be in the region of $10M to provide enough interest to ensure adequate funds are available for fellow sponsorship. (3.2 Financial Position) Action Item: Due to time constraints, this item will deferred to a telephone conference to be set for a later date.	Dr. Michael Wang
4	**Standing Committee Reports** A. **Annual Meeting Committee/Scientific Program Committee**: (4.A Registration Analysis)	Dr. Zo Ghogawala; Dr. Adam Kanter

	Dr. Ghogawala reported the overall revenue from 2015 as well as last six years (4.A Meeting Analysis). Industry attendance has been decreasing as well as spine section members attending the annual meeting which is reaching a critical point. Dr. Mummaneni reiterated the need to "advertise" the DSPN meeting for 2016 at the end of all talks and presentations. Despite members attending the annual conference decreasing, resident and ortho colleagues attendance has been increasing although their meeting fees have been complimentary. It was felt that residents should continue to be sponsored and ortho colleagues should be asked to pay the annual member rate dues to attend. It was suggested that poster presentations be discontinued and be replaced with a two minute podium presentation which would encourage more residents & fellows to submit. Discussions with respect to trying to re-engage current members to attend and the significant decrease in marketing by CNS (previously noted at $60K down to $18K with CNS asking for significant increases in contract). Overall profits have decreased from 2010 to 2014 although 2015 showed a slight increase from the 2014 total due to difference in expenses rather than actual revenue. Action Plan: delinquent members to be polled asking why they are not attending the annual meeting. The membership committee will also be asked to provide a list of members who are behind in paying their dues and this list will be sent to active members who, in turn, will call these colleagues (within their own states) to ask why they are not paying and attending the meetings to obtain meaningful feedback. Discussion with respect to financial restraints that may restrict some members from attending because of their local budget cuts was reviewed. Dr. Nate Selden of the CNS commented that attendance at national meetings comes down to budgetary constraints and time. Attendance information can be shared if requested. He invited any members to contact he or Regina Shupak for any concerns or requests for information. The Spine Section is very important to the CNS and they would be happy to help in any way. Action: 1. to send out survey to acquire appropriate data 2. to have EC section members contact members within their own states that are delinquent in their dues for at least two years 3. take the information acquired and bring back to discuss at a strategic planning meeting as the last was in 2014 in Miami Dr. Justin Smith reported that IMAST has discontinued poster presentations replacing them with two minute sessions which has worked very well increasing meeting attendance. Dr. Uribe reiterated this has also been done at ISASS with good success. Dr. Mummaneni stressed that it is important to increase the attendance at the annual meeting to ensure sustainability. **Scientific Program Committee**: - Global Challenges: Universal Solutions (theme for upcoming	Dr. Adam Kanter

	CNS meeting); no further updates	
	B. **Education Committee**: no report	Dr. Dom Coric
	C. **Media Committee**: (4.C Newsletter Report Spring 2015) - reviewed the current website and changes can be made or repurposed - wonders how long to keep Dr. Kuntz memorial on website - suggests collaboration with CNS NEXUS/endcase projects to utilize their video hosting content MOTION: Dr. Mummaneni moved to engage CNS Nexus/E-rounds projects to host DSPN content though CNS links. Seconded by Dr. Knightly. Passed unanimously. - funds will be requested by CNS to help fund Nexus – need to position DSPN to ensure access to revenue stream. MOTION: Dr. Mummaneni moved to have Dr. Ratliff review financial implications. Seconded by Dr. Wang. Passed unanimously.	Dr. John Ratliff
	D. **Nominating Committee**: Dr. Hurlbert briefly reviewed that work is in progress with Dr. Jacobs who is going over the Rules and Regulations items/loopholes that need to be revamped. As well, the next slate of officers will be provided at the CNS Exec meeting. (4.D Nominating Committee Report) Dr. Mummaneni noted that a slate of potential AANS board members was requested by the AANS – these names can be submitted to either him, Dr. Knightly or Dr. Groff. He mentioned that there are a number of spine section members who have a potential opportunity of making the AANS board (Dr. Reg Haid as well as Dr. John Wilson for Treasurer)	Dr. R. John Hurlbert
	E. **Payor Response Committee**: 1) Wellpoint response for cervical disc replacement. Provided evidence to support coverage and access to care. They reported that there was no evidence to support more than one level. They also reported that there was no more than 5 year follow-up data. We cited literature to support 2 level Replacements, and also cited literature for 7 year data. 2) Wellpoint response for sacro-iliac joint fusions. Discussion of recent clinic trial. Although only 6 month follow-up data was available, we commented on some promising points on this 6 month data, and that for the appropriately worked up patient, a SI joint fusion should be accessible to our patients. We also stated that further follow-up on the clinical trial would be useful, and this topic would need to be readdressed when the time comes.	Dr. Joe Cheng (excused)/report given by Dr. Charley Sansur
	F. **Research and Awards Committee**: (4.F Research & Awards Committee Report) - reported that Globus had submitted a payment in February to support the award they had committed to.	Dr. John Chi

	- Current committee has reviewed current four research and four fellowship awards however funds need to be researched to ensure sustainability - If NREF funds can be used, these can be directed to funding some awards - If there has been a financial loss, those awards should be cut - Need to review financial maintenance particularly with respect to research fellowship and industry sponsorship - Change of fellowships versus research – no need to worry on offending those whose names are attached to awards - Industry cannot fund beyond their own budgetary cycles and perhaps the funds should be requested in advance - As this is a significant item for discussion, further discussion was tabled due to time constraints.	
	G. **Rules and Regulations Committee**: (4.G R&R Cmte Report) - Discussed succession issues. He is working with the Nominating Committee on revisions particularly with respect to unexpected vacancies. - General amendment bylaw reviewed comparing these to AANS and CNS and wondered if this needs to be changed to be similar. However, may not be relevant to DSPN. Dr. Michael Groff proposed that a motion to accept the vacancy amendment be added to the rules and regulations. Dr. Mummaneni seconded. Passed unanimously. Dr. Jacobs suggested another minor change to succinct mission statement. Dr. Mummaneni and Jacobs to discuss with nominating committee to come up with appropriate wording which will be circulated via email. This will be tabled for a future meeting – rules and regulations cannot go forward until AANS and CNS sign off. Action: need to be finalized before CNS to approve details at their annual meeting so that it can go live before the end of the calendar year. The information will be circulated to the chair and chair elect by the nominating committee within the next six weeks.	Dr. W. Brad Jacobs

5.	**AD HOC COMMITTEE REPORTS**:	
	A. **AANS Board Liaison**: Div. 2 submission form May 2015	Dr. Deb Benzil
	B. **CPT**: (5.B CPT Executive Committee Report) – discussed upcoming difficulties with the incoming ICD 10 codes and a request has been submitted to the Washington committee for a two year transition period. Lumbar fusion and laminectomy issues discussed. As this is a significant issue, this item has been tabled for future discussion.	Dr. Lu Tumialan
	C. **D&D (ASTM/FDA Drug and Devices Committee)**: planned attendance at May and fall ASTM meeting	Dr. Jake Gologorsky
	D. **Exhibits Committee**: see conference call (5.D 2015 Exhibits Report)	Dr. Dan Hoh
	E. **Fellowship Committee**: as indicated in the previous minutes, this report was discussed at the recent conference call – previous report attached – Dr. Mummaneni asked that Dr. Sciubba discuss further with Regina Shupak and Dr. Branch to get in writing details on infolded fellowships (PGY7) that will only be considered by DSPN.	Dr. Dan Sciubba
	F. **Future Sites Committee:** see conference call report	Dr. Chris Wolfla (absent)
	G. **Guidelines Committee**: nothing more to add at this point from what has been previously discussed and submitted (5.G NSQIP Response)	Dr. Jay Dhall
	H. **Inter-Society Liaison**: 1. Another round of proposals reviewed for SRS Research Committee. Minimum submissions from the neurosurgery side. Significant funding available for worthy research proposals. Next round neurosurgery controls oversight and funding allocation. Please consider submitting proposals in need of financial support. 2. Will be attending the Spine Summit on May 18th with Katie Orrico on behalf of the Spine Section. We have Podium time to present the Registry.	Dr. Michael Rosner (absent)
	I. **Membership Committee**: (5.I Membership Report) - Orthopaedic, Neurosurgical & Peds Membership Drive – letters will be sent to all prospective members - DO Membership Drive – plan is to drop delinquent (two years or more) by November - Clarification of dues issues discussed at prior conference call Waiver of past dues with attendance at annual meeting - New member reception at Annual Meeting - New member ribbons - Two year no-pay list – personal calls will be made	Dr. Aruna Ganju/Dr. Kurt Eichholz (call-in)
	J. **NeuroPoint Alliance (AANS)/N2QOD**: - discussion about N2QOD and data to use to for scientific advancement of spine care. Will streamline this access process	Dr. Praveen Mummaneni

	and formulate a bridge to analyze spine data and policies established.	
	K. **NREF**: (5.K Signed Transfer Authorization) 1. Authorization to transfer restricted assets – letter discussed MOTION: Dr. Mummaneni moved to have funds from old NREF moved to new NREF with caveat that DSPN has complete control on how the funds are to be utilized. Seconded by Dr. Ghogawala. Passed unanimously.	Dr. Chris Shaffrey
	L. **Outcomes Committee**: see conference call – (report pending) -Dr. McGirt has been asked to join the Outcomes Committee by Dr. Mummaneni	Dr. Paul Park
	M. **Maintenance of Certification (MOC) Committee**: 1. MOC book is now out and there have been no difficulties. The textbook should be available by mid to late May. Spine section is completed. 2. N2QOD: deformity module. Agenda for operational meeting Scheduled for Saturday, May 2 is appended.	Dr. Juan Uribe Dr. Jack Knightly/ Dr. Matthew McGirt
	N. **Peripheral Nerve Task Force**: no updates	Dr. Lynda Yang
	O. **Public Relations**: - discussed future committee duties and responsibilities with Dr. Mummaneni - discussed past committee duties and responsibilities with Dr. Dhall - will be meeting with Dr. Potts and her own IT Department about the DSPN social medial presence (twitter and Facebook) - will be combining efforts with the Washington committee on the social media presence	Dr. Michele Thompson
	P. **Publications**: (5.P Publications Committee Report)	Dr. Justin Smith
	Q. **Strategic Planning**: - with the outstanding job done by Dr. Dan Hoh, not much more to add - courses by members that are taking place at international meetings will help “brand” DSPN	Dr. Michael Groff
	R. **Washington Committee**: (5.Q&R N2QOD QIW Agenda) - Briefly reviewed that a neurosurgery quality council has been organized using 21 measures that are spine specific centric approved by CMS (repurposed PQS measures). QIW being restructured. S. Young Neurosurgeons Committee: no updates	Dr. Jack Knightly 6Dr. Laura Snyder
6	**New Business**: (6. AANS Consultant Invitation, 6.A.a. ARC IAC and 6.A.b ARC Table of Contents)	Dr. Praveen Mummaneni

	ARC Committee on Diagnostic Imaging/Interventional Radiology – new AANS representatives for expert panels - Dr. Dhall reviewed current projects the Guidelines committee is working on including the upcoming joint guidelines meeting as well as work on the thoracolumbar group guidelines. Anyone interested in working on this committee (3 year cycle) should contact Drs. Mummaneni, Dhall, and Marjorie Wang to advise.	
8	Discussions about top abstract submissions submitted to JNS and Neurosurgery following annual meeting – how many to each journal, length of time for reviews and final dispositions - Dr. Nelson Oyesiku – Neurosurgery Editor-in-Chief – slide presentation which reviewed the journal and publication processes, guidelines and initiatives. Dr. Oyesiku indicated the journal is more than willing to accommodate spine submissions. Dr. Mummaneni proposed that any abstracts submitted from the DSPN annual meeting, although blinded, have a sideline indicating the paper was presented at that meeting. Dr. Oyesiku readily agreed to this and will ensure that this is noted in any publications. (8. DSPN Spine Slides) Dr. Rutka – J. of Neurosurgery Editor-in-Chief reviewed the recent redesign for the Spine Section. With the new guidelines in place, there has been an increase in the number of submissions which now rivals all of the other spine journals – of the 1200 submissions over the last year, there has been a 25% acceptance rate. In addition, there has been an increase in the numbers of submissions from ortho spine. As well, there is now a mechanism in place to note submissions from DSPN podium presentations. Following these presentations after discussions, the following actions were noted: - the top 20 abstract submissions would be sent letters from each journal inviting them to submit their manuscripts for publication - the top 20 candidates will be asked to provide their accompanying manuscript by the end of January for review prior to the annual meeting (top 10 mandatory, next 10 strongly suggested) with possible awards - these manuscripts will be reviewed by the Publications and SRC committees to ensure quality meets DSPN publication standards MOTION: Dr. Mummaneni asked for a vote to approve these actions. Seconded by Dr. Ghogawala. Passed unanimously.	Dr. James Rutka & Dr. Nelson Oyesiku
9	Other non-agenda items: A. Dr. Shaffrey reported he has been approached by the	

	SRS to help coordinate a course on patient safety in February, 2016. The DSPN has been asked to provide faculty for the course but all costs will be covered by the SRS MOTION: Dr. Mummaneni asked for a vote to approve this request. Seconded by Dr. Hurlbert. Passed unanimously. B. Dr. Mummaneni advised the members that the contract with the CNS expired following the last annual meeting. The CNS has offered another 3 – 4 year contract but with a 30% increase in costs or possible revenue sharing. This lead to considerable discussion with the members with respect to past experiences, timing, complexity of negotiations, financial implications and feasibility. Action: The current officers will engage CNS for a one year period then enter into negotiations with bids going out to Broadwater, AANS, and CNS. CNS will be asked to keep the current $100K base with the possibility of a $15K bonus if the past years profit is increased by at least 15%. An AdHoc committed comprised of the nominating committee, past chair and chair elect will be tasked to begin these bids and negotiations. Dr. Mummaneni called for a vote on this action, seconded by Dr. Groff. Passed unanimously.	
	Following completion of the agenda items, the meeting was adjourned by Dr. Mummaneni at 1255 hrs. reminding everyone of the next meeting to be held in Orlando. (2016 Save the Date)	

	FY '13 Final	FY '14 Final	YTD FY '14	FY '15 Budget
Revenues				
Registration Fees	269,430	286,465	286,465	237,085
Exhibitor Fees	672,500	248,200	248,200	248,200
Exhibitor Sponsorship Revenue	0	456,930	456,930	456,930
Special Event Revenue	2,225	900	900	50,280
Total Revenue	**944,155**	**992,495**	**992,495**	**992,495**
Expenses				
Scientific Program	275,924	448,289	448,289	418,807
Abstract Management	12,145			12,509
Program Book	26,846			27,651
Opening Reception	65,673			0
Social Events/General	0	116,824	116,824	116,824
Committee Dinners/Events	59,015			0
Exhibit Program	70,517	58,670	58,670	48,670
Advanced Registration	62,369			50,199
Annual Meeting Promotion	13,128			0
On-Site Coordination	16,751	20,017	20,017	9,339
Annual Meeting Planning Cmte	4,608	50,199	50,199	0
Staff Coordination	100,000	100,000	100,000	100,000
Total Expenses	**706,976**	**793,999**	**793,999**	**783,999**
Net Excess (Loss)	**237,179**	**198,496**	**198,496**	**208,496**

Return to Agenda

American Association of Neurological Surgeons

AANS/CNS Section on Disorders of the Spine and Peripheral Nerves
Statement of Activities
For the Six Months Ending Wednesday, December 31, 2014

	FY '13 Final	FY '14 Final	YTD FY '14	YTD FY '15	FY '15 Budget
Revenues					
Membership Dues	70,996	94,136	94,136	38,700	94,600
Mailing List Sales	345				0
Fellowship/Award Sponsorship	165,000	190,000	190,000	115,000	210,000
Contributions for Operating Expenses	7,903	8,176	8,176	3,498	8,235
Annual Meeting Revenue	944,155	992,495	992,495	0	992,495
Total Revenues & Support	**1,188,399**	**1,284,807**	**1,284,807**	**157,198**	**1,305,330**
Expenses					
Audio Visual	6,964	7,526	7,526		7,500
Bank Fees	889	1,028	1,028	275	1,050
Contributions and Affiliations	140,000	140,000	140,000		140,000
Decorating	405	613	613		500
Food & Beverage	5,977	8,755	8,755		8,700
Gifts and Gratuities	439				1,000
Honoraria & Awards	216,773	197,269	197,269	0	239,000
Office & Other Supplies	272	98	98		550
Photocopy				12	25
Postage & Distribution	731	1,164	1,164	182	1,500
Printing/Typesetting	250	275	275	224	0
Other Personal Service Fees		5,876	5,876	2,727	20,000
Newsletter Professional Fees	900	875	875	900	1,000
Staff Travel	832				1,000
Telephone	147	61	61	27	2,200
Volunteer Travel	2,254				4,000
Website	2,388	590	590		12,500
Staff Coordination	8,791	8,224	8,224	4,394	9,413
Guidelines Development	36,973	27,900	27,900		10,000
Annual Meeting Expense	706,976	793,999	793,999	0	783,999
Total Expense	**1,131,962**	**1,194,254**	**1,194,254**	**8,742**	**1,243,937**
Investment Earnings	214,397	243,057	243,057	(26,593)	0
Net Excess (Loss)	**270,834**	**333,610**	**333,610**	**121,863**	**61,393**

Return to Agenda

American Association of Neurological Surgeons

AANS/CNS Section on Disorders of the Spine and Peripheral Nerves
Statement of Financial Position
For the Six Months Ending Wednesday, December 31, 2014

	Current Year 12/31/2014	Prior Year 12/31/2013
Assets		
Checking & Short Term Investments	1,044,167	916,613
Accounts Receivable, net of Allowa... Uncollectible Accounts	82,875	125,925
Long-Term Investment Pool, at Mar...	2,927,896	2,889,948
Dues To/From AANS	0	0
Total Assets	**4,054,937**	**3,932,487**
Liabilities and Net Assets		
Liabilities		
Accounts Payable and Current Liabi...	47,500	85,000
Deferred Dues	95,100	97,800
Deferred Contribution Revenue	0	40,000
Total Liabilities	**142,600**	**222,800**
Net Assets		
Unrestricted	3,733,477	3,405,215
Unrestricted- Peripheral Nerve Task...	(791)	1,217
Unrestricted- Fellowships	57,788	4,322
Net Revenue (Expense)	121,863	298,932
Total Net Assets	**3,912,337**	**3,709,687**
Total Liabilities and Net Assets	**4,054,937**	**3,932,487**

Return to Agenda

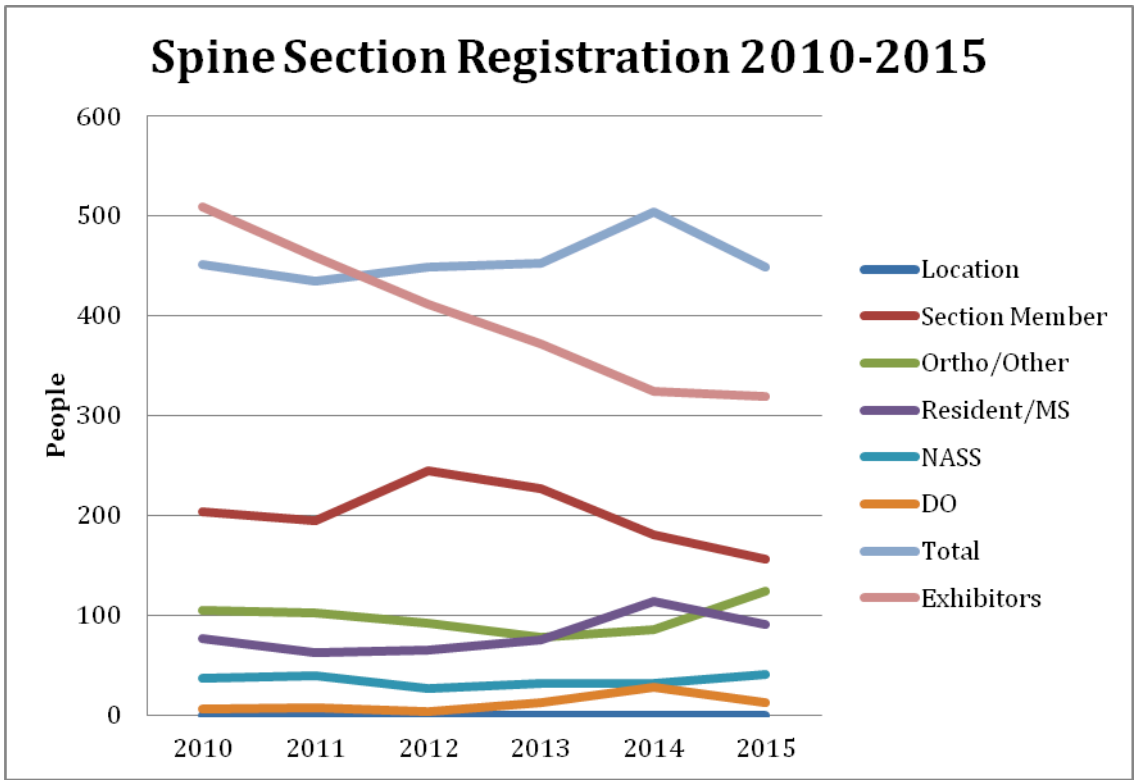
Annual Meeting of the AANS/CNS Section on Disorders of the Spine and Peripheral Nerves
Registration Summary

Name	2007 Phoer	2008 Orlan	2009 Phoer	2010 Orlan	2011 Phoer	2012 Orlan	2013 Phoer	2014 Orlan	2015 Phoer	2016 Orlando
Spine Sectic	176	210	212	204	195	244	227	181	156	
NASS Mem	45	51	33	37	39	26	31	31	41	
DO - ACOS	0	0	6	6	7	3	12	27	12	
Nonmembe	70	94	106	105	102	92	78	86	35	
Medical Student-Comp starting in 2015									31	
Resident-Se	46	42	56	53	55	40	50	88	60	
Nurse	16	13	13	13	10	7	11	9	11	
Physician A	14	25	19	9	20	12	18	14	14	
Resident - (	25	25	25	24	7	25	25	25	0	
Brazilian Sp	N/A	N/A	N/A	N/A	N/A	N/A	N/A	17	N/A	
Chinese Ort	N/A	N/A	N/A	N/A	N/A	N/A	N/A	22	N/A	
Mexican Neurosurgery Member - (not counted in total)									20	
ACSR Member (2015)									12	
Non Physician, Non Member									16	
SRS Membe	N/A	N/A	N/A	N/A	N/A	N/A	N/A	4	19	
AO Spine Member (2015)									21	
CSRS Member (2015)									7	
ISASS Member (2015)									3	
SMISS Member (2015									11	
Medical Re	**392**	**460**	**470**	**451**	**435**	**449**	**452**	**504**	**449**	
Exhibitor St	270	190	225	215	225	178	208	134	114	
Exhibitor St	204	256	272	294	234	233	164	190	205	
Exhibitor R	**474**	**446**	**497**	**509**	**459**	**411**	**372**	**324**	**319**	

Return to Agenda

Spine Section Meeting Analysis 2010-2015

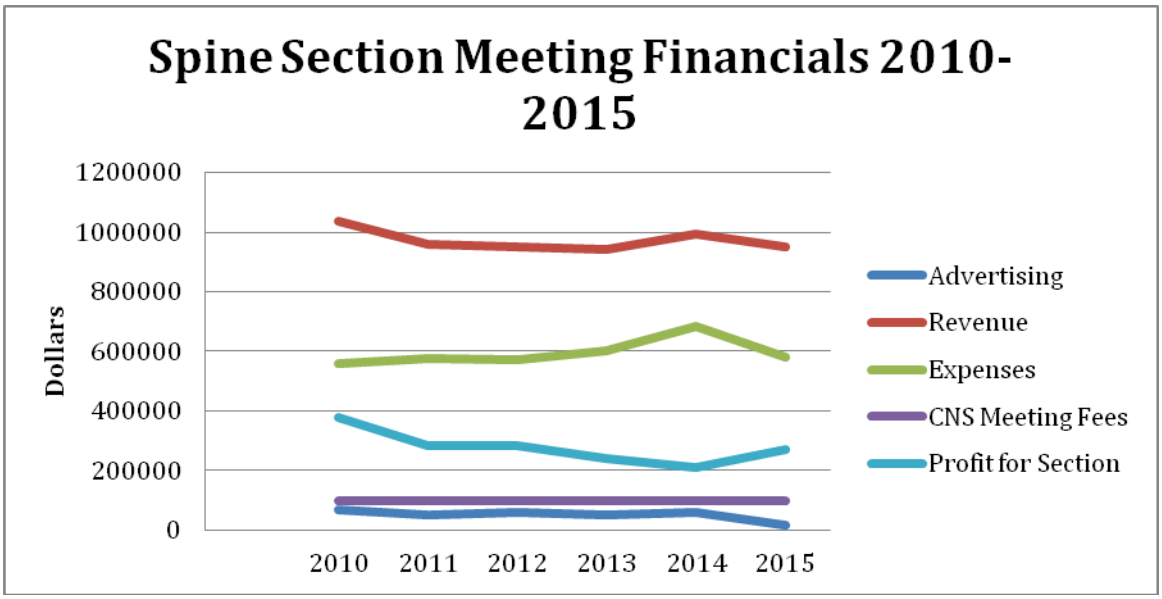
Reported by Zo Ghogawala May 3, 2015



Major Points

- Section Member Attendance is declining from 2012-2015. Down from 244 to 156 (36% decline)
- Exhibitor Attendance is steadily declining from 2010-2015.
- Orthopaedic Surgeon attendance is slowly increasing. Highest in 2015.
- International Society average is 20-but most do not pay for registration.
- Nurse/PA – flat over time at 25 total.
- Resident/Medical Student participation is increasing.

Section Meeting Financials



Major Points

- Annual Meeting Revenue flat 950K to 1 million.
- Overall Profit is down from nearly 400K to 270K.
- Increased expenses in 2014 reduced profit margin.
- Marketing for 2015 meeting was much lower than previous years.

NET REVENUE & EXPENSES SUMMARY		2015 Phoenix PRELIMINARY Actual	2015 Phoenix Budget	2014 Orlando Actual	2013 Phoenix Actual	2012 Orlando Actual	2011 Phoenix Actual	2010 Orlando Actual	2009 Phoenix Actual
Revenue									
	Registration	206,025	218,110	237,085	224,440	222,890	216,570	230,295	228,710
	Exhibits	205,400	560,400	248,200	304,925	331,125	360,155	372,240	427,225
	Contributions/Sponsorships	496,000	137,500	456,930	367,500	347,500	342,500	389,159	337,500
	Social Events	1,600	1,000	900	2,300	2,600	2,000	2,000	2,300
	Special Courses/Luncheon Symposia	39,800	65,025	49,380	44,990	47,460	38,000	44,110	47,900
	Miscellaneous				-	-	-	-	-
Total Gross Revenue		**$ 948,825**	**$ 982,035**	**$ 992,495**	**$ 944,155**	**$ 951,575**	**$ 959,225**	**$ 1,037,804**	**$ 1,043,635**
Expenses									
	Scientific Program/Special Courses	292,575	300,456	390,428	273,313	233,135	249,335	237,890	232,609
	Social Events	109,500	132,567	116,824	169,380	154,396	156,186	141,475	145,927
	Marketing	18,023	39,090	57,861	49,403	60,624	52,463	67,929	63,870
	Exhibit Hall Program	118,999	141,034	48,670	31,985	49,600	48,660	49,122	43,188
	AM Registration	33,315	52,160	50,199	61,849	52,149	54,585	50,598	47,826
	Onsite Coordination & Offices	7,751	16,257	20,017	16,751	18,024	12,810	9,423	12,213
	AM Planning General				-	2,528	-	2,145	1,016
Total Expenses		**580,163**	**$ 681,564**	**$ 683,999**	**$ 602,681**	**$ 570,455**	**$ 574,039**	**$ 558,582**	**$ 546,647**
Net Revenue		**$ 368,662**	**$ 300,471**	**$ 308,496**	**$ 341,474**	**$ 381,120**	**$ 385,186**	**$ 479,222**	**$ 496,988**
Meeting Management fee paid by AANS to CNS		$ 100,000	$ 100,000	$ 100,000	$ 100,000	$ 100,000	$ 100,000	$ 100,000	$ 100,000
NET SURPLUS TO SPINE SECTION		**$ 268,662**	**$ 200,471**	**$ 208,496**	**$ 241,474**	**$ 281,120**	**$ 285,186**	**$ 379,222**	**$ 396,988**

	2010	2011	2012	2013	2014
Location	Orlando	Phoenix	Orlando	Phoenix	Orlando
Section Member	204	195	244	227	181
Ortho/Other	105	102	92	78	86
Resident/MS	77	62	65	75	113
NASS	37	39	26	31	31
DO	6	7	3	12	27
Total	451	435	449	452	504
Exhibitors	509	459	411	372	324
Advertising	67,929	52,463	60,624	49,403	57,861
Revenue	1,037,804	959,225	951,575	944,155	992,495
Expenses	558,582	574,039	570,455	602,681	683,999
CNS Meeting Fees	100,000	100,000	100,000	100,000	100,000
Profit for Section	379,222	285,186	281,120	241,474	208,496

	2015
Phoenix	
	156
	124
	91
	41
	12
	449
	319
	18,023
	948,825
	580,163
	100,000
	268,662

Return to Agenda

Media/Newsletter report

Website

We are transitioning day-to-day maintenance of the website and trying to give Potts a break. He and Ben Rosenbaum have been the workhorses maintaining the site and keeping everything up to date.

While they remain invaluable, the Media team is trying to offload some of their work.

In the near term, there is a wealth of video that is archived on the site. This content needs to be organized to be useful. We may reach out to young Section members to assist in this work. There may be an opportunity for collaboration with CNS in sharing this content, although the nature of that relationship would have to be determined. An option would be for the Spine Section to contribute to the Nexus project maintained by Peter Nakaji. The Nexus effort is potentially a profit-generator for CNS, profit sharing for the spine portion of Nexus is a potential benefit for the section. Any relationship would have to be explored and endorsed by the DSPN EC.

ACTION ITEM: I would request permission from the DSPN EC for the Media Committee to explore this with CNS and then to report back either at or before the Fall EC meeting.

Newsletter

The fifth iteration of the Newsletter in its new format came out the same week as the DSPN Section meeting. We have converted to a biannual format, with one edition coming out at the time of our annual meeting and one to coincide with the CNS.

Each edition will now have an interview with a recent president. Mike Groff gave comments for this Newsletter. Line Jacques and Lynda Yang provided info on nerve specific meetings, grants, and educational content.

We hope to continue to run a page of nerve-specific content in future editions. This addition will give a vehicle for reliably getting nerve content to Section members. We will also continue to provide RUC and reimbursement updates relevant to Section members.

We track readership through Bitly links to the content. Here are the full-version download counts for the last editions:

Autumn 2013	131
Winter 2013	103
Winter 2014	227
Autumn 2014	200
Spring 2015	917

These counts may undercount the total number of downloads; some readers may download the individual page content as opposed to the entire PDF. Downloads from the website for editions up to Autumn 2014 could be accessed directly from the website, without triggering a count on Bitly.

For the March 2015 edition, we converted to a Bitly-only approach, meaning the content was not archived on the website except as a Bitly link. Hence the only way to access the content as a PDF was to trigger a Bilty counted click. We will track over time if this readership increase is an artifact or real. The next stage in developing the Newsletter will be to set an HTML-format email that allows direct access to newsletter content by members. I would like one additional edition where we use the Bitly counts just to see how many times this is being accessed.

My Bitly account may be accessed and used by any Section EC member.

Login: lehoyo. Password: Newsletter.

Any other content that members want included should be submitted to Ratliff or O'Toole.

Return to Agenda

AANS/CNS SECTION ON DISORDERS OF THE SPINE AND PERIPHERAL NERVES

A Section of the
American Association of Neurological Surgeons
and
Congress of Neurological Surgeons

CHAIRPERSON

Praveen V. Mummaneni, MD
UCSF/Neurosurgery
Phone: (415) 353-3998
E-mail: vmum@aol.com

CHAIR-ELECT

John Joseph Knightly, MD
Atlantic Neurosurgical Specialists
Phone: (973) 285-7800
E-mail: jknightly@ansdocs.com

SECRETARY

Marjorie C. Wang, MD
Kadlec Neuroscience Center
Phone: (509) 942-3080
Fax: (509) 942-3085
E-mail: marjorie.wang@gmail.com

TREASURER

Michael Y. Wang, MD
University of Miami
Phone: (305) 243-3337
E-mail: mwang2@med.miami.edu

IMMEDIATE PAST CHAIRPERSON

R. John Hurlbert, MD
Foothills Medical Center
Phone: (403) 283-4449
Fax: (403) 283-5559
E-mail: jhurlber@ucalgary.ca

April 15, 2015

Nominating Committee Report
DSPN Executive Committee Meeting, May 3 2015, Washington DC (AANS)

2016/17

- Chair: John Knightly
- Past chair: Praveen Mummaneni
- Secretary: Marjorie Wang
- Treasurer: Michael Wang

2017/18

- Slate will be proposed to EC at fall meeting (CNS)
- If approved - subject to vote at AGM in Orlando

Rules and Regs

- Currently being updated to help define increasing role of Nominating Committee
    - DSPN Continuity
    - EC Committee membership
    - EC Committee accountability
    - EC Committee ascension

R. John Hurlbert, MD, PhD, FRCSC, FACS
Joint Section on Disorders of the Spine and Peripheral Nerves
Nominating Committee Chair

Return to Agenda

Research and Fellowship Awards Committee

May 2015

- New Member Muhammed Shamji (University of Toronto) replacing Charlie Sansur
- Funding from Globus for Haid Deformity Award WAS provided for Feburary, 2015. But they have indicated they will not be renewing this.

Feedback from committee regarding the future of the structure of the awards.

- Priority on **research awards**, not fellowships
    - Agreement that fellowships could be eliminated
        - But what if industry is willing to fund fellowship? Leave money on table?
    - Agreement that research awards could be reduced to increase competitiveness and quality.
        - But which awards get kept vs cut?
- Priority on sustainability
    - Will not offer awards if funding not committed
        - Letters will be sent now, responses for funding will be by Sept so award applications can be accepted thereafter
        - Or can accept applications with disclosure that award number may vary.
    - Will need to coordinate with NREF and One Ask, etc
        - Currently, 1 research award could be endowed by the spine section with reclaimed funds from NREF
- Will not grant award until funding is secured (approved by treasurer prior to announcing awardees.

Contracts/Agreements with industry need to be renewed for 2016 in the coming months.

Return to Agenda

DSPN Rules & Regulation Committee Report

Prepared by: Brad Jacobs, Chair, DSPN Rules & Regulation Standing Committee

April 24, 2015

1. Following discussions with the Chairperson of the Nominating Committee, a number of changes to the Nominating Committee structure, function and timing of committee activity have been proposed to the Rules & Regulations document. These tentative changes have been submitted to the Nominating Committee Chairperson for review with the DSPN Nominating Committee.

2. To clarify/formalize the process for succession planning within the DSPN, specifically with respect to the inability of an EC member to fulfill their designated role during their term of commitment, I would propose the addition to ARTICLE IV (Officers & Executive Committee) of a new Section (Section 4.06 Vacancies):

   Section 4.06 Vacancies

   If a member of the Executive Committee is unable to readily fulfill the commitments of their designated position due to personal circumstance, illness or death, that position may be declared vacant by majority vote of the Executive Committee. Any such vacancy may be filled until the next Annual Business Meeting by the affirmative vote of a majority of members of the Nominating Committee.

3. On review of the structure of the standing committees, as defined in the Rules & Regulations, the Education Committee chairperson term length is currently undefined (unlike all other Standing Committees). I would propose a statement to define this as a three-year term (which, I believe, is the current practice).

4. I have reviewed the AANS and CNS amendment by-law processes to determine if the DSPN process is in line with that of the parent organizations. The major difference is:

A. The AANS requires voting by ballots sent to the general membership, within 45 days of the Annual Business Meeting, following presentation of proposed amendments at the Annual Business meeting. The CNS requires ballots sent to the general membership following presentation of proposed amendments at the Annual Business meeting, in cases where proposed amendments fail to receive unanimous affirmative vote. At present, the DSPN by-laws require only two-thirds affirmative vote for proposed amendments by members present at the Annual Business Meeting.

5. The Executive Committee has previously suggested the addition of a succinct "Mission Statement" to the DSPN Rules & Regulations document. This statement would effectively summarize Article II (Objectives & Functions). One proposal is:

   "To advance spine and peripheral nerve surgery through education and research and to advocate on behalf of spine surgeons and patients"

Return to Agenda

CPT Executive Committee Report

Passage of H.R. 2 Medicare Access and CHIP reauthorization act

1. Repeals Medicare's (SGR) physician payment system
2. Replaces it with a new streamlined value-based incentive payment system, the Merit-Based Incentive Payment System (MIPS).
3. MIPS consolidates the three existing Medicare incentive programs — Physician Quality Reporting System (PQRS), Electronic Health Records (EHR) and Value-Based Payment Modifier (VM) — and allows physicians to opt-out of the fee-for-service system in favor of participating in alternative payment models (APMs), such as accountable care organizations, patient-centered medical homes and other similar arrangements.
4. Prevents CMS from eliminating the 10- and 90-day global surgery payments.
    a. ***BUT:*** Starting on Jan. 1, 2017, CMS will—based on a representative sample of physicians—collect data to assess the number and level of E&M visits and post-op services that are built into the global surgery codes. This information will be reported on an additional claim filed at the end of the global period. CMS may reassess the need for this data collection review every four years. CMS may withhold a portion of the global fee to encourage participation in the data collection
5. Requires EHR interoperability by 2018
    a. This has the potential to add significant cost to HER for a practice.
6. Delays two-midnight rule and allows CMS to continue use the "probe and educate" program to assess provider understanding and compliance through Sept. 30, 2015

Legislative Details

The main provisions are as follows:

<u>Stabilizes Fee Updates</u>

- Repeals the SGR
- Prevents the 21 percent pay cut, continuing current payment rates through June 30, 2015
- Provides for a 0.5 percent pay update from July 1 through Dec. 31, 2015 and each year thereafter through Dec. 31, 2019
- Freezes updates from 2020-25, although physicians have the opportunity to receive additional payments through the MIPS program
- In 2026 and beyond, physicians participating in APMs will receive a 0.75 percent annual pay increase and all others will receive a 0.25 percent base pay increase

<u>Consolidates Current Medicare Quality Programs</u>

- Creates a new Merit-Based Incentive Payment System (MIPS) program, which eliminates the existing penalties for PQRS, EHR and VBPM programs at the end of 2018
- Beginning on Jan. 1, 2019, under the MIPS, physicians will receive bonuses or penalties based on a composite score on a 0-100 scale. The components of the score are based on a consolidation of the existing quality programs as follows:
    - 30 percent quality
    - 30 percent resource use

    - 15 percent clinical practice improvement activities
    - 25 percent EHR meaningful use
- Physicians will only be assessed on measures/activities that apply to them and scoring weights may be adjusted if necessary to ensure individuals are measured equitably
- Under the MIPS payment pool all physicians are eligible to receive bonus payments (although if all physicians do in fact meet the quality threshold, most will only receive the annual update and only those who are the highest performers will receive a small bonus if they exceed the performance threshold—which is a mean of all composite scores over rolling three-year period)
- Maximum bonuses and penalties (the bonuses and penalties are assessed based on a linear scale and those that are clustered around the mean will receive a smaller bonus/penalties and those who are the top and bottom performers will receive the higher bonus/penalties) are as follows:
    - 4.0 percent in 2019
    - 5.0 percent in 2020
    - 7.0 percent in 2021
    - 9.0 percent in 2022 and beyond
- An additional bonus pool of funds ($500 million per year) is available to distribute to the highest performing physicians
- Physicians can opt-out of the fee-for-service MIPS program and participate in alternative payment models (APM) instead. Under this program, physician could earn annual 5.0 percent bonus payments from 2019-24
- Certain low-Medicare volume providers and physicians new to the Medicare program (for one year) are not subject to the MIPS requirements
- Physicians will be able to participate in the MIPS program (including qualified clinical data registries) as individuals or group practices
- Participation in qualified clinical data registries (QCDR), maintenance of certification programs and other clinical improvement activities are recognized in this new program
- Physician specialty societies will have an enhanced opportunity to identify and submit quality measures (especially if developed for use in QCDRs) that are relevant to their specialties, without having to first go through the current National Quality Forum and other measure endorsement processes

Access to Information on Physicians and Expanded Data Availability

- CMS is required to publish quality, resource use, utilization and payment data on the Physician Compare website
- CMS is required to make claims data available to QCDRs; registries must pay for the costs associated with providing this data

Return to Agenda

2015 AANS Annual Meeting
Exhibits Committee Report
Chair: Daniel Hoh
Members: Michael Steinmetz, Michele Johnson, Todd Francis, Wilson Ray

2015 Annual Meeting Recap

	2015
Educational Grants	$225,000
Exhibit Sales	$205,400
Sponsorship/ Advertising	$271,000
TOTAL	**$701,400**

Exhibits Hall
- *Summary*
  - 43 exhibitors
  - 8 new exhibitors
- *Finances*
  - Total Sponsorship = **Net Revenue = $205,400**

Cadaver lab
- *Summary*
  - 13 sponsored stations
  - 30 lab attendees
- *Finances*
  - Total Sponsorship = $130,000
  - Total Registration = $5,800
  - Total Cost = $83,837.51
  - **Net Revenue = $51,960.49**

Non-CME Luncheon Seminars
- *Summary*
  - Registered attendees
    - Globus Medical: 50
    - Medtronic: 36
    - NuVasive: 45
    - DePuy: 43
  - 160+ actually attended
- *Finances*
  - Total Sponsorship = **Net Revenue = $80,000**

What's New Sessions
- *Summary*
  - 6 sponsoring companies
  - 8 sessions (Thursday morning/afternoon, Friday morning/afternoon)
- *Finances*
  - Total Sponsorship = **Net Revenue = $23,000**

2016 Annual Meeting Plan
- *Contacted all 43 exhibitors for feedback* - Already several verbal commitments for 2016 exhibits
- *Wine with Exhibitors (Thursday late afternoon)*
  - Non-CME sponsorship opportunities (e.g. What's New Sessions)
  - Debate style discussions? Auction?
- *Incorporate ARNP course into the cadaver lab*

Preliminary Outline for 2016 Annual Meeting non-CME sponsorships

Wednesday	1:00 - 1:30 pm	non-CME Lunch x 1 (@$6,000)	$6,000
	1:30 - 5:30 pm	CME Special Courses x 4	
	6:00 - 7:30 pm	Opening Reception	
	7:30 - 9:00 pm	non-CME Dinner x 1 (@$20,000)	$20,000

Thursday	7:00-10:30 am	Scientific Program CME	
	10:30 - 11:00 am	What's New Sessions x 2 (@$3,000)	$6,000
	11:00 - 12:00 pm	Scientific Program CME	
	12:00 - 1:00 pm	non-CME Lunch Symposia x 2 (@$20,000)	$40,000
	1:00 - 3:30 pm	Scientific Program CME	
	3:30 - 4:00 pm	What's New Sessions x 2 (@$3,000)	$6,000
	4:00 - 6:00 pm	Scientific Program CME	
	6:00 - 7:00 pm	What's New Sessions x 2 (@$3,000) during Wine with Exhibitors	$6,000

Friday	7:00 - 9:30 am	Scientific Program CME	
	9:30 - 10:00 am	What's New Sessions x 2 (@$3,000)	$6,000
	10:00 - 1:00 pm	Scientific Program CME	
	1:00 - 2:00 pm	non-CME Lunch Symposia x 2 (@$20,000)	$40,000
	2:00 - 3:30 pm	CME Special Courses	
	2:00 - 6:00 pm	non-CME Cadaver Lab (@$120,000)	$120,000

2016 Exhibit Committee Goals

- Cadaver lab = $120,000
- Non-CME symposia = $106,000
- What's New Sessions = $24,000
- Exhibit Sales = $205,400 *(*2015 total)*
- Educational Grants = $225,000 *(*2015 total)*
- Additional Advertising (program book ads, brochures, etc.) = $38,000 *(*2015 total)*
- **Projected Total = $718,400** *(2015 total = $701,400)*

Return to Agenda

The Executive Committee of the AANS/CNS Joint Section on Disorders of the Spine and Peripheral Nerves has reviewed the recent study published in SPINE comparing spine surgery outcomes by specialty (orthopedic surgery and neurosurgery). In summary, this study "30-Day Perioperative Outcomes in Spinal Fusion by Specialty within the NSQIP Database" reviewed the NSQIP database of spinal fusions and assessed short term perioperative outcomes comparing orthopedic spine surgeons to neurosurgeons.[2] The authors concluded that there were significantly longer hospital stays and higher complication rates amongst the patients operated on by orthopedic surgeons as compared to neurosurgeons. While an interesting study, the reader must be aware that studies that utilize nationwide databases are subject to significant limitations primarily related to the complexity of surgeries that is often not reflected in the data collected. While seemingly small, these missed details can results in studies that may not reflect realistic outcomes. As an example, there have been two other studies that have evaluated the same NSQIP database that have concluded there is no difference in outcomes between orthopedic spine surgeons and neurosurgeons.[1,3] Further, as the field of spine surgery evolves and collaboration grows between orthopedic surgeons and neurosurgeons, it is the belief of our organization that both specialties have made and continue to make tremendous contributions to the advancement of quality and safety in spinal surgery.

1. Kim BD1, Edelstein AI, Hsu WK, Lim S, Kim JY.Spine surgeon specialty is not a risk factor for 30-day complication rates in single-level lumbar fusion: a propensity score-matched study of 2528 patients.Spine (Phila Pa 1976). 2014 Jul 1;39(15):E919-27.
2. McCutcheon BA, Ciacci JD, Marcus LP, Noorbakhsh A, Gonda DD, McCafferty R, Taylor W, Chen CC, Carter BS, Chang DC. 30-Day Perioperative Outcomes in Spinal Fusion by Specialty within the NSQIP Database.Spine (Phila Pa 1976). 2014 Sep 8.
3. Minhas SV1, Chow I, Patel AA, Kim JY.Surgeon specialty differences in single-level anterior cervical discectomy and fusion. Spine (Phila Pa 1976). 2014 Sep 15;39(20):1648-55

Spine (Phila Pa 1976). 2014 Sep 8. [Epub ahead of print]

30-Day Perioperative Outcomes in Spinal Fusion by Specialty within the NSQIP Database.

McCutcheon BA1, Ciacci JD, Marcus LP, Noorbakhsh A, Gonda DD, McCafferty R, Taylor W, Chen CC, Carter BS, Chang DC.

Author information

Abstract

Study Design. Cross-sectional analysis of the American College of Surgeons' National Surgical Quality Improvement Program (NSQIP) database between 2005 and 2011.Objective. Determine whether differences exist in 30-day rate of return to the operating room, mortality, and other perioperative outcomes for spinal fusion by specialty.Summary of Background Data. While both neurosurgeons and orthopedic surgeons perform spinal fusions, it is unclear whether surgeon specialty impacts perioperative outcomes.Methods. Unadjusted bivariate analysis was performed to determine whether outcomes differed by surgeon specialty. A Bonferroni correction was applied to account for multiple comparisons. For outcomes with a statistically significant association, further multivariate analysis was performed.Results. 9,719 patients receiving a spinal fusion were identified. 54.0% had their operation completed by a neurosurgeon. Orthopedic surgeons had practices with a greater percentage of lumbar spine cases (76.0% vs. 65.0%, p<0.001). There was not a statistically significant difference in the number of levels fused or operative technique used between specialties. There was no difference in the majority of perioperative outcomes between orthopedic and neurosurgeons including death, rate of return to the operating room, and other complications associated with significant morbidity. On unadjusted analysis neurosurgeons were associated with a decreased incidence of operations requiring blood transfusion relative to orthopedic surgeons (8.3% vs. 14.6%, p<0.001). This trend persisted on multivariate analysis controlling for pre-operative hematocrit, history of bleeding disorder, anatomical location of the operation, number of levels fused, operative technique, demographics, and comorbidities (OR 0.49, 95% CI 0.43-0.57).Conclusion. Spine surgeons, regardless of specialty, appear to achieve equivalent outcomes on measured metrics of mortality, 30-day readmission, and surgical site infection. Observed differences in blood transfusion rates by specialty were noted, but the etiology of this difference is unclear and warrants further investigation to assess the impact of this difference, if any, on patient outcomes and cost.

Return to Agenda

Dr. Kurt Eichholz

Here is the Membership Report/Agenda for the conference call this evening:

- Outstanding Dues: Currently over 4 members with outstanding dues. Renewals are sent in late November. In the past, the list of outstanding dues is down significantly by that time. 2-3 years ago, there were 25 outstanding dues at that time, half of which were overseas, and I personally called the North American ones. This year, it was close to 70, so we sent an email to those at that time. The ones of concern are the ones that are two years overdue. Obviously, this indicated a lack of interest by the members, and many of those resign or switch to lifetime membership.

- DO's: There are 11 osteopathic neurosurgery training programs in the US. I am going to try to obtain a list of the faculty and residents (probably through seeing what is listed on their respective websites, or through the American Orthopedic Association). Once we have these names, we can send them a letter similar to what we send to the graduating residents inviting them to become members of the CNS and the Spine Section

- Orthopedic Surgeons: In the same vein, I will see if I can come up with a list of orthopedic spine fellowships, and target their graduating ortho-spine fellows, as well as their Ortho spine faculty. There is not much sense in targeting general orthopedic surgeons or orthopedics who are not spine surgeons

- Consider adding a "new member reception" to the Spine Section meeting next year. We could have a wine a cheese reception one day after the scientific sessions, and try to get EC members and past presidents to show up and meet the new members to get them involved from their first meeting forward. This could be done in the exhibit hall, but would probably be more effective as a separate event, similar to the Young Neurosurgeon's Committee receptions that they have at the AANS and CNS.

- As Marjorie mentioned, we could have new members from the past calendar year receive a "New Member" ribbon on their name badge, just like we get "committee member" ribbons for our badge. We could also encourage EC members to look for those with new member ribbons and engage them. I guess that if we decided to do this we would have to talk to the CNS, who coordinates our meetings to see if they could make up a "New Member" Ribbon. We may also want to have the staff put this on their badge before it is given to the new members, as some people (like me), don't bother to put the ribbons on their badge.

Return to Agenda

AANS/CNS SECTION ON DISORDERS OF THE SPINE AND PERIPHERAL NERVES

American Association of Neurological Surgeons

A Section of the
American Association of Neurological Surgeons
and
Congress of Neurological Surgeons

CHAIRPERSON

Praveen V. Mummaneni, MD
UCSF/Neurosurgery
Phone: (415) 353-3998
E-mail: vmum@aol.com

CHAIR-ELECT

John Joseph Knightly, MD
Atlantic Neurosurgical Specialists
Phone: (973) 285-7800
E-mail: jknightly@ansdocs.com

SECRETARY

Marjorie C. Wang, MD
Kadlec Neuroscience Center
Phone: (509) 942-3080
Fax: (509) 942-3085
E-mail: marjorie.wang@gmail.com

TREASURER

Michael Y. Wang, MD
University of Miami
Phone: (305) 243-3337
E-mail: mwang2@med.miami.edu

IMMEDIATE PAST CHAIRPERSON

R. John Hurlbert, MD
Foothills Medical Center
Phone: (403) 283-4449
Fax: (403) 283-5559
E-mail: jhurlber@ucalgary.ca

Authorization TO TRANSFER RESTRICTED ASSETS

The undersigned, on behalf of the AANS/CNS Joint Section on Disorders of the Spine and Peripheral Nerves (the "Donor"), hereby authorizes and directs the transfer of assets previously donated by Donor on or about October 30, 2006, and currently held by the American Association of Neurological Surgeons (the "AANS"), for the benefit of the Neurosurgery Research and Education Foundation, to the account of the Neurosurgery Research and Education Foundation, an Illinois not-for-profit corporation, EIN 46-2905743 (the "Foundation").

The Donor and the Foundation agree that any expenditure of the assets donated by Donor must be directed and approved, in writing, by the AANS/CNS Joint Section on Disorders of the Spine and Peripheral Nerves Executive Committee. The Donor and the Foundation further agree that subject to the above language, use of the assets by the Foundation are subject to the same terms and conditions as set forth in the Agreement previously entered into on or about October 30, 2006 between the Donor and the AANS (a copy of the Agreement is attached hereto as Exhibit A).

April 27, 2015

Praveen Mummaneni, MD Date

Chair, AANS/CNS Joint Section on

Disorders of the Spine and Peripheral Nerves

Acknowledged and Agreed to by:

4-28-15

Thomas A Marshall Date

Executive Director

American Association of Neurological Surgeons

Return to Agenda

Publications Committee Report for DSPN EC Meeting at the AANS Meeting (May 3, 2015)

Following selection of abstracts for podium presentation at the 2015 DSPN Annual Meeting, letters were sent from *Journal of Neurosurgery* and from *Neurosurgery* to the presenters of the top 14 abstracts inviting submission of a corresponding manuscript for consideration for publication. These letters were sent in November 2014 with a deadline for submission of June 1, 2015. These letters offered expedited review but not a guarantee of publication. The top 14 abstracts included 10 that had been submitted to the DSPN meeting and 4 that were top abstracts from other societies invited to attend and participate in the meeting.

In March of 2015, following the DSPN meeting, letters were sent to the same 14 top abstract presenters from *Journal of Neurosurgery* and from *Neurosurgery* to the presenters as a reminder of the invitation to submit a corresponding manuscript for consideration for publication. The deadline of June 1, 2015, as well as the offer an expedited review but not a guarantee of publication, was included in the reminder letter.

Going forward, we will plan to track the number of these 14 abstracts submitted to each journal, as well as the time of review and the ultimate status (acceptance or rejection). We will also plan to discuss with the respective journals whether there is a desire to increase the number of top abstract presenters that are invited to submit manuscript for consideration for publication for subsequent years. The respective journal Editors are invited to attend the DSPN EC meeting at the 2015 AANS meeting in order to discuss these manuscript submissions.

This report submitted by Justin Smith, MD, PhD (DSPN Publications Committee Chair) on April 17, 2015.

Return to Agenda

NEUROPOINT ALLIANCE
est. 2008

N²QOD
NATIONAL NEUROSURGERY QUALITY & OUTCOMES DATABASE

N²QOD Operations Committee Meeting

May 2, 2015 - Saturday

3:30 – 5:00 p.m.

University of DC, Level M1
Marriott Marquis Washington DC
901 Massachusetts Avenue NW
Washington DC, 20001

3:30 – 3:35 p.m.	**Call to Order, Welcome**	Dr. Watridge
3:35 – 3:40 p.m.	**N²QOD Update and Successes** a) Number of Participating Centers b) Extent of Data Collected c) Number of Patients Enrolled	Dr. Asher
3:40 – 3:55 p.m.	**VIMPH/PBLN Report** a) New Modules – CV/Deformity b) N²QOD Practice-Based Learning, On-the Job Training c) N²QOD Data Analysis	Dr. Speroff
3:55 – 4:05 p.m.	**Subcommittee Reports** a) N²QOD Accrual, Data Quality & Validity b) N²QOD Diagnosis Consistency / Accuracy / Expansion	Drs. Knightly, Mummaneni Dr. Bambakidis
4:05 – 4:30 p.m.	**N²QOD Data Collection Efficiencies**	Dr. Sorenson, Subcommittee
4:30 – 4:45 p.m.	**N²QOD 2015 PQRS-QCDR Reporting**	Dr. Speroff, Dr. Asher
4:45 – 4:50 p.m.	**Development of the Young Neurosurgeon Quality Scientist Network**	Dr. Asher
4:50 – 5:00 p.m.	**Q & A, Comments**	Committee
5:00 p.m.	**Adjournment**	Dr. Watridge

AANS/CNS Quality Improvement Workgroup
MEETING AGENDA
Sunday, May 3, 2015; 11:00 am – 12:45 pm
Marriott Marquis, Washington University Room, Level M1

American Association of Neurological Surgeons

CNS

Members: Adelson (JGC), Angevine, Asher (NPA/N2QOD), Babu (CSNS), Batjer (ABNS), Bekelis (CSNS Resident Fellow), Bloomgarden (SQA), Cloninger (NERVES), Cockroft (CV, JGC), Cohen-Gadol (Stereotactic), Cozzens (PCPI), Diaz, Ghogawala, Groman (staff), Harbaugh (NPA), Harris (Trauma), Heary (Spine), Kaiser, Khalessi (CV), Knightly (NQF, N2QOD), Litvack (PCORI), McGirt (N2QOD), Penar (Vice-Chair, NQF/SQA), Ratliff (Chair, RUC Advisor), Reeder (PCPI), Resnick, Rodgers (Trauma), Rughani, Schirmer, Sillay, Steinmetz, Tomei, Walter, Weinstein (SNS), Wohns, Zacko, Zusman

Ex Officio Member: John A. Wilson, MD, Chair, AANS/CNS Washington Committee

Staff: Katie O. Orrico, Director, AANS/CNS Washington Office
Rachel Groman, Hart Health Strategies

	Agenda Item	**Discussant**
I.	Welcome/Introductions • Approval of Minutes • Reorganization of the QIW	John Ratliff
II.	SGR Repeal (Pub.L. 114-10): The Future of Value-Based Payments • Merit-Based Incentive Payment System (MIPS) and Alternative Payment Reforms	John Ratliff/Rachel Groman
III.	Meaningful Use Proposed Rules • 2015-2017 Meaningful Use • Stage 3 Meaningful Use	Rachel Groman
IV.	NPA/N2QOD Update	Tony Asher
V.	NQF Update	Paul Penar
VI.	CSNS Ad Hoc Safety Committee Update	Gregory Smith, Chair Wayel Kaakaji, Vice Chair

Future QIW Meetings

Sunday, September 27, 2015 11:00 am-12:45 pm New Orleans, LA

QIW Meeting Minutes
Boston, MA
October 19, 2014

Attendance

Asher, Babu, Batjer, Cockroft, Cozzens, Ghogawala, Groman, Harbaugh, Heary, Khalessi, Knightly, Orrico, Penar, Reeder, Resnick, Rodgers, Rughani, Wilson

PQRS/EHR Incentive Program/Value Modifier

- Questions raised about PQRS participation rates among neurosurgeons. 40% report for the PQRS, but how many are reporting on their own versus through their group or institution (the PQRS Experience Reports don't dig down to this level)
- Cozzens expressed concerns about putting all our eggs in the QCDR basket vs. trying to develop individual measures
- While Ratliff reminded the group that the NQF process is not easy, Asher noted that the process is changing and that face validity is really all you need for a measure. If we were to develop our own measure, perhaps we can model it off of the thoracic surgeon structural measure that simply recognizes reporting to a registry. We could ask STS or the YALE CORE folks for assistance.
- Khalessi noted that the Yale group also does lots of tech assessments related to CV and that we should use a group that CMS already has a relationship with/credibility.
- Cozzens note that vascular surgeons look at a numerator of all patients discharged home by a certain number of days and the number of all patients undergoing a specific procedure with very specific criteria (e.g., if patient was discharged within 24 hrs). You can use this one measure for multiple procedures. We should look into to what extent these measures have gone through the official validation process/been approved.
- Harbaugh noted how we could also use this reporting for Part 4 MOC.
- Asher reminded the group that while we can't develop novel measures by December, we should think about that for next future.
- Resnick noted that this will be a 2 phase process; before we put resources into checking boxes, we need to figure out who actually needs it. Anyone in an academic center doesn't. It's a substantial investment. We need to know how many folks are actually going to use this. Instead we should invest in a true QI data collection mechanism.
- Khalessi agreed that an in-house registry offers the benefit of driving the collection of data, quality measures to ask us different questions over time.
- Asher: we originally launched N2QOD b/c folks were threatening to invest in their own system and we wanted it housed in one place.
- The group discussed that strategy of narrowly defining the patient population in order to shrink the denominator.
- Asher discussed the option of working with a vendor such as CECity.
- Ratliff continued to remind the group that only about 40% would be eligible for this, so we have to be cautious with price points since the majority of members don't need this.

ACTION: **Asher will talk to CE City and share whatever details he gathers.**

Over the longer term, neurosurgery will develop more specific measures.

N2QOD Update

Asher provided the following update:

- For lumbar spine there are now 53 centers and 7 more being brought on board.
- For cervical spine, there are 32 centers, which is well above 80%.
- Across the board, the12-month follow-up is greatly improving.
- Plans to work with IHI on a prospective readmission project.
- Reactivating deformity module in next month. Large academic centers are looking at it now, trying to determine if it requires too much data.
- 2nd quarter of next year, looking to have a tumor module.
- There is interest in a simple module to help members satisfy PQRS, MOC, etc.
- Missing data is a problem- likely not intentional, but it's affecting analyses. 12-month follow-up is below 75%. Efforts to better look into data completeness and accuracy. Self-initiated audits at centers look at diagnostic errors, but will also have to start looking at source documentation. Is data being inputted accurately? Looking into 10% on-site audit.

In regards to NSQIP, Asher noted that he's made repeated attempts to reach out to Cliff Ko at ACS, but has had no success. A lot of what we collect also goes into NSQIP so there's no reason not to share; also NSQIP has expressed interest in a neurosurgical module. Knightly noted that users should be able to format N2QOD dashboard so it takes advantage of NSQIP data.

Open Payments Website

Knightly demonstrated search. Reeder raised questions about appeal process for correcting information. Knightly reminded the group that this is much better than the initial launch. Orrico noted that while there is currently an exception for certain CME things, CMS trying to do away with this. Babu warned that even if this data is not accessible by patients, third parties are extracting it and making it available.

Reorganization of QIW

Orrico reminded the group that the leadership of both the AANS and CNS support QIW's mission and stand ready to approve resources for whatever it identifies as priorities. Wilson noted that quality efforts across neurosurgery need to be better aligned and that the QIW can fill that role. The QIW should be the purveyor of quality measurement for all of neurosurgery. Asher highlighted that there is currently no vehicle to facilitate PQRS participation, there's a lack of specialty specific measures, and that we're behind where many other groups are now. QIW needs to fill this role- a clearinghouse for these efforts. Even if it doesn't take on all of these projects, it should be the convener of all stakeholders.

QUALITY IMPROVEMENT

Administrative Issues

The AANS/CNS Quality Improvement Workgroup has recently had a change in leadership. The new appointments are for two-year terms:

- John Ratliff, MD, Chair
- Paul Penar, MD, Vice-Chair

Going forward, the QIW will be restructured and renamed the Neurosurgery Quality Council (NCS) to reflect a realignment of neurosurgery's quality strategy.

Medicare Physician Quality Improvement System (PQRS)

2014 marked the last year that physicians were eligible for an incentive payment under the PQRS. Those who fail to satisfy reporting requirements in 2015 are subject to a 2.0% penalty in 2017 and going forward.

CMS also has dramatically increased the reporting requirements for 2015. To avoid the 2017 penalty, physicians reporting individual PQRS measures must report on at least 9 measures across at least 3 National Quality Strategy (NQS) domains for 50% of applicable Medicare Part B FFS patients. CMS also will require that at least one of the 9 measures come from a CMS-defined set of "cross-cutting" measures. Unfortunately, these reporting requirements, paired with the retirement of multiple measures, will dramatically affect a neurosurgeon's ability to participate meaningfully in the program through traditional claims-based reporting in 2015.

The one silver lining is that CMS now recognizes reporting to a qualified clinical data registries (QCDR) as an alternative to more traditional PQRS reporting mechanisms. QCDRs provide specialties with the opportunity to collect and submit data to CMS on uniquely selected and more meaningful measures that are not offered through the traditional PQRS measure set. To avoid the 2017 PQRS penalty, those participating through a QCDR in 2015 must report on 9 QCDR measures across three NQS domains for 50% of ALL patients (both Medicare and non-Medicare). Of the measures reported, two must be outcomes measures.

The N^2QOD was recently approved by CMS to serve as a QCDR for 2015, which will allow organized neurosurgery to offer its members a more relevant tool for reporting and avoiding penalties. In an effort led largely by Drs. Asher and Knightly, the N^2QOD developed a reporting tool that includes 21 spine-focused measures, some of which were modeled off of existing PQRS or National Quality Forum-endorsed measures. This "stand-alone" product can be used by both individuals who are not presently participating in the N^2QOD to satisfy PQRS requirements, as well as by current participants since it embeds elements of the existing registry.

The N^2QOD leadership recognizes the pressing need for a reporting tool that is relevant across neurosurgery, but due to a tight application deadline, opted to focus first on measures expected to have the greatest impact. Over the next year, the N^2QOD will work to develop an "essentials" platform that can be used across neurosurgery and/or additional sub-specialty specific modules so that non-spine care providers can also take advantage of this tool to satisfy federal quality reporting requirements (hopefully, by 2016).

Prepared by Rachel Groman and Katie Orrico
April 2015

These efforts will continue with the overall goal of providing neurosurgeons with a minimally burdensome tool that not only allows them to avoid PQRS penalties, but also results in more meaningful data. To that end, the AANS/CNS Washington Office recently conducted a member survey to learn more about PQRS participation trends and recently posted online guidance documents for the general membership about these changing federal quality reporting requirements.

Physician Value-Based Payment Modifier

Under the Affordable Care Act (ACA), Congress directed CMS to apply budget neutral adjustments to physician payments based on quality and cost performance beginning in 2015. Under statute, the Physician Value-Based Payment Modifier (VM) must apply to all physicians by 2017 (based on 2015 reporting).

For the 2017 adjustment, CMS will apply a lower penalty of 2% to smaller group practices (2-9 eligible professionals or EPs) and solo practitioners for failure to satisfy PQRS in 2015. Groups with 10 or more EPs will be subject to a 4% penalty. All physicians also will be subject to "quality tiering" in 2017, which is CMS' mechanism for adjusting payments based on quality and cost performance. However, CMS will ***hold harmless from performance-based penalties practices with two to nine and solo practitioners***. These EPs may only receive a neutral or upward performance-based payment adjustment (up to +2x). In 2017, larger practices (10 or more EPs) may receive cuts of up to 4% percent, bonuses up to +4x, or no adjustment one way or the other. As in the past, the upward payment adjustment factor ("x") will be determined after the performance period has ended and, due to the budget neutral nature of this program, is based on the aggregate amount of downward payment adjustments.

For 2017 payment adjustments (based on 2015 reporting), CMS will continue to calculate performance based on PQRS measures reported by the group or individual; 3 outcome measures automatically calculated by CMS; and multiple cost measures that evaluate total per capita costs as well as total costs related to an inpatient hospitalization. In response to concerns voiced by neurosurgery and others, CMS is working to develop more granular episode-based cost measures for use under the VM. However, until that work is complete, it will continue to rely on these broad-based cost measures, which reveal very little about a neurosurgeon's cost of care.

In late February 2015, CMS posted results for the 2015 VM, which is the very first year that the VM applies to group practices of 100 or more eligible professionals. CMS identified 1,278 groups of 100 or more eligible professionals (as identified by their Tax Identification Numbers or TINSs). Two hundred sixty-eight of the 1,278 TINs are not subject to the VM in 2015 because one or more physicians under the TIN participated in the Shared Savings Program, Pioneer ACO Model, or Comprehensive Primary Care Initiative in 2013.

Of the remaining 1,010 groups subject to the CY 2015 VM, 691 groups either self-nominated for the PQRS as a group and reported at least one measure or elected the PQRS Administrative Claims option as a group (note: this option is no longer available). Three hundred nineteen groups failed to self-nominate for PQRS as a group and report at least one measure or elect the PQRS Administrative Claims option as a group and were therefore subject to an automatic -1.0% Medicare payment adjustment.

Of the 691 groups that met the minimum reporting requirement as a group, 127 groups elected to have their CY 2015 VM calculated using the quality-tiering methodology; therefore, only these 127 groups will receive an upward, neutral, or downward adjustment in CY 2015 based on their performance on the quality and cost measures in CY 2013. Twenty-one of the 127 groups will receive a neutral adjustment in CY 2015 because CMS has insufficient data to calculate either their quality or cost composite.

Of the remaining 106 groups for which CMS was able to calculate both quality and cost composites, 14 groups fell into tiers that will result in an upward adjustment of +1.0x; 11 groups are in tiers that will result in a downward adjustment of -0.5 or -1.0 percent; and 81 groups are in tiers that will result in a neutral VM (meaning no adjustment to their payments) in CY 2015. No groups earned the +2.0x adjustment available to groups that were high quality and low cost. Furthermore, of the groups that are eligible for an upward adjustment, none of the groups are eligible to receive an additional +1.0x adjustment to their Medicare payments for treating high-risk beneficiaries.

Quality and Resource Use Reports

In the fall of 2014, CMS distributed 2013 Quality and Resource Use Reports (QRURs) to *all* groups and solo practitioners. In the late summer of 2015, CMS will disseminate QRURs based on 2014 data to all groups and solo practitioners. These reports provide a preview of the methodologies that CMS will use to apply the VM to group practices and solo practitioners. For larger groups already impacted by the VM, these reports outline the basis for payment adjustment determinations.

In February, the AANS/CNS Washington Office solicited feedback from members who may have accessed their QRURs in an effort to identify issues related to the accuracy and utility of the data and the usability of its format.

Health Information Technology

Electronic Health Record Incentive Program (Meaningful Use)

2014 was the last opportunity for an eligible professional (EP) to earn an incentive under this program. A 1% penalty was applied beginning January 1, 2015 to EPs who did not successfully demonstrate meaningful use in 2013 (or 2014 for first-time participants) and did not receive a 2015 hardship exception. EPs who did not successfully demonstrate meaningful use in 2014 and do not receive a hardship exception will see a 2% pay cut in 2016. EPs will have until July 2015 to apply for a hardship waiver to avoid 2016 penalties. EPs who fail to demonstrate meaningful use in 2015 will see a 3% pay cut in 2017, and the Meaningful Use penalty can increase to as high as -5.0 percent by 2019. In addition to these penalties, successful participation in the EHR Incentive Program based on 2015 data also will be publicly reported on the Physician Compare website starting in 2016.

Once an EP starts the program, he/she must continue to use certified EHR technology to meet higher stages of meaningful use over time in order to avoid penalties. Unfortunately, the program continues to take an all-or-nothing approach to compliance, which means that if an EP fails to meet a single requirement, he/she will receive a penalty.

In late March, CMS released a proposed rule specifying Stage 3 requirements for eligible professionals in the EHR Incentive Program. Stage 3 focuses on the advanced use of EHRs to improve patient outcomes. While CMS claims these proposed updates will reduce program complexity and create more flexibility, some provisions would actually substantially raise the reporting burden and further box specialists into one-size-fits all objectives.

The Stage 3 proposed rule's scope is limited to the requirements for those satisfying meaningful use in 2017 and beyond. CMS is pursing additional changes to meaningful use beginning in 2015 through separate rulemaking (see below). The Stage 3 proposals include:

- Establishing a single, aligned reporting period for providers based on the calendar year (rather than the current 90 days);

- Allowing providers the option to start Stage 3 of meaningful use in either 2017 or 2018 (required in 2018), which gives providers an extra year to start than under current regulation;
- Reducing the overall number of objectives to 8 to focus on advanced use of EHRs and quality improvement (versus the current requirement of 18 objectives).
- Removing measures that are redundant or received wide-spread adoption (including removal of "topped out" measures, such as "recording demographics");
- Simplifying meaningful use objectives and measures and reporting requirements by allowing more flexible measures under health information exchange, consumer engagement, and public health reporting that would fit their own patient population or practice;
- Revised objectives heavily on interoperability and patient engagement.
    - For the latter, providers would have to report on all three of the following measures, but successfully meet thresholds on two of them:
        - For the controversial Stage 2 measure of getting patients to view, download, and transmit their data, the agency has proposed a 25% threshold to providers. This would be up from 5%, which is the requirement in Stage 2.
        - Stage 3 would require that for more than 35% of all patients seen by the provider or discharged from the hospital, a secure message was sent using the electronic messaging function of certified EHR technology, or in response to a secure message sent by the patient.
        - More than 15% of patients to contribute patient-generated health data or data from a non-clinical setting into the certified EHR technology during the EHR reporting period.
    - For health information exchange, for more than 50% of patients referred there must be a summary of care record using certified electronic health record technology (CEHRT) and an electronic exchange of the summary of record. For new patients, providers must incorporate into the EHR an electronic summary of care document from a source other than their EHR system for more than 40% of patients. For more than 80% of patients, providers must implement clinical information reconciliation with medication, medication, and the patient's current problems.
- Aligning clinical quality measure reporting with other CMS programs to allow for single submissions; and
- Proposing the use of application programming interface (APIs) that could enable the development of new functionalities to build bridges across systems and provide increased data access.

Unfortunately, CMS did not propose to allow a provider to fail any two objectives and still meet meaningful use or to allow providers to receive an incentive payment or avoid a downward payment adjustment based on varied percentages of performance, and removing all measure thresholds. This was a proposal that has been largely supported across organized medicine.

At the same time, the Office of the National Coordinator for HIT (ONC) released a proposed rule on the 2015 Edition HIT Certification Criteria. This rule outlines the functionalities that EHRs, which are federally certified for meaningful use reporting, are expected to comply with. The rule proposes to adopt new standards that support the goals of ONC's recently released Interoperability Roadmap (see below), as well as improved outcomes and reduced patient harm. It also would open the ONC Health IT Certification Program to other types of HIT beyond EHRs such as Health Information Service Providers, Health Information Exchanges, or Laboratory Information Systems.

In April, CMS published a separate, but aligned, proposed rule outlining revised requirements for Meaningful Use 2015 through 2017. The overall goal is to merge Stage 1 and 2 requirements and eventually align them with a single set of Stage 3 requirements that every eligible professional would be held accountable to by 2018, regardless of their year of participation. As part of this process, CMS

proposes to require all providers, starting in 2015, to attest to a single set of streamlined objectives/measures that represent a modified version of those previously finalized for Stage 2. CMS proposes to remove redundant, duplicative, and topped-out measures and to also make modifications to existing objectives and measures, such as those that require patient actions over which a professional may have little control.

Since these proposed changes were released in the middle of the 2015 reporting year and will not be finalized until later in the year, CMS proposes an alternative set of reporting requirements and other special exclusions for professionals who were previously scheduled to participate in Stage 1 in 2015. To accommodate these changes, CMS also proposes to extend the 90-day reporting period for all eligible professionals in 2015, regardless of their prior participation in the program. In 2016, *new* participants would still be able to attest to meaningful use for any continuous 90-day period within the calendar year. However, if an eligible professional has previously demonstrated meaningful use, he/she must report for the full calendar year in 2016 to avoid the 2018 payment adjustment. Comments on the Stage 3 and Interoperability rules are due **May 29, 2015**, and comments on the rule regarding the 2015-2017 reporting years are due **June 15, 2015**.

Federal Efforts to Improve Interoperability and Adoption of HIT

In December, ONC released a draft 5-year HIT Strategic Plan, which maps out ways to better gather, share and put to use interoperable health data. The HIT Strategic Plan also sets the context for the Nationwide Interoperability Roadmap, which was released by ONC in January 2015. This includes more specific proposals for moving towards national standards for handling electronic clinical data by the end of 2017. The document covers core technical standards and functions, certification, privacy, security and governance standards and is open for public comment through April 3, 2015.

Also in late January, a coalition of 35 physician organizations, including the AANS and CNS, submitted a letter to the Director of the Office of the National Coordinator (ONC) for HIT, voicing growing frustration with EHRs and the multitude of requirements that come from the federal meaningful use program. Concerns included the fact that EHRs are cumbersome, do not meet physician workflow needs, decrease efficiency, and have limited, if any, interoperability. The letter also expressed concerns about the downstream effects of meaningful use requirements on patient safety. It called on the government to focus on functionality — in particular interoperability, safety and usability — rather than meaningful use criteria.

Public Reporting: Physician Compare

Up until last year, CMS had used this ACA-mandated website to report only on whether physicians had satisfactorily *participated* in federal quality reporting programs. However, starting in 2014, CMS also began reporting *performance* data for select measures reported by larger group practices and ACOs. In late 2015, it will report on select measures reported by group practices of 2 or more EPs in 2014 and by late 2016, CMS plans to report on all 2015 PQRS measures reported by individuals, including QCDR measures.

To ease concerns about accuracy/utility, prior to public reporting, all measures, including QCDR measures, must: meet a minimum sample size of 20 patients; must prove to be statistically valid, reliable, comparable, and accurate (data will be analyzed and reviewed by CMS' Technical Expert Panel); will be tested on consumers; and must have a benchmark (i.e., no first year measures will be publicly reported). Physicians also will have 30 days to review data before it is posted.

The AANS and CNS continue to work with the Physician Compare contractor to make improvements to both the format and the underlying methodologies, including proposals for future benchmarking.

On the private side, in March 2015, Drs. Ratliff and Asher participated on the Medical Advisory Panel for the U.S. News Hospital Ratings in Common Care on a panel responsible for reviewing its methodology. Each panel is responsible for:

- Identifying quality measures that U.S. News should consider incorporating into its methodology;
- Identifying methodological limitations and proposing practical means of addressing them;
- Recommending further actions US. News should take to ensure the ratings serve patients' needs.

HHS and Private Sector Set Value-Based Payment Goals

In early February, the Secretary of HHS announced new measurable goals intended to move the Medicare program further toward value-driven health care. The framework sets out to have 85% of all Medicare FFS payments tied to quality or value by 2016, and 90% by 2018, noting the role of the ongoing Hospital Value-based Purchasing and Hospital Readmissions Reduction programs as leverage in meeting these ambitious targets. It also sets a goal of tying 30% of FFS Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payments by the end of 2016, and tying 50% of payments to these models by the end of 2018. Additional information about this announcement is available here.

This announcement represents the first time that the federal agency has set specific goals for overhauling the payment system for standard Medicare beneficiaries. Currently, 20% of Medicare payments for traditional beneficiaries are made through alternative payments models, such as bundled payment arrangements.

Immediately following this announcement, 28 heath care entities, including providers, payers, and employers, announced the creation of a private-sector alliance, the Health Care Transformation Task Force, which will aim to transform 75% of their payment models to novel mechanisms that incentivize quality and lower health care costs by 2020.

Around the same time, the Pacific Business Group on Health (PBGH) announced that it would be expanding its bundled payment program with hospitals to include spinal surgeries. The PBGH's Employers Centers of Excellence Network (ECEN) steers employees of participating companies to specific providers for high-cost procedures. The hospitals that will provide the spinal surgeries to the PBGH participating employers (such as Lowes and Wal-Mart) include Geisinger Medical Center in Danville, Pennsylvania, Mercy Hospital in Springfield, Missouri, and Virginia Mason Medical Center in Seattle.

March also marked the official launch of the Health Care Payment Learning and Action Network, which aims to bring public and private groups together to share best practices and to help speed the shift toward rewarding quality and value. More than 2,800 health care providers, patients and consumer groups have agreed to take part in the network. The network held its first official working meeting in late March and is expected to set goals of alternative payment models by September. Organized neurosurgery will continue to track the activities of this group and look for potential opportunities.

Shared Savings Program and Accountable Care Organizations

The ACA created the Medicare Shared Savings Program (MSSP), under which networks of providers known as ACOs contract to reduce health spending and meet quality targets in exchange for a share of savings that exceed certain quality and spending benchmarks. As of late December, there were slightly more than 400 Medicare ACOs. However, most remain in upside-only contracts (i.e., one-

sided risk) where they share in less savings (50% compared to 60%), but do not have to pay losses back to CMS. Also, as of December, only 58 ACOs held spending below their benchmarks by a total of $705 million and earned shared savings payments of more than $315 million. Another 60 ACOs had expenditures below their benchmark, but not by a sufficient amount to earn shared savings. Multiple hospital systems also dropped out of the Pioneer ACO program, which was targeted to those most prepared to engage in the highest level of risk, citing concerns about their ability to meet quality benchmarks and earn shared savings payments.

In early December, CMS proposed revised rules to improve MSSP participation, including:

- Allowing ACOs to continue with the program's one-sided risk track for a second three-year term, but at a lower maximum shared savings rate;
- Adding a modified two-sided risk track that offers greater potential financial rewards and, for the first time, prospective beneficiary assignment for ACOs that feel they are ready for such a model;
- Seeking comments on offering risk-bearing MSSP ACOs certain waivers, as well as an alternative methodologies that would make ACO benchmarks for determining shared savings/losses gradually more independent of the ACO's past performance and more dependent on the ACO's success in being more cost efficient relative to its local market; and
- Proposing to refine the way Medicare beneficiaries are assigned to an ACO to place greater emphasis on primary care services and to exclude certain specialties from the beneficiary assignment process. This would allow neurosurgeons to participate in multiple ACOs rather than being exclusive to one.

The AANS and CNS commented on this rule through the Alliance of Specialty Medicine.

In February 2015, the AANS and CNS declined to sign on to an AMA letter since it painted too rosy of a picture about moving towards more widespread implementation of the ACO and similar models over the long run.

In March 2015, CMS announced the "Next Generation ACO" model. Recognizing that there has been very little participation to date in Medicare two-sided risk models, this model aims to make a number of changes to address impediments to assuming a higher level of risk. These include higher shared savings rates; more stable and predictable payments; protection against losses by outliers; prospectively set benchmarks (vs. year-end benchmarks under the Shared Savings and Pioneer models); and the ability to engage beneficiaries through benefit enhancements, such as lower copays for aligning with an ACO. There is also a voluntary "capitation" element to this, as well.

This model, which aligns with CMS' goal of tying 50% of Medicare FFS payments to value-based payment methodologies by the end of 2018, was announced outside of the rule making process. However, similar changes to the Medicare Shared Savings Program will soon be finalized through rule making.

Comparative Effectiveness Research

The AANS and CNS continue to participate in high-level discussions related to CER and the PCORI by commenting on their reports/proposals and through our position on the steering committee of the Partnership to Improve Patient Care (PIPC). PCORI recently expressed interest in engaging specialty societies on high profile specialty conditions, as well rare or understudied conditions. As part of this process, the AANS and CNS, through the Council of Medical Specialty Societies (CMSS), submitted a list of priority topics relevant to neurosurgery that it believes PCORI should focus on.

In March, the Government Accountability Office (GAO) issued a report that PCORI is operating in accordance with the requirements of the ACA. The study of the five-year institute noted that PCORI plans to distribute the first CER results in 2017. However, research that is conclusive enough to influence medical practice may not be available until around 2020, and it may be difficult to measure the impact of the research on care delivery. As of October 2014, PCORI had awarded 360 contracts worth $671 million out of $3.5 billion it is authorized to spend under the ACA. About $106 million of the total spent so far has gone to PCORnet, an alliance of 29 separate networks that are developing ways to speed the research using EHRs and other data sources. PCORnet is expected to start its first clinical trial this year. However, the process of developing a common data model has been slowed because of the lack of standardized data in the EHRs used by the different networks. The report noted that the network may need to secure outside funding once its authorization ends in 2019.

Registry Regulatory Burdens

Physician Clinical Registry Coalition Activities

Over the last year or so, neurosurgery has been a leading member of the Physician Clinical Registry Coalition (PCRC), which includes other physician organizations that have registries and aims to address common regulatory and legislative issues. To address the coalition's ongoing concerns regarding the Privacy and Commons Rules, and the need for further clarification on the ability to collect prospective patient data for quality improvement purposes, the coalition has been interacting with HHS' Secretary's Advisory Committee on Human Research Protections (SACHRP), the Office for Civil Rights (OCR) and Office for Human Research Protections (OHRP). The coalition has repeatedly put pressure on OHRP to respond to its repeated requests for clarification that the Common Rule does not apply to registry data collection efforts for quality improvement purposes, even if such data is subsequently used in a de-identified way to answer research questions.

The coalition made some headway in October, largely thanks to neurosurgery, when the OHRP posted its correspondence with Tony Asher in letters dated Aug. 11, 2011 and Dec. 29, 2011 responding to questions about the application of the Common Rule to the activities related to the N^2QOD. The letters were made available to the public, with a few clarifying bullet points, with the intent of offering other stakeholders guidance. However, the OHRP still has not responded directly to the letters or clarified the original regulatory language.

The PCRC is working on multiple fronts to address registry-related issues:

- Commented on 2015 Medicare Fee Schedule provisions related to QCDRs.
- Met with MedPAC to educate them about the value of clinical registries, particularly QCDRs after MedPAC's executive director dismissed the value of physician-led registries for purposes of quality improvement, likening this to the fox watching the hen house.
- Developed a document titled "Guidance on Legal Challenges and Regulatory Obligations for Clinical Data Registries," which includes information on a variety of legal and regulatory matters facing registries.
- Working with Congress to push for legislative language that would support expanded recognition of and investments in clinical data registries. Both the 21sy Century Cures Act and the Medicare Access and CHIP Reauthorization Act of 2015 (i.e., the SGR replacement bill) included important language to expand access to Medicare data by QCDRs and to ensure a national interoperable health information infrastructure.
- Working to draft legislative language to protect registry data from discovery.

Outside of the PCRC, but related to these efforts, the AANS, CNS, PCRC, and ABMS recently nominated Dr. Asher in February to serve on the SACHRP.

NeuroPoint Alliance

The NPA has implemented a number of projects related to the collection, analysis and reporting of clinical data relevant to neurosurgical practice, including MOC, PQRS and the N^2QOD. To date, over 50 centers are participating. In addition to the spine modules, the CV and Deformity Modules were launched nationwide in December 2014. The N^2QOD is currently seeking additional sites to commit. Additional plans also are in the works to develop more subspecialty modules including tumor, and an "essentials" module to encourage more physicians to participate in this initiative.

NPA leaders and Washington Office staff also are working to position the NPA as a one-stop portal for purposes of MOC, PQRS and quality reporting. As noted earlier, the N^2QOD was recently approved to be a QCDR for the 2015 PQRS.

Also, in September 2014, ASTRO and the AANS partnered to develop a joint stereotactic radiosurgery registry that will be managed by the NPA. Brainlab is providing the majority of the sponsorship for the SRS registry, which is planned to launch in April 2015

Quality Improvement Organizations

AMA Physician Consortium for Performance Improvement (PCPI)

Over the years, the PCPI has developed, in partnership with professional societies, over 350 measures, many of which are used in federal reporting programs. Due to the large expense of developing and maintaining these measures, the PCPI recently announced a measure transition plan, under which it will charge for its services going forward. The PCPI also recently approved a new PCPI Governance Framework, which will allow more non-physician stakeholders to have a voice in the coalition, while still remaining physician-led. This decision is largely a result of CMS telling the AMA that it can fund more projects if the PCPI's structure is more independent and multi-stakeholder in nature.

The PCPI also recently created the National Quality Registry Network (NQRN), a voluntary network of multi-stakeholders operating registries and others interested in increasing the usefulness of clinical registries to measure and improve patient health outcomes. The AANS and CNS are now members of the NQRN Council, and Dr. Asher was appointed in July to serve as the chair of the NQRN's new Privacy and Research Task Force. In June 2014, the NQRN released a Registry Maturational Framework. Click here for more information on the NQRN, including additional resources for developing or existing registries.

Ralph Reeder continues to serve alongside Jeff Cozzens as neurosurgery's representatives to the AMA PCPI.

National Quality Forum (NQF)

Multiple neurosurgeons serve on important NQF measure vetting committees, including:

- Dr. Asher participated on the NQF Surgery Measures Steering Committee on behalf of the ABMS, which recently vetted the PQRS perioperative measures.
- Dr. Ghogawala serves on the Musculoskeletal Measures Standing Committee, which recently reviewed and failed to endorse two previously endorsed measures: 1) CMS' measure on MRI of Lumbar Spine for LBP; and 2) NCQA's measure Use of Imaging Studies for LBP due to methodological issues.

- Dr. Ratliff serves on the NQF Cost and Resource Use Standing Committee, which has not yet evaluated any measures directly related to neurosurgery.

Ongoing frustration with the NQF's resource-intensive, continually changing, and often inconsistently applied process has been mounting. Organized neurosurgery recently signed on to an AMA letter and met with NQF leadership on various occasions, including through the Surgical Quality Alliance (SQA), to express ongoing specialty society concerns with the NQF process, including challenging timeframes and concerns over the elimination of surgical measures and the lack of relevant surgical measures. CMS also is in the process of updating its evaluation criteria, measure testing, and eMeasure requirements. The NQF seems to recognize they are under fire and seems committed to addressing at least some of these concerns.

Measures Application Partnership (MAP)

In early December 2014, the NQF-convened Measure Applications Partnership (MAP) received for review over 200 performance measures that HHS is considering for future use in more than 20 federal health programs. MAP Workgroups met in mid-December to review these measures and subsequently released preliminary recommendations for public comment. Organized neurosurgery submitted feedback on relevant measures in early January 2015, and the MAP subsequently issued a final set of recommendations for HHS to consider for future rulemaking.

In April 2015, the MAP recently had an open nomination period for individuals and organizations to serve on its workgroups. Organized neurosurgery nominated the AANS as an organizational representative to the MAP Clinician Workgroup (with Ratliff as its point person); Paul Penar as an individual to serve on the MAP Hospital Workgroup; and Ton Asher to serve as an individual to the MAP Clinician Workgroup.

Surgical Quality Alliance (SQA)

Paul Penar, MD, now also serves as the AANS/CNS representative to the SQA. The SQA meets in the fall and spring. Its recent work has heavily focused on registries and EHR interoperability challenges, ways to improve the NQF process and evaluation criteria, and challenges that surgical societies face in satisfying PQRS and Meaningful Use. The SQA also recently created a repository of surgical society guideline projects. A link to neurosurgery's guidelines website has been included as part of this SQA-member resource.

Blue Cross Blue Shield Association

In October 2014, Knightly selected to assist BCBSA with updating their Blue Distinction Program for Spine Surgery. This latest update will focus on cost of care metrics.

HHS | Hart Health Strategies Inc.

Medicare and CHIP Reauthorization Act of 2015: Timeline of Implementation

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026+
Base Update	Jan–Jun: 0 July-Dec: 0.5	0.5%	0.5%	0.5%	0.5%	Base Conversion Factor Update of 0.0% each year						0.25%*
Electronic Health Record Incentive Program	EHR Incentives continue under current law				EHR Meaningful Use Incorporated into MIPS							
Physician Quality Reporting System	PQRS continues under current law				Quality reporting incorporated into MIPS							
Physician Value-Based Payment Modifier	VBM Continues under current law				Parts of VBM incorporated into MIPS							
"Merit Based" Incentive Payment System (MIPS), *****	N/A				(+/-) 4%	(+/-) 5%	(+/-) 7%	(+/-) 9%				
Alternative Payment Models	N/A				5% lump sum bonus on the previous year's covered professional services for "qualifying APM participants"****							0.75%

* In 2026 and subsequent years, the non-APM conversion factor will be set as "equal to the respective conversion factor for the previous year (or, in the case of 2026, equal to the single conversion factor for 2025) multiplied by the update established under paragraph (20) for such respective conversion factor for such year."

** The Secretary has the authority to create additional MIPS bonuses for "exceptional performers."

*** "Partial Qualifying APM Participants" (as defined in the legislation) who report on applicable MIPS measures are considered to be a "MIPS eligible professional" in that year. The Secretary may also base the determination by using "counts of patients in lieu of using payments and using the same or similar percentage criteria . . .as the Secretary determines appropriate."

**** "APM Qualifying Participant": **2019-2020**: 25% of Medicare revenues furnished as part of an eligible APM; **2021-2022**: 50% of Medicare revenues furnished as part of an eligible APM; *or* professionals with at least 25% of Medicare revenues from services furnished as part of an eligible APM *AND* at 50% of all payer revenues (excluding VA and DOD) for services provided as part of an APM (provided that the professional is willing to provide data to CMS to be able to make that determination). **2023 and subsequent years**: 75% of Medicare revenues furnished as part of an eligible APM; *or* professionals with at least 25% of Medicare revenues from services furnished as part of an eligible APM *AND* at 75% of all payer revenues (excluding VA and DOD) for services provided as part of an APM (provided that the professional is willing to provide data to CMS to be able to make that determination). 2021 and subsequent years: The Secretary may also base the determination by using "counts of patients in lieu of using payments and using the same or similar percentage criteria . . .as the Secretary determines appropriate."

ADDITIONAL DATES & DEADLINES:

2015

January 1, 2015: The **Secretary** shall make payments "for **chronic care management services** furnished on or after January 1, 2015 . . ."

~ May 2015: Statutory change that automatically renews **Medicare opt-out** period for additional two year periods unless "not later than 30 days before the end of the previous 2-year period" provides notice to the Secretary. **(**Effective date "shall apply to affidavits entered into on or after the date that is 60 days after the date of enactment.")

~October 2015: The **Secretary** and **CMS** must make public a list of **episode groups** and related descriptive information ("not later than 180 days after the date of enactment"); the **Secretary** shall accept public input for 120 days after posting (eventually for **resource use analysis**).

~October 2015: Make appointments to the **Physician-Focused Payment Model Technical Advisory Committee,** which will provide recommendations on moving providers into alternative payment models ("180 days after date of enactment").

~October 2015: The **Secretary** and **HHS OIG** shall submit a report to Congress with legislative recommendations to amend fraud and abuse laws (e.g. Stark and Anti-Kickback Statute) in order to allow **gainsharing arrangements** that can improve care and reduce waste and inefficiency ("Not later than 6 months after the date of enactment.").

2016

January 1, 2016: The **Secretary** shall develop and post a **draft plan for development of quality measures** and accept comments through March 1, 2016. Secretary must post final plan for measure development no later than May 1, 2016.

February 1, 2016: The **Secretary** shall make publicly available the number and characteristics of **opt-out physicians and practitioners** and update annually.

~March 2016 The **Secretary** shall post a draft list of **patient relationship categories** and **codes** for **episode attribution methodology** purposes ("Not later than one year after the date of enactment . . ."); the **Secretary** shall seek comment for 120 days; not later than 240 days after comment period the **Secretary** shall post an operational list of **patient relationship categories** and **codes.**

~March 2016: The **Secretary** shall conduct a study and submit a report to Congress on the feasibility of mechanisms (e.g. a Website) that would allow users to **compare the interoperability of EHR products** ("not later than 1 year after the date of enactment").

July 1, 2016: **Secretary** must submit a report to Congress on the feasibility of including participation in **Alternative Payment Models into the Medicare Advantage** payment system; this should include feasibility of including a value-based modifier and whether such modifier should be budget neutral.

July 1, 2016: **Qualified Entities (QEs)** may use combined data to conduct additional non-public analyses for the purposes of assisting providers to develop and participate in quality and patient care improvement activities including developing new models of care.

July 1, 2016: **Qualified Clinical Data Registries (QCDRs)** may request **Medicare claims data** (and in certain circumstances Medicaid data) to link with clinical outcomes data and perform risk-adjusted, scientifically valid analyses and research to support quality improvement or patient safety. Costs of providing the data apply.

July 1, 2016: The **Secretary** shall establish metrics to determine whether the national objective of achieving widespread EHR interoperability is being met.

~September 2016: **GAO Report** on alignment of quality measures between public and private programs with recommendations on how to reduce **administrative burden of reporting** ("not later than 18 months after the date of enactment").

~October 2016: The **Secretary** shall post a draft list of **care episodes** and **patient condition codes** ("270 days after the end of the comment period"); The **Secretary** shall accept comments for 120 days; within 270 days the Secretary shall post an operational list of **care episode** and **patient condition codes** (and the criteria and characteristics assigned to such code).

November 1, 2016: The **Secretary**, through notice and comment, shall establish criteria for **physician-focused payment models** including for specialist physicians (that could also be used by the **Physician-Focused Payment Model Technical Advisory Committee** on which to make comments and recommendations).

2016: The **Secretary** shall post physician data ("similar to the type of information in the Medicare Provider Utilization and Payment Data: Physician and Other Supplier Public Use File released by the Secretary with respect to 2012") available on **Physician Compare** by 2016.

2017

January 1, 2017: **GAO Report** on whether **entities that pool financial risk** for physician practices (i.e. independent risk managers) can play a role in supporting physician practices.

~April 2017: The **Secretary** (in consultation with the **OIG**) shall conduct a study and send a report to Congress on **fraud and abuse laws and impact** on Alternative Payment Models ("not later than 2 years after enactment").

~April 2017: The **GAO** shall submit a report to Congress on studies on **telehealth and remote patient monitoring**, which shall include legislative and administrative recommendations ("not later than 24 months after the date of enactment").

May 1, 2017: The **Secretary** shall post a report on the **progress made in measure development** (to be conducted annually).

July 1, 2017: The **Secretary** shall make available timely ("such as quarterly") **performance feedback reports** for MIPS participants. The current Physician Feedback Reports requirements will end in 2017.

July 1, 2017: Initial **MedPAC Report** on total and rate of growth of physician and healthcare profession expenditures.

December 31, 2017: The **Secretary** shall submit a report to Congress on the use of chronic care management services by individuals living in rural areas and by racial and ethnic minority populations.

2018

July 1, 2018: The **Secretary** shall make available to MIPS participants data about items and services that are furnished to that MIPS' patients *by other providers and suppliers.*

December 31, 2018: **Congressional declaration** that it is a national objective to achieve widespread exchange of health information through interoperable certified EHR technology nationwide.

2019

July 1, 2019: **MedPAC Report** on spending on professional services from 2015-2019 and its impact on efficiency, economy, quality of care, access, and recommendations for future payment updates.

December 31, 2019: The **Secretary** shall submit a report to Congress in the event the Secretary makes a determination that we have not achieved national widespread EHR interoperability identifying the barriers to adoption and making recommendations that the Federal government can take to achieve adoption.

2021

July 1, 2021: Final **MedPAC Report** on total and rate of growth of physician and healthcare profession expenditures.

October 1, 2021: **GAO Report** on the MIPS program including the distribution of performance and performance scores of participants, recommendations for improvement, and the impact of technical assistance on the ability of professionals to transition to APMs (particularly for practices in HPSAs and MUAs).

October 1, 2021: **GAO Report** on transition of professionals in rural areas, HPSAs, and MUAs into APMs.

* * *

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470	114th Congress – P.L. 114-10
SGR Repeal and Annual Updates			
General	Permanently repeals the SGR update mechanism, provides stable annual updates of 0.5% for five years (2014 through 2018), and ensures no changes are made to the current payment system for four years. Professionals will receive an annual update of 0.5% in each of the years 2014 through 2018. The rates in 2018 will be maintained through 2023, while providing professionals with the opportunity to receive additional payment adjustments through the Merit-Based Incentive Payment System (MIPS). In 2024 and subsequent years, professionals participating in alternative payment models (APMs) that meet certain criteria would receive annual updates of 1.0%, while all other professionals would receive annual updates of 0.5%.	Does the same, but modifies timeline: stable annual update of 0.5% will be offered from 2015 through 2019. Maintains stable rate through 2025, with opportunity for additional adjustments through the Merit-Based Incentive Payment System (MIPS). Starting in 2026, those participating in APMs would receive annual updates of 1.0%, while all other professionals would receive annual updates of 0.5%.	Same, but starting in 2026, those participating in APMs would receive annual updates of **0.75%,** while all other professionals would receive annual updates of **0.25%.**
	Requires Medicare Payment Advisory Commission (MedPAC) to submit report to Congress in 2018 evaluating the impact that the 2014-2018 updates have on beneficiary access and quality of care, with recommendations regarding further updates. MedPAC also must submit reports in 2017 and 2021 that assess the relationship between spending on services furnished by professionals under Medicare Part B and total expenditures under Medicare Parts A, B, and D.	Also pushes back timeline for the first Medicare Payment Advisory Commission (MedPAC) report by a year (2019); maintains timeline for additional reports that assess the relationship between spending on services furnished by professionals under Medicare Part B and total expenditures under Medicare Parts A, B, and D.	

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470	114th Congress – P.L. 114-10
Merit-Based Incentive Payment System			
Consolidating Current Programs	Payments to professionals will be adjusted based on performance in the unified MIPS starting in 2018. Consolidates the three existing programs: Physician Quality Reporting System (PQRS), Value-Modifier (VBM), and Meaningful Use (MU).	Same, but adjusts timeline so that performance-based payments begin in 2019.	Same.
Sunsetting Current Law Payment Penalties	Sunsets penalties associated with these three programs at the end of 2017, including the 2.0% penalty for failure to report PQRS quality measures, the up to 4.0% penalty under the VBM, and the 3.0% (increasing to 5.0% in 2019) penalty for failure to meet electronic health record (EHR) MU requirements. The money from penalties that would have been collected would now remain in the physician fee schedule, **significantly increasing total payments** compared to the current law baseline.	Same, but penalties sunset at end of 2018.	Same.
Eligible Professionals	MIPS will apply to: doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, chiropractors, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists beginning in 2019. Other professionals paid under the physician fee schedule may be included in the MIPS beginning in 2021, provided there are viable performance metrics available. Qualifying APM participants (described below) and	Same, but moves up implementation dates by a year.	Same.

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470	114th Congress – P.L. 114-10
	partial qualifying APM participants (described below) who do not report measure data are not eligible for MIPS. However, a partial qualifying APM participant who reports applicable measure data and activities described under this section is eligible. Also excluded from MIPS are professionals who do not exceed a low-volume threshold selected by the Secretary, which may include one or more or a combination of: a minimum number of treated beneficiaries; a minimum number of items/services furnished to such beneficiaries; or a minimum amount of Medicare Part B allowed charges billed.		
Performance Assessment Categories	MIPs will rely on four categories to assess performance: 1. **Quality**. Quality measures will be published annually in a final measures list developed under the methodology specified below. In addition to measures used in existing quality programs, the Secretary will solicit newly recommended measures and fund professional organizations and others to develop additional measures. Measures used by qualified clinical data registries (QCDRs) may also be used to assess performance under this category. 2. **Resource Use**. Will include measures used in the current VBM program. The Centers for Medicare and Medicaid Services (CMS) will continue to develop a methodology to measure resources associated with specific care episodes, but will rely more heavily on public input and an additional process that	Same.	Same.

directly engages professionals and allows them to report their specific role in treating the beneficiary (e.g., primary care or specialist) and the type of treatment (e.g., chronic condition, acute episode) to address current concerns about patient attribution. These measures will also incorporate ongoing work to improve risk adjustment methodologies.

3. **Meaningful Use**. Current EHR MU requirements, including use of a certified system, will continue to apply in order to receive credit in this category. To prevent duplicative reporting, professionals who report quality measures through certified EHR systems for the MIPS quality category are deemed to meet the meaningful use clinical quality measure component.
4. **Clinical Practice Improvement Activities**. Gives credit to professionals working to improve their practices through clinical practice improvement activities, which should facilitate future participation in APMs. The menu of recognized activities will be established in collaboration with professionals, but must at least include the following subcategories:
   - Expanded practice access (e.g., same day appointments for urgent needs and after hours access to clinician advice).
   - Population management (e.g. monitoring health conditions of individuals to provide timely health

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470	114th Congress – P.L. 114-10
	care interventions or participation in a QCDR). – Care coordination (e.g., timely communication of test results, timely exchange of clinical information to patients and other providers, and use of remote monitoring or telehealth) – Beneficiary engagement (e.g., establishment of care plans for individuals with complex care needs, beneficiary self-management assessment and training, and using shared decision making mechanisms). – Patient safety and practice assessment (e.g., use of clinical or surgical checklists and practice assessments related to maintaining certification). – Participation in an alternative payment model (APM). In defining Clinical Practice Improvement Activities, the Secretary must solicit recommendations for additional activities and related criteria. The Secretary may contract with entities to assist with such activities and to determine whether an EP meets the applicable criteria. The Secretary must give		

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470	114th Congress – P.L. 114-10
	consideration to small practices (those with 15 or fewer professionals) and those in rural or health professional shortage areas.		
Annual Selection of Quality Measures	Similar to the current process, the Secretary, through annual rulemaking, will publish by November 1 (prior to the performance year) a list of eligible quality measures to be used in the forthcoming MIPS performance period. Leading up to a rulemaking, the public will continue to have the opportunity to submit measures for consideration. In addition to measures used in existing quality programs, the Secretary will solicit newly recommended measures and fund professional organizations and others to develop additional measures. Measures may be submitted for consideration regardless of whether such measures were previously published in a proposed rule or endorsed by the National Quality Forum (NQF). Any measure selected for inclusion in such list that is not endorsed by a consensus-based entity must be evidence-based. To the extent practicable, quality measures selected for inclusion on the final list will address all five of the following quality domains: clinical care, safety, care coordination, patient and caregiver experience, and population health and prevention. Before including a new measure in the final list, the	Same.	Same.

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470	114th Congress – P.L. 114-10
	Secretary will submit the measure for publication in an applicable specialty appropriate peer-reviewed journal, including the method for developing and selecting the measure. Measures used by QCDRs may also be used to assess performance under this category. However, QCDR measures and existing quality measures will not be subject to the publication requirement and will be automatically included in the first program year's final list of quality measures. These measures will remain in the MIPS program unless they are removed under the rulemaking process.		
Funding for Quality Measure Development	Funding will be provided for measure development gaps and priorities. The Secretary, with stakeholder input, is required to develop and publish a plan for the development of quality measures for use in the MIPS and in APMs, taking into account how measures from the private sector and integrated delivery systems could be utilized in the Medicare program. The plan, which must be finalized by May 1, 2015, will prioritize outcome measures, patient experience measures, care coordination measures, and measures of appropriate use of services, and consider gaps in quality measurement and applicability of measures across health care settings. The Secretary will contract with entities with quality measure development expertise to develop priority measures and focus on measures that can be e-specified and are supported by clinical practice guidelines. By May 1, 2016, and annually thereafter, the Secretary must report on the progress made in	Same, but all dates pushed back one year.	Same.

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470	114th Congress – P.L. 114-10
	developing quality measures, including descriptions of measures under development and quality areas being considered for future measure development. Funding will be $15 million annually in 2014 to 2018 for professional quality measure development. The funding will remain available through fiscal year 2021.		
Performance Period	The performance period must begin and end prior to the beginning of a year for which a performance-based incentive payment will apply (no length specified), and must be as close as possible to such year.	Same.	Same.
Performance Standards and Scoring	In setting performance standards for measures and activities, the Secretary must take into account historical performance standards, improvement rates, and the opportunity for continued improvement. Professionals will receive a composite performance score of 0-100 based on their performance in each of the four performance categories listed above. Professionals will only be assessed on the categories, measures, and activities that apply to them. Weights would be assigned to each performance category and each underlying measure or clinical practice improvement activity as follows: • 30% for the quality performance category (and notes that multiple-payer quality data may be included in the analysis); • 30% for the resource use performance category (except for year 1 and 2 of the	Same.	Same.

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470	114th Congress – P.L. 114-10
	program when such weight must be 10% and 15%, respectively, with commensurate increases in the weight for quality to 50% and 45% in years 1 and 2, respectively); • 25% for the EHR meaningful use performance category. If EHR adoption reaches 75%, the weight for the EHR meaningful use performance category may be reduced to as low as 15%, with compensating adjustments made to other category weights; and • 15% for the clinical practice improvement performance category. Secretary must adjust weights if there are not sufficient measures and clinical practice improvement activities applicable available to each type of eligible professional (EP) involved. To create an incentive to report, EPs who fail to report on an applicable measure or activity that is required to be reported by the professional, the EP shall be treated as achieving the lowest potential score applicable to such measure or activity. For the Clinical Practice Improvement Activities category score, EPs need not perform activities in each of the subcategories to achieve the highest potential score for this performance category. Also, EPs who participate in an APM are eligible to earn a minimum score of ½ of the highest potential score for this performance category. EPs in a practice that is certified as a patient-centered medical home or comparable specialty practice, as determined by		

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470	114th Congress – P.L. 114-10
	the Secretary, are eligible for the highest potential score.		
MIPS Payment Adjustment	Each EP's composite score will be compared to a performance threshold, which will be the mean or median of the composite performance scores for all MIPS EPs during a period prior to the performance period (details to be determined by the Secretary). Professionals will know what composite score they must achieve to obtain incentive payments and avoid penalties at the beginning of each performance period. Payment adjustments will follow a linear distribution. EPs whose composite performance scores fall above the threshold will receive positive payment adjustments and EPs whose composite performance scores fall below the threshold will receive negative payment adjustments. • **Negative adjustments**. Capped at 4.0% in 2018, 5.0% in 2019, 7.0% in 2020, and 9.0% in 2021. EPs whose composite performance score falls between 0 and 1/4 of the threshold will receive the maximum possible penalty for the year. EPs with composite performance scores closer to the threshold will receive proportionally smaller negative payment adjustments. These negative adjustments will fund positive payment adjustments to those with scores above the threshold, • **Zero adjustments**. EPs whose composite performance score is at the threshold will	Same, but implementation years are pushed back a year. Additional incentive payment funding pool applies from 2019-2024.	Same.

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470	114th Congress – P.L. 114-10
	not receive a MIPS payment adjustment. • **Positive adjustments**. EPs whose composite performance scores are above the threshold will receive positive payment adjustments. EPs with higher performance scores will receive proportionally larger incentive payments up to a maximum of three times the annual cap for negative payment adjustments. ○ ***Additional Incentive Payment***. Provides an additional funding pool of $500 million per year for 2018 through 2023 to reward exceptional performance. These payments will enable some professionals to receive incentive payments even if all professionals score above the initial threshold. The threshold for awarding these additional amounts could be set at either the 25th percentile of the range of possible composite performance scores (e.g., if the performance threshold is a score of 60, the additional performance threshold would be a score of 70) or at the 25th percentile of the actual composite performance scores for a prior period (i.e., 75% of professionals who receive a positive payment adjustment would receive an additional payment adjustment). EPs with scores above this threshold will receive an additional incentive payment, which will be allocated according to a linear distribution, with better performers	GAO report must be issued by 2021.	

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470	114th Congress – P.L. 114-10
	receiving larger incentive payments. A professional's payment adjustment in one year will have no impact on their payment adjustment in a future year. Beginning with the second year to which the MIPS applies, in addition to the achievement of a threshold (see below), the scores from both the quality and resource use measure categories must take into account improvement if sufficient data to measure is available. For the other performance categories, the Secretary *may* take into account improvement (although the Secretary may assign a higher weighting score to achievement vs. improvement). The GAO is required to evaluate the MIPS and issue a report in 2018, including an assessment of the professional types, practice sizes, practice geography, and patient mix that are receiving MIPS payment increases and reductions.		
Public Reporting	Secretary must publicly report EPs' composite scores and scores for each performance category on the Physician Compare website and may report scores for each underlying measure or activity. Must also report the names of EPs in an eligible APM and, if feasible, performance in such models. Must include a disclaimer, where appropriate, that this data "may not be representative of the eligible professional's entire patient population, the variety of services furnished by the eligible professional, or the health conditions of individuals treated."	Same.	Same.

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470	114th Congress – P.L. 114-10
	EPs must be given an opportunity to review/submit corrections to data prior to its being made public. The Secretary must also periodically post on the Physician Compare website aggregate data, including the range of composite scores for all eligible professionals and the range of the performance with respect to each performance category.		
Technical Assistance	$40 million annually from 2014 to 2018 to help practices with 15 or fewer professionals improve MIPS performance or transition to APMs. $10 million of this funding is reserved for practices in areas designated as health professional shortage areas or medically underserved areas. Priority, in general, will be given to practices with low MIPS scores and those in rural and underserved areas.	Total funding reduced to $20 million and would apply from 2016 to 2020. Priority given to (but no specific portion reserved for) practices located in rural areas, health professional shortage areas, medically underserved areas, and practices with low composite scores.	Same.
Confidential Feedback	Professionals will receive confidential performance feedback related to the quality and resource use categories at least quarterly, likely through a web-based portal. Professionals may also receive confidential feedback on performance through QCDRs.	Same.	Same.
Other Provisions	The Secretary shall encourage the use of QCDRs and certified EHRs. The Secretary shall also account for risk factors in regards to both measures and performance methodologies used under MIPS. EPs will have the option to be assessed as a group or as a "virtual" group.	Same. Same. Same. Same, but exception for use of hospital outpatient measures was broadened to	Same.

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470	114th Congress – P.L. 114-10
	The Secretary may use measures used for other payment systems (e.g. inpatient hospital measures) for purposes of the quality and resource use categories, but may not use hospital outpatient department measures, except in the case of emergency physicians. Multiple provisions to encourage collaboration with physicians and other stakeholders to improve resource use measurement for both the MIPS and APMs. This includes the development of care episodes, patient condition groups and classification codes, as well as patient relationship categories and codes to improve attribution of patients to physicians. Physicians and other applicable practitioners will be required to include these new codes on their claims on or after January 1, 2017, so that the Secretary can better analyze resource use. Relevant stakeholders will be given the opportunity to provide input throughout this process.	include not only emergency physicians, but also items/services provided by radiologists, and anesthesiologists. Same, but implementation date for reporting of new codes pushed back to January 1, 2018.	
Encouraging Participation in Alternative Payment Models (APMs)			
Qualifying APM Participants	Professionals who receive a significant share of their revenues through APMs that involve risk of financial losses and a quality measurement component will receive a 5.0% percent bonus each year from 2018-2023. Two tracks will be available for professionals to qualify for the bonus: 1. Based on receiving a significant percent of Medicare revenue through an APM. 2. Based on receiving a significant percent of APM revenue combined from Medicare	Same, but dates pushed back one year so that APM bonus applies each year from 2019-2024. The dates included in the definition of a "qualifying" APM participant are also pushed back a year.	Same.

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470	114th Congress – P.L. 114-10
	and other payers. A "significant percent" is defined as follows: • For 2018 and 2019, at least 25% of Medicare payments from an APM. • For 2020 and 2021, at least 50% of Medicare payments or at least 50% of total payments (with at least 25% of Medicare payments) from an APM. • For 2022 and beyond, at least 75% of Medicare payments or at least 75% of total payments (with at least 25% of Medicare payments) from an APM. These determinations will be made based on covered professional services furnished by such professional during the most recent period for which data are available, which may be less than a full year. Payments made by the Secretaries of Defense/Veterans Affairs are not counted as part of the total payments. Medicaid payments are also not counted in states in which no medical home or Medicaid APM is available. Eligible APMs must involve the use of certified EHR technology and quality measures comparable to those used by Medicare. The Secretary may, as appropriate, base determination of whether an EP is a qualifying or partially qualifying APM participant by using counts		

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470	114th Congress – P.L. 114-10
	of patients in lieu of using payments and using the same or similar percentage criteria.		
Partially Qualifying APM Participants	EPs participating in an APM who meet somewhat lower payment thresholds than those for a qualifying APM participant are not eligible for additional payments available to qualifying APMs, but may be eligible for the MIPS if they report applicable measure data and activities (see above). These partially qualifying APM participants are defined as: • For 2018-2019, at least 20% of Medicare payments. • For 2020-2021, at least 40% of Medicare payments or at least 40% of total payments (with at least 20% of Medicare payments). • For 2022 and beyond, at least 50% of Medicare payments or at least 50% of total payments (with at least 20% of Medicare payments).	Same, but dates pushed back a year.	Same.
Submission and Review of Physician-Focused Payment Models	Establish, upon enactment, a Physician-Focused Payment Model Technical Advisory Committee composed of 11 federally appointed national experts in physician-focused payment models and related delivery of care. Members would have 3 year staggered terms. No more than 5 members shall be providers and no member may be a federal employee. By November 1, 2016, Secretary must through Request For Information (RFI) and rulemaking, establish criteria for physician-focused payment models, including models for specialist physicians, that could be used by the Committee for making	Same.	Same.

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470	114th Congress – P.L. 114-10
	recommendations. MedPAC may also submit comments during this period. On an ongoing basis, the public may submit to the Committee proposals for physician-focused payment models that meet the established criteria. The Committee will review these models and make recommendations to the Secretary as to whether they meet the criteria. The Secretary's detailed response must be posted publicly. Language also included to specifically encourage the development and testing of models that focus on: • Non-primary care services; • Smaller practices (15 or fewer professionals); • Risk-based models for small physician practices which may involve two-sided risk and prospective patient assignment, and which examine risk-adjusted decreases in mortality rates, hospital readmissions rates, and other relevant measures; • Medicaid/CHIP; and • Other public, private, and state-based payment models.		
Other Provisions	• Not later than 2 years after enactment, Secretary must present recommendations to Congress on ways to reduce potential fraud vulnerabilities in APMs. • By July 1, 2015, Secretary must submit a study to Congress on integrating APMs into the Medicare Advantage payment system,	Same, but pushes implementation date back a year.	Same.

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470	114th Congress – P.L. 114-10
	including the feasibility of a value-modifier.		
Encouraging Care Management for Individuals with Chronic Care Needs			
General	Directs the Secretary to establish one or more HCPCS codes for chronic care management (CCM) services and to make payments to applicable providers for services furnished on or after January 1, 2015. Applicable providers are defined as a physician, physician assistant or nurse practitioner, clinical nurse specialist, or certified nurse midwife who furnishes services as part of a patient-centered medical home or a comparable specialty practice.	Revised language states that the Secretary, as deemed appropriate, shall make payment for CCM services furnished on or after January 1, 2015, by a physician, physician assistant or nurse practitioner, clinical nurse specialist, or certified nurse midwife. Language about providing services as part of a patient-centered medical home was removed. CMS is also directed to conduct an education and outreach campaign to inform physicians about the benefits of CCM services, and encourage those with chronic care needs to receive such services. **NOTE**: *CMS finalized payment for CCM codes as part of the 2015 MPFS Final Rule, effective January 1, 2015.*	Same.
	In order to prevent duplicative payments, only one professional or group practice will receive payment for these services provided to an individual during a specified period. Payment for these codes will be budget-neutral within the physician fee schedule. Payments for chronic care management would not require that an annual wellness visit or an initial preventive physician examination be furnished as a condition of payment.	Same, but language about budget neutrality was removed.	
	Secretary must submit report to Congress by December 31, 2017 on the use of chronic care management services by individuals living in rural areas and by racial and ethnic minority populations.	Same.	

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470	114th Congress – P.L. 114-10
Transparency/Empowering Beneficiary Choices through Access to Information on Physician Services			
General	Not later than July 1, 2015, for physicians and July 1, 2016, for other professionals, in addition to the quality and resource use information that would be posted through the MIPS, the Secretary is required to publish utilization and payment data for professionals on the Physician Compare website. With emphasis on the services a professional most commonly furnishes, such information will include the number of services furnished, as well as submitted charges and payments for such services. It will be searchable by the EP's name, provider type, specialty, location, and services furnished. The website will indicate, where appropriate, a disclaimer that information may not be representative of the EPs entire patient population, variety of services furnished, or the health conditions of the individuals treated. Professionals will continue to have an opportunity to review and correct this information prior to its posting on the website.	Minor revision to state that on an annual basis, beginning with 2015, the Secretary is required to publish utilization and payment data for both physicians and other professionals, as appropriate. The Secretary will integrate this information on the Physician Compare website starting in 2016. This version also clarifies that information made available under this section shall be similar to, and released in a similar manner as, the Medicare Provider Utilization and Payment Data: Physician and Other Supplier Public Use File released with respect to 2012. The disclaimer language no longer appears in this section nor does the language giving professionals an opportunity to review this data.	Same.
Expanding Claims Data Availability to Improve Care			
Qualified Entities	Consistent with relevant privacy and security laws, entities that currently receive Medicare data for public reporting purposes (known as qualified entities or "QEs") will be permitted to provide or sell non-public analyses and claims data to physicians, other professionals, providers, medical societies, and hospital associations to assist them in their quality	Same.	Same.

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470	114th Congress – P.L. 114-10
	improvement activities or in developing APMs. Any data or analyses must be de-identified, though the provider accessing the data or analysis can receive identifiable information on the services furnished to his or her patient. QEs will be permitted to provide or sell non-public analyses to health insurers (who provide claims data to the QE) and self-insured employers (only for purposes of providing health insurance to their employees or retirees). Providers identified in such analyses will have an opportunity to review and submit corrections before the QE provides or sells the analysis to other entities. To ensure the privacy, security, and appropriate use of Medicare claims information, QEs must: have a data use agreement with providers and entities to which they provide data; and be subject to an assessment for breach of such agreement. Further, providers and entities receiving data and analyses are prohibited from re-disclosing them or using them for marketing. QEs that provide or sell analyses or data shall provide an annual report to the Secretary that provides an accounting of: 1. The analyses provided or sold, including the number of analyses and purchasers, the amount of fees received, and the topics and purposes of the analyses; and 2. A list of entities that were provided or sold data, the uses of that data, and the fees received by the QE for such data. The claims data available to QEs will also include Medicaid/CHIP data.		

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470	114th Congress – P.L. 114-10
Qualified Clinical Data Registries	Consistent with relevant privacy and security laws, the Secretary is required to make data available to QCDRs to support quality improvement and patient safety activities. The Secretary may charge a fee that covers the cost of preparing the data.	Same.	Same.
Reducing Administrative Burden and Other Provisions			
General	Provides that the development, recognition, or implementation of any guideline or other standard under any Federal health care provision, including Medicare, cannot be construed to establish the standard of care or duty of care owed by a health care professional to a patient in any medical malpractice or medical product liability action or claim. This ensures that MIPS participation cannot be used in liability cases. This provision would not preempt any state or common law governing medical professional or medical product liability actions or claims.	Same.	Same.
Medicare and Other Health Extenders			
Geographic Practice Cost Index (GPCI) floor		N/A	Extends existing 1.0 floor on the "physician work" cost index through 2018.
Therapy Caps Process		N/A	Extends therapy caps extensions through 2017.
Funding for Quality Measure		N/A	Provides funding for FY 2016 and FY 2017 for the National Quality

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470	114th Congress – P.L. 114-10
Endorsement and Selection			Forum's (NQF) measure review, endorsement and maintenance process, as well as the pre-rulemaking process and measure dissemination/review activities. Extension of funding for quality measure endorsement, input, and selection.
Other Provisions			
Medicare Opt-Out	Allows professionals who opt-out of Medicare to automatically renew at the end of each two-year cycle. Requires regular public reporting of opt-out physician characteristics.	Same	Same.
EHR Interoperability	Requires that EHRs be interoperable by 2017 and prohibits providers from deliberately blocking information sharing with other EHR vendor products.	Moves date back to 2018.	Same.
Gainsharing	Requires the Secretary to issue a report recommending how a permanent physician-hospital gainsharing program can best be established.	Same.	Same.
Telemedicine	Requires GAO to report on barriers to expanded use of telemedicine and remote patient	Same.	Same.

Proposal	113th Congress -- H.R.4015/S.2000	114th Congress -- H.R.1470	114th Congress – P.L. 114-10
	monitoring.		
Remote Patient Monitoring	Requires Comptroller General to study remote patient monitoring technology in the private health insurance market, including dissemination and financial incentives, and barriers to adoption in the Medicare Program, among other things.	Same.	Same.
Multiple Procedure Payment Reduction	Requires the Secretary to publish information used to establish the multiple procedure payment reduction policy for imaging.	Language not included at bill introduction.	Same.

MEANINGFUL USE STAGE 3 AND CERTIFICATION PROPOSED RULES

The following provides a brief summary of the Meaningful Use (MU) Stage 3 and 2015 Edition certification proposed rules. Comments on the rules are due on May 29, 2015.

Overview

- Stage 3 would be the last stage of MU.
- The Centers for Medicare & Medicaid Services (CMS) proposes to remove the 90-day reporting period for Medicare newly eligible professionals (EPs), requiring a full calendar year reporting period after 2015.
- Stage 3 requirements would be optional in 2017 and mandatory for all EPs in 2018, no matter when they started the MU program.
- The pass/fail approach would remain; however, the concept of core vs. menu measures would be removed.
- Stage 3 requirements would be divided into 8 objectives listed below (though each objective would have several measures):

Program Goal/Objective	Delivery System Reform Goal Alignment
Protect Patient Health Information	Foundational to Meaningful Use and Certified EHR Technology Recommended by HIT Policy Committee
Electronic Prescribing (eRx)	Foundational to Meaningful Use National Quality Strategy Alignment
Clinical Decision Support (CDS)	Foundational to Certified EHR Technology Recommended by HIT Policy Committee National Quality Strategy Alignment
Computerized Provider Order Entry (CPOE)	Foundational to Certified EHR Technology National Quality Strategy Alignment
Patient Electronic Access to Health Information	Recommended by HIT Policy Committee National Quality Strategy Alignment
Coordination of Care through Patient Engagement	Recommended by HIT Policy Committee National Quality Strategy Alignment
Health Information Exchange (HIE)	Foundational to Meaningful Use and Certified EHR Technology. Recommended by HIT Policy Committee. National Quality Strategy Alignment.
Public Health and Clinical Data Registry Reporting	Recommended by HIT Policy Committee. National Quality Strategy Alignment.

A more detailed list of the objectives and associated measures are included in a separate chart.

- EPs would be required to attest to the numerators and denominators of all measures associated with an objective; however, for certain objectives physicians would only need to meet the thresholds for some of the measures. These objectives include:
    - Coordination of Care through Patient Engagement;
    - Health Information Exchange; and
    - Public Health Reporting.
- CMS also proposes to remove redundant, duplicative, or ‘‘topped out” measures, or measures CMS feels are no longer useful in gauging performance (e.g., recording certain demographics).
- The Office of the National Coordinator (ONC) proposes that all physicians use EHR technology certified to the 2015 Edition for the 2018 reporting period.

- Measures in the Stage 1 and Stage 2 final rules that included paper-based workflows, chart abstraction, or other manual actions would be removed or transitioned to an electronic format utilizing EHR functionality for Stage 3.
- To better align quality reporting programs, CMS proposes to address clinical quality measure reporting requirements for 2017 and subsequent years in the Medicare Physician Fee Schedule.
- Given the multiple technological and clinical care standard changes associated with EHR technology, CMS states that they may need to consider other changes to the objectives and measures of MU and, if warranted, will address such needed changes in future rulemaking.

Key provisions in detail

Reporting Period

- Stage 3 would require a full calendar year reporting period; the 90-day reporting period for the first year of Medicare EPs would be removed.
    - There would be an exception for Medicaid EPs and eligible hospitals (EHs) demonstrating meaningful use for the first time—these entities would continue to use a 90-day reporting period.
- Physicians would have two months following the close of their full EHR reporting period to attest.
- 2017:
    - CMS proposes physicians may either repeat a year at their current stage or move up stage levels.
    - A physician may not move backward in their progression.
    - For example, a physician who participated in Stage 1 in 2016 would be able to attest to Stage 1or they could move to Stage 2 or Stage 3 in 2017.
    - For example, a physician who participated in Stage 2 in 2016 could attest to the Stage 2 objectives and measures or move on to Stage 3 in 2017; however, the EP would not be permitted to return to Stage 1.
- 2018:
    - Physicians, regardless of their prior participation or the stage level chosen in 2017, would be required to attest to Stage 3 objectives and measures for 2018.

STAGE OF MEANINGFUL USE CRITERIA BY FIRST YEAR

First Year as a Meaningful EHR User	Stage of Meaningful Use										
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021 and future years
2011	1	1	1	2*	2	2	2 or 3	3	3	3	3
2012		1	1	2*	2	2	2 or 3	3	3	3	3
2013			1	1	2	2	2 or 3	3	3	3	3
2014				1	1	2	2 or 3	3	3	3	3
2015					1	1	1, 2 or 3	3	3	3	3
2016						1	1, 2 or 3	3	3	3	3
2017							1, 2 or 3	3	3	3	3
2018 and future years								3	3	3	3

*Please note, a provider scheduled to participate in Stage 2 in 2014, who instead elected to demonstrate stage 1 because of delays in availability of EHR technology certified to the 2014 Edition, is still considered a stage 2 provider in 2014 despite the alternate demonstration of meaningful use. In 2015, all such providers are considered to be participating in their second year of Stage 2 of meaningful use.

Payment Adjustments and Hardships

CMS does not propose to change the MU penalties and maintains the previously designated four hardship categories:

- The lack of availability of internet access or barriers to obtain IT infrastructure;
- A time-limited exception for newly practicing EPs or new hospitals that would not otherwise be able to avoid payment adjustments;
- Unforeseen circumstances such as natural disasters that would be handled on a case-by-case basis; and
- Exceptions due to a combination of clinical features limiting physician's interaction with patients or, if the EP practices at multiple locations, lack of control over the availability of CEHRT at practice locations constituting 50 percent or more of their encounters. This is for EPs only (not EHs).

Quality

- CMS proposed long-term vision is to have hospitals, clinicians, and other health care providers report through a single, aligned mechanism for multiple CMS programs.
- CMS has proposed EHRs be certified to more than the minimum number of clinical quality measures (CQM) required by MU, phasing in the number of quality measures vendors would need to be certified to handle.
- Manual abstraction of data from an EHR would not be considered acceptable for the purposes of meeting data capture using a certified EHR. However, electronic information that is interfaced or electronically transmitted from a non-certified EHR (e.g., automated blood pressure cuff) would satisfy the "capture" requirement, as long as data is visible to the physician in the EHR.
- CMS expects to continue encouraging electronic submission of CQM data for all physicians where feasible in 2017. They propose to require the electronic submission of CQMs where feasible in 2018. Starting in 2018, attestation would no longer be accepted when electronic submission is possible.
- The reporting period will be a year starting in 2017 (with the exception of Medicaid).
- It is CMS' intent to move to yearly quality measure updates and better align the MU quality measures with the Physician Quality Reporting System (PQRS). CQM requirements would be published as part of the annual Physician Fee Schedule rule moving forward.

Proposed eCQM Reporting Timelines for Medicare & Medicaid EHR Incentive Program				
Year	2017 only	2017 only	2018 and subsequent years	2018 and subsequent years
Reporting Method Available	Attestation	Electronic Reporting	Attestation	Electronic Reporting
Provider Type who May Use Method	All Medicare providers Medicaid providers must refer to state requirements for reporting	All Medicare Providers Medicaid providers must refer to state requirements for reporting	Medicare Providers with circumstances rendering them unable to eReport Medicaid providers must refer to state requirements for reporting	All Medicare Providers Medicaid providers must refer to state requirements for reporting
CQM Reporting Period	1 CY for Medicare 1 CY for returning Medicaid 90 days for first time meaningful user Medicaid	1 CY for Medicare 1 CY for returning Medicaid 90 days for first time meaningful user Medicaid	1 CY for Medicare 1 CY for returning Medicaid 90 days for first time meaningful user Medicaid	1 CY for Medicare 1 CY for returning Medicaid 90 days for first time meaningful user Medicaid
eCQM Version Required **(CQM electronic specifications update)**	2016 Annual Update	2016 Annual Update	2016 Annual Update or more recent version	2017 Annual Update
CEHRT Edition Required	2014 Edition Or 2015 Edition	2014 Edition Or 2015 Edition	2015 Edition	2015 Edition

Registries

- CMS has proposed to create a stand-alone registry objective that includes multiple parts, but includes credit for specialty developed clinical data registries.

EPs Practicing in Multiple Practices/Locations

- To be a meaningful user, CMS would maintain its policy that an EP have 50 percent or more of his or her outpatient encounters during the EHR reporting period at a practice/location or practices/locations equipped with CEHRT.
    - An EP who does not conduct at least 50 percent of their patient encounters in any one practice/location would have to meet the 50 percent threshold through a combination of practices/locations equipped with CEHRT.

Denominators

- The denominators of the measures that reference "office visits" would be limited to only those patients whose records are maintained using CEHRT. An office visit would be defined as any billable visit that includes the following:
    - Concurrent care or transfer of care visits;
    - Consultant visits; or
    - Prolonged physician service without direct, face-to-face patient contact (for example, telehealth).
- As proposed, CMS would count in the denominator medication, laboratory, and diagnostic imaging orders created during the reporting period.
- Transitions of care and referrals would include at least:
    - When the EP is the recipient of the transition or referral, the first encounter with a new patient and encounters with existing patients where a summary of care record (of any type) is provided to the receiving EP; and
    - When the EP is the initiator of the transition or referral, transitions and referrals ordered by the EP.
- CMS would define transitions of care as the movement of a patient from one setting of care to another.
    - CMS proposes that for the purposes of distinguishing settings of care in determining the movement of a patient, that a transition or referral may take place when a patient is transitioned or referred between providers with different billing identities, such as a different National Provider Identifier (NPI) or hospital CMS Certification Number (CCN).
    - CMS also proposes that in the cases where a provider has a patient who seeks out and receives care from another provider without a prior referral, the first provider may include that transition as a referral if the patient subsequently identifies the other provider of care.

Telehealth

- CMS would consider a patient seen through telehealth as a patient "seen by the EP" to count for MU. Telehealth may include commonly known telemedicine as well as telepsychiatry, telenursing, and other diverse forms of technology-assisted health care.
- In cases where the EP and the patient do not have a real time physical or telehealth encounter, but the EP renders a consultative service for the patient, such as reading an EKG, virtual visits, or asynchronous telehealth, the EP may choose whether to include the patient in the denominator as "seen by the EP."

Patient-Authorized Representatives

- As part of the objectives concerning "Coordination of Care through Patient Engagement" and the "Patient Electronic Access," CMS proposes the inclusion of patient-authorized representatives in the numerators and encourages providers to provide access to health information in accordance with all applicable laws.

Audit Logs

- The Stage 3 rule notes that audit logs can be a valuable resource in ensuring the protection of electronic health information. While CMS recognizes legitimate instances where the function must be disabled for a short time, they strongly recommend physicians ensure this function is enabled at all times when the CEHRT is in use.

Medicaid

- Medicaid physicians demonstrating MU for the first time in 2017 would still use a 90-day reporting period.
- CMS proposes to continue to allow states to set up a CQM submission process that physicians may use to report on CQMs for 2017 and subsequent years.
- The rule also proposes amendments to state reporting on Medicaid EPs as well as implementation and oversight activities.

Certification

- Both EHR technology certified to the 2014 Edition and the 2015 Edition would support attestations for Stage 1 or Stage 2 in 2017.
- CMS has proposed that all physicians would be required to use EHR technology certified to the 2015 Edition for the EHR reporting period in 2018.
- ONC also proposes more focus on improving how data is exchanged, including provider directories, patient matching, and the application programming interface (API) concept, which is expected to improve interoperability as well as access to data in an actionable format.
- The certification rule also proposes vendor product post-market surveillance, public disclosures for product costs, such as implementation and use, and an improvement in the Certified Health IT Product List (CHPL).

Stage 3 Meaningful Use - Proposed Objectives and Measures

#	OBJECTIVE NAME	OBJECTIVE DESCRIPTION	MEASURES	EXCLUSIONS	NOTES
1	**Protect Patient Health Information**	Protect electronic protected health information (ePHI) created or maintained by the certified EHR technology (CEHRT) through the implementation of appropriate technical, administrative, and physical safeguards.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the security (including encryption) of data stored in CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), implement security updates as necessary, and correct identified security deficiencies as part of the provider's risk management process.	None	○ EPs, EHs, and CAHs must conduct the security risk analysis upon installation of CEHRT or upon upgrade to a new Edition. ○ The initial security risk analysis and testing may occur prior to the beginning of the first EHR reporting period using that certified EHR technology. ○ In subsequent years, a provider must review the security risk analysis of the CEHRT and the administrative, physical, and technical safeguards implemented, and make updates to its analysis as necessary, but at least once per EHR reporting period. ○ Office of the National Coordinator for Health IT (ONC) provides guidance and a Security Risk Assessment (SRA) tool created in conjunction with OCR on its website at: http://www.healthit.gov/providers-professionals/security-risk-assessment ○ The SRA Tool is a self-contained application available at no cost to the provider.
2	**Electronic Prescribing (eRx)**	Generate and transmit permissible prescriptions electronically (eRx).	**EP Measure:** More than **80 percent** of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT. **EH Measure:** More than **25 percent** of hospital	**EP:** Any EP who: (1) writes fewer than 100 permissible prescriptions during the EHR reporting period; or (2) does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within10 miles of the EP's practice location at the start of his or her EHR reporting period.	• CMS has proposed that providers who practice in a state where controlled substances may be electronically prescribed may include these for meeting MU. • They also propose to continue to define "prescription" as the authorization by a provider to dispense a drug that would not be dispensed without such authorization. This includes authorization for refills of previously authorized drugs. • OTC medicines will still not be allowed to be counted but CMS seeks comment on this exclusion.

#	OBJECTIVE NAME	OBJECTIVE DESCRIPTION	MEASURES	EXCLUSIONS	NOTES
			discharge medication orders for permissible prescriptions (for new and changed prescriptions) are queried for a drug formulary and transmitted electronically using CEHRT.	**EH:** Any EH or CAH that does not have an internal pharmacy that can accept electronic prescriptions and there are no pharmacies that accept electronic prescriptions within 10 miles at the start of their EHR reporting period.	
3	**Clinical Decision Support (CDS)**	Implement CDS interventions focused on improving performance on high-priority health conditions.	**Must meet both measures** **Measure 1**: The EP, EH, or CAH must implement **five** clinical decision support interventions related to four or more CQMs at a relevant point in patient care for the entire EHR reporting period. Absent four CQMs related to an EP, EH, or CAH's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions. **Measure 2**: The EP, EH, or CAH has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.	**Measure 2:** For the second measure, any EP who writes fewer than 100 medication orders during the EHR reporting period.	• Interventions must be presented in the CEHRT to a health care professional who can exercise clinical judgment about the CDS before action is taken on the patient. • In alignment with the HHS National Quality Strategy goals, providers are encouraged to implement CDS related to quality measurement and improvement goals on the following areas: o Preventive care. o Chronic condition management. o Heart disease and hypertension. o Appropriateness of diagnostic orders or procedures such as labs, diagnostic imaging, genetic testing, pharmacogenetic and pharmacogenomic test result support or other diagnostic testing. o Advanced medication-related decision support, to include pharmacogenetic and pharmacogenomic test result support.
4	**Computerized Provider**	Use CPOE for medication, laboratory,	**Must meet all three measures**	**Measure 1:** Any EP who writes fewer than 100	• CMS is proposing to expand the objective to include diagnostic imaging, which is a broader category

#	OBJECTIVE NAME	OBJECTIVE DESCRIPTION	MEASURES	EXCLUSIONS	NOTES
	Order Entry (CPOE)	and diagnostic imaging orders directly entered by any licensed healthcare professional, credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant; who can enter orders into the medical record per state, local, and professional guidelines.	**Measure 1**: More than **80 percent** of medication orders created by the EP or authorized providers of the EH's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry; **Measure 2**: More than **60 percent** of laboratory orders created by the EP or authorized providers of the EH's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry; and **Measure 3**: More than **60 percent** of diagnostic imaging orders created by the EP or authorized providers of the EH's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.	medication orders during the EHR reporting period. **Measure 2:** Any EP who writes fewer than 100 laboratory orders during the EHR reporting period. **Measure 3:** Any EP who writes fewer than 100 diagnostic imaging orders during the EHR reporting period.	including other imaging tests such as ultrasound, magnetic resonance, and computed tomography in addition to traditional radiology. • Orders entered by any licensed healthcare professional or credentialed medical assistant would count toward this objective. A credentialed medical assistant may enter orders if they are credentialed to perform the duties of a medical assistant by a credentialing body other than the employer. If a staff member of the eligible provider is appropriately credentialed and performs assistive services similar to a medical assistant, but carries a more specific title due to either specialization of their duties or to the specialty of the medical professional they assist, orders entered by that staff member would be included in this objective. Medical staff whose organizational or job title, or the title of their credential, is other than medical assistant may enter orders if these staff are credentialed to perform the equivalent duties of a credentialed medical assistant by a credentialing body other than their employer and perform such duties as part of their organizational or job title. CMS defers to the provider's discretion to determine the appropriateness of the credentialing of staff to ensure that any staff entering orders have the clinical training and knowledge required to enter orders for CPOE. This determination must be made by the EP or representative of the EH or CAH based on: • Organizational workflows; • Appropriate credentialing of the staff member by an organization other than the employing organization; • Analysis of duties performed by the staff member in question; and • Compliance with all applicable federal, state, and local laws and professional guidelines.

#	OBJECTIVE NAME	OBJECTIVE DESCRIPTION	MEASURES	EXCLUSIONS	NOTES
					• If the individual entering the orders is not the licensed healthcare professional, the order must be entered with the direct supervision or active engagement of a licensed healthcare professional. • CPOE function should be used the first time the order becomes part of the patient's medical record and before any action can be taken on the order.
5	**Patient Electronic Access to Health Information**	The EP, EH, or CAH provides access for patients to view online, download, and transmit their health information, or retrieve their health information through an API, within 24 hours of its availability.	**Must meet both measures** **Measure 1**: For more than **80 percent** of all unique patients seen by the EP or discharged from the EH or CAH inpatient or emergency department (POS 21 or 23): <u>Option 1:</u> The patient (or patient-authorized representative) is provided access to view online, download, and transmit their health information within **24 hours** of its availability to the provider; **or** <u>Option 2:</u> The patient (or patient-authorized representative) is provided access to an ONC-certified API that can be used by third-party applications or devices to provide patients (or patient-authorized representatives) access to their	**Measure 1, Exclusions:** • An EP may exclude from the measure if they have no office visits during the EHR reporting period. • Any EP, EH, or CAH that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude the measure. **Measure 2, Exclusions:** • An EP may exclude from the measure if they have no office visits during the EHR reporting period. • Any EP, EH, or CAH that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to	• Patients must be able to access this information on demand, such as through a patient portal or API and have everything necessary to access the information (including any necessary instructions) even if they opt out. • This objective should not require the provider to make extraordinary efforts to assist patients in use or access of the information, but the provider must inform patients of these options, and provide sufficient guidance so that all patients could leverage this access. • All three functionalities (view, download, and transmit) or an API must be present and accessible to meet the measure. The functionality must support a patient's right to have his or her protected health information sent directly to a third party designated by the patient consistent with the provision of access requirements of HIPAA privacy requirements. • Provider is only required to provide access to the information through these means. The patient is not required to take action in order for the provider to meet this objective. • Provider would not be required to separately purchase or implement a "patient portal," nor would they need to implement or purchase a separate mechanism to provide the secure download and transmit functions for their patients because the API would provide the patient the ability to download or transmit their health information to a third party.

#	OBJECTIVE NAME	OBJECTIVE DESCRIPTION	MEASURES	EXCLUSIONS	NOTES
			health information, within **24 hours** of its availability to the provider. **Measure 2**: The EP, EH or CAH must use clinically relevant information from CEHRT to identify patient-specific educational resources and provide electronic access to those materials to more than **35 percent** of unique patients seen by the EP or discharged from the EH or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period.	the latest information available from the FCC on the first day of the EHR reporting period may exclude the measure.	• If the provider elects to implement an API, the provider would only need to fully enable the API functionality, provide patients with detailed instructions on how to authenticate, and provide supplemental information on available applications which leverage the API. • Certification criteria would require vendors to make available this capability. • CMS is also seeking comment on whether to mandate both options under Measure 1, which would require providers to offer the view, download and transmit function and API option instead of choosing between the two.
6	**Coordination of Care through Patient Engagement**	Use communications functions of certified EHR technology to engage with patients or their authorized representatives about the patient's care.	**Must attest to the numerator and denominator for all three measures but only required to meet the threshold for 2 out of the 3 measures.** **Measure 1:** During the EHR reporting period, more than **25 percent** of all unique patients seen by the EP or discharged from the EH or CAH inpatient or emergency department (POS 21 or 23) actively engage with the electronic health record made	**Measure 1 (either option):** • Any EP who has no office visits during the EHR reporting period may exclude from the measure. • Any EP, EH or CAH that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude from the measure.	• For measure 1, for the API option, CMS proposes providers must attest that they have enabled an API and that at least one application which leverages the API is available to patients (or the patient-authorized representatives) to retrieve health information from the provider's certified EHR. • For measure 2, "communicate" means when a provider sends a message to a patient (or the patient's authorized representatives) or when a patient (or the patient's authorized representatives) sends a message to the provider. In patient-to-provider communication, the provider must respond to the patient (or the patient's authorized representatives). • For measure 2, CMS proposes to include in the measure numerator situations where providers communicate with

#	OBJECTIVE NAME	OBJECTIVE DESCRIPTION	MEASURES	EXCLUSIONS	NOTES
			accessible by the provider. An EP, EH or CAH may meet the measure by **either:** Option 1: More than **25 percent** of all unique patients (or patient-authorized representatives) seen by the EP or discharged from the EH or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period view, download or transmit to a third party their health information; **or** Option 2: More than **25 percent** of all unique patients (or patient-authorized representatives) seen by the EP or discharged from the EH or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period access their health information through the use of an ONC-certified API that can be used by third-party applications or devices. **Measure 2:** For more than **35 percent** of all	**Measure 2:** • Any EP who has no office visits during the EHR reporting period may exclude from the measure. • Any EP, EH, or CAH that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude from the measure. **Measure 3:** • Any EP who has no office visits during the EHR reporting period may exclude from the measure. • Any EP, EH, or CAH that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude from the measure.	other care team members using the secure messaging function of certified EHR technology, and the patient is engaged in the message and has the ability to be an active participant in the conversation between care providers. • For secure messages CMS says they must contain relevant health information specific to the patient in order to meet the measure of this objective. They assert providers are the best judge of what health information should be considered relevant in this context. They propose messaging content may include, but is not limited to, questions about test results, problems, and medications; suggestions for follow-up care or preventative screenings; confirmations of diagnosis and care plan goals; and information regarding patient progress. However, they note that messages with content exclusively relating to billing questions, appointment scheduling, or other administrative subjects should not be included in the numerator. • For measure 3, the use of the term "clinical" means for purposes of this measure only, that a non-clinical setting shall be defined as a setting with any provider who is not an EP, EH or CAH as defined for the Medicare and Medicaid EHR Incentive Programs. This may include, but is not limited to, health and care-related data from care providers such as nutritionists, physical therapists, occupational therapists, psychologists, and home health care providers as well as data obtained from patients themselves. • The sources of data vary and may include mobile applications for tracking health and nutrition, home health devices with tracking capabilities such as scales and blood pressure monitors, wearable devices such as activity trackers or heart monitors, patient reported outcome data, and other methods of input for patient and

#	OBJECTIVE NAME	OBJECTIVE DESCRIPTION	MEASURES	EXCLUSIONS	NOTES
			unique patients seen by the EP or discharged from the EH or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient's authorized representatives), or in response to a secure message sent by the patient (or the patient's authorized representative). **Measure 3:** Patient-generated health data or data from a non-clinical setting is incorporated into the certified EHR technology for more than **15 percent** of all unique patients seen by the EP or discharged by the EH or CAH during the EHR reporting period.		non-clinical setting generated health data. CMS emphasizes that these represent several examples of the data types that could be covered under this measure. The scope of data covered by this measure is broad but it may not include data related to billing, payment, or other insurance information.
7	**Health Information Exchange (HIE)**	The EP, EH, or CAH provides a summary of care record when transitioning or referring their patient to another setting of care, retrieves a summary of care record upon the first patient encounter with a new patient, and incorporates summary of	**Must attest to the numerator and denominator for all three measures but only required to meet the threshold for 2 out of the 3 measures.** **Measure 1:** For more than **50 percent** of transitions of care and referrals, the EP, EH or CAH that transitions or refers their patient	**Measure 1:** • An EP neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period. • Any EP that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information	• For the first measure, data must be captured in a structured format with the EHR to generate a summary of care document. • All summary of care documents must contain the most recent and up-to-date information on all elements. • In the event that there are no current diagnoses for a patient, the patient is not currently taking any medications, or the patient has no known medication allergies; the EP, EH, or CAH must record or document within the required fields that there are no problems, no medications, or no medication allergies recorded for the

#	OBJECTIVE NAME	OBJECTIVE DESCRIPTION	MEASURES	EXCLUSIONS	NOTES
		care information from other providers into their EHR using the functions of certified EHR technology.	to another setting of care or provider of care: (1) creates a summary of care record using CEHRT; **and** (2) electronically exchanges the summary of care record. **Measure 2:** For more than **40 percent** of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP, EH or CAH incorporates into the patient's EHR an electronic summary of care document from a source other than the provider's EHR system. **Measure 3:** For more than **80 percent** of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP, EH, or CAH performs a clinical information reconciliation. The provider would perform reconciliations for the following three clinical information sets: • Medication. Review of the patient's medication, including the name, dosage,	available from the FCC on the first day of the EHR reporting period may exclude the measures. • Any EH or CAH operating in a location that does not have 50 percent or more of its housing units with 4Mbps availability according to the latest information available from the FCC at the start of the EHR reporting period. **Measure 2:** • Any EP, EH or CAH for whom the total of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, is fewer than 100 during the EHR reporting period is excluded from this measure. • Any EP that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude the measures. • Any EH or CAH operating in a location that does not have 50 percent or more of its housing units with 4Mbps availability according to the latest information available from	patient to satisfy the measure of this objective. • For summary of care documents at transitions of care, while a current problem list must always be included, the provider can use his or her judgment in deciding which items historically present on the problem list, medical history list (if it exists in the CEHRT), or surgical history list are relevant given the clinical circumstances. • The provider has the discretion to define the relevant clinical notes or relevant laboratory results to send as part of the summary of care record, providers must be able to provide all clinical notes or laboratory results through an electronic transmission of a summary of care document if that level of detail is subsequently requested by a provider receiving a transition of care or referral or the patient is transitioning to another setting of care. • For both the first and second measures, CMS proposed that a provider may use a wide range of health IT exchange to receive or send an electronic summary of care document but must use their certified EHR technology to create the summary of care document. • They also proposed that the receipt of the summary of care document (CCDA) may be passive (provider is sent the CCDA and incorporates it) or active (provider requests a direct transfer of the CCDA or provider queries an HIE for the CCDA).

#	OBJECTIVE NAME	OBJECTIVE DESCRIPTION	MEASURES	EXCLUSIONS	NOTES
			frequency, and route of each medication. • Medication allergy. Review of the patient's known allergic medications. • Current Problem list. Review of the patient's current and active diagnoses.	the FCC at the start of the EHR reporting period. **Measure 3:** • Any EP, EH or CAH for whom the total of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, is fewer than 100 during the EHR reporting period is excluded from this measure. • Any EP that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude the measure. • Any EH or CAH operating in a location that does not have 50 percent or more of its housing units with 4Mbps availability according to the latest information available from the FCC at the start of the EHR reporting period.	
8	**Public Health and Clinical Data Registry Reporting**	The EP, EH, or CAH is in *active engagement* with a PHA or CDR to submit electronic public health data in a meaningful way using certified EHR	**EP must choose from measures 1 through 5 and successfully attest to any combination of three measures** **EHs and CAHs must choose**	**Measure 1:** Any EP, EH, or CAH meeting one or more of the following criteria may be excluded from the immunization registry reporting measure if the EP, EH, or CAH:	• For purposes of meeting this new objective, EPs, EHs and CAHs would be required to demonstrate that "active engagement" with a PHA or CDR has occurred. Active engagement means that the provider is in the process of moving towards sending "production data" to a PHA or CDR, or— is sending production data to a PHA or CDR.

#	OBJECTIVE NAME	OBJECTIVE DESCRIPTION	MEASURES	EXCLUSIONS	NOTES
		technology, except where prohibited, and in accordance with applicable law and practice.	**from measures 1 through 6, and would be required to successfully attest to any combination of four measures**. The measures are as shown in **Table 5 (below).** As noted, measures four and five for Public Health Registry Reporting and Clinical Data Registry Reporting may be counted more than once if more than one Public Health Registry or Clinical Data Registry is available. **Measure 1 – Immunization Registry Reporting:** The EP, EH, or CAH is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS). **Measure 2 – Syndromic Surveillance Reporting**: The EP, EH, or CAH is in active engagement with a public health agency to submit syndromic surveillance data from a non-urgent care ambulatory	(1) does not administer any immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or immunization information system during the EHR reporting period; (2) operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or (3) operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data at the start of the EHR reporting period. **Exclusion for EPs for Measure 2:** Any EP meeting one or more of the following criteria may be excluded from the syndromic surveillance reporting measure if the EP: (1) does not treat or diagnose or directly treat any disease or condition associated with a syndromic surveillance system in their jurisdiction; (2) operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition	CMS notes that the term "production data" refers to data generated through clinical processes involving patient care, and it is here used to distinguish between this data and "test data" which may be submitted for the purposes of enrolling in and testing electronic data transfers. • CMS also proposed to provide support to providers seeking to meet the requirements of this objective by creating a centralized repository of national, state, and local PHA and CDR readiness. They expect that the centralized repository will include readiness updates for PHAs and CDRs at the state, local, and national level. • For EPs, CMS proposed an exclusion for a measure does not count toward the total of three measures. If the EP qualifies for multiple exclusions and the remaining number of measures available to the EP is less than three, the EP can meet the objective by meeting all of the remaining measures available to them and claiming the applicable exclusions. • Measure 1: CMS proposed that to successfully meet the requirements of this measure, bidirectional data exchange between the provider's certified EHR technology and the immunization registry/IIS is required. • Measure 4: CMS proposed to define a "public health registry" as a registry that is administered by, or on behalf of, a local, state, territorial, or national PHA and which collects data for public health purposes. While immunization registries are a type of public health registry, CMS proposed to keep immunization registry reporting separate from the public health registry reporting measure to retain continuity from Stage 1 and 2 policy in which immunization registry reporting was a distinct and separate objective. • Measure 5: CMS proposed to further differentiate between clinical data registries and public health

#	OBJECTIVE NAME	OBJECTIVE DESCRIPTION	MEASURES	EXCLUSIONS	NOTES
			setting for EPs, or an emergency or urgent care department for EH's and CAHs (POS 23). **Measure 3 - Case Reporting**: The EP, EH, or CAH is in active engagement with a public health agency to submit case reporting of reportable conditions. **Measure 4 - Public Health Registry Reporting**: The EP, EH, or CAH is in active engagement with a public health agency to submit data to public health registries. **Measure 5 – Clinical Data Registry Reporting:** The EP, EH, or CAH is in active engagement to submit data to a clinical data registry. **Measure 6 – Electronic Reportable Laboratory Result Reporting:** The EH or CAH is in active engagement with a public health agency to submit electronic reportable laboratory results. This measure is available to EH's and CAHs only.	at the start of the EHR reporting period; or (3) operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from EPs at the start of the EHR reporting period. **Exclusion for EHs/CAHs for Measure 2:** Any EH or CAH meeting one or more of the following criteria may be excluded from the syndromic surveillance reporting measure if the EH or CAH: (1) does not have an emergency or urgent care department; (2) operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data from EH or CAHs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or (3) operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from EHs or CAHs at the start of the EHR reporting period. **Measure 3:** Any EP, EH, or CAH meeting one or more of the following criteria may be excluded from the case reporting	registries as follows: for the purposes of meaningful use, "public health registries" are those administered by, or on behalf of, a local, state, territorial, or national public health agencies; and "clinical data registries" are administered by, or on behalf of, other non-public health agency entities. • ONC will consider the adoption of standards and implementation guides in future rulemaking. Should these subsequently be finalized, they may then be adopted as part of the certified EHR technology definition as it relates to meeting the clinical data registry reporting measure through future rulemaking for the EHR Incentive Programs. • Any EP, EH, or CAH may report to more than one public health registry to meet the total number of required measures for the objective. For example, if a provider meets this measure through reporting to both the National Hospital Care Survey and the National Healthcare Safety Network registry, the provider could get credit for meeting two measures.

#	OBJECTIVE NAME	OBJECTIVE DESCRIPTION	MEASURES	EXCLUSIONS	NOTES
				measure if the EP, EH, or CAH: (1) does not treat or diagnose any reportable diseases for which data is collected by their jurisdiction's reportable disease system during the EHR reporting period; (2) operates in a jurisdiction for which no public health agency is capable of receiving electronic case reporting data in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or (3) operates in a jurisdiction where no public health agency has declared readiness to receive electronic case reporting data at the start of the EHR reporting period. **Measure 4:** Any EP, EH, or CAH meeting at least one of the following criteria may be excluded from the public health registry reporting measure if the EP, EH, or CAH: (1) does not diagnose or directly treat any disease or condition associated with a public health registry in their jurisdiction during the EHR reporting period; (2) operates in a jurisdiction for which no public health agency is capable of accepting electronic registry transactions in the specific	

#	OBJECTIVE NAME	OBJECTIVE DESCRIPTION	MEASURES	EXCLUSIONS	NOTES
				standards required to meet the CEHRT definition at the start of the EHR reporting period; or (3) operates in a jurisdiction where no public health registry for which the EP, EH, or CAH is eligible has declared readiness to receive electronic registry transactions at the beginning of the EHR reporting period. **Measure 5:** Any EP, EH, or CAH meeting at least one of the following criteria may be excluded from the clinical data registry reporting measure if the EP, EH, or CAH: (1) does not diagnose or directly treat any disease or condition associated with a clinical data registry in their jurisdiction during the EHR reporting period; (2) operates in a jurisdiction for which no clinical data registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or (3) operates in a jurisdiction where no clinical data registry for which the EP, EH, or CAH is eligible has declared readiness to receive electronic registry transactions at the	

#	OBJECTIVE NAME	OBJECTIVE DESCRIPTION	MEASURES	EXCLUSIONS	NOTES
				beginning of the EHR reporting period. **Measure 6:** Any EH or CAH meeting one or more of the following criteria may be excluded from the electronic reportable laboratory result reporting measure if the EH or CAH: (1) does not perform or order laboratory tests that are reportable in their jurisdiction during the EHR reporting period; (2) operates in a jurisdiction for which no public health agency is capable of accepting the specific ELR standards required to meet the CEHRT definition at the start of the EHR reporting period; or (3) operates in a jurisdiction where no public health agency has declared readiness to receive electronic reportable laboratory results from an EH or CAH at the start of the EHR reporting period.	

TABLE 5: MEASURES FOR OBJECTIVE 8: PUBLIC HEALTH AND CLINICAL DATA REGISTRY REPORTING OBJECTIVE		
Measure	Maximum times measure can count towards objective for EP	Maximum times measure can count towards objective for EH or CAH
Measure 1 – Immunization Registry Reporting	1	1
Measure 2 – Syndromic Surveillance Reporting	1	1
Measure 3 – Case Reporting	1	1
Measure 4 - Public Health Registry Reporting*	3	4
Measure 5 - Clinical Data Registry Reporting**	3	4
Measure 6 - Electronic Reportable Laboratory Results	N/A	1

*EPs, EHs, and CAHs may choose to report to more than one public health registry to meet the number of measures required to meet the objective.
**EPs, EHs, and CAHs may choose to report to more than one clinical data registry to meet the number of measures required to meet the objective.

Return to Agenda

ACR® AMERICAN COLLEGE OF RADIOLOGY

QUALITY IS OUR IMAGE

acr.org

March 19, 2015

Rachel Groman
American Association of Neurological Surgeons
5550 Meadowbrook Drive
Rolling Meadows, IL 60008-3852

Dear Ms. Groman:

Dr. E. Kent Yucel, Chair of the ACR Committee on Diagnostic Imaging/Interventional Radiology (DI/IR) Appropriateness Criteria, would like to invite AANS to select new representatives for the American College of Radiology Appropriateness Criteria® (AC) Expert Panels.

The term for the current representatives (see attached) will be ending on May 31, 2015. We appreciate the contributions made by these representatives and would like to continue to have AANS representation on the panels. We feel the expertise of your members contributes to producing stronger, more relevant recommendations.

The representatives will work with the panels to develop and update topics for select neurological conditions. All AC topics and general information about the AC program and its methodology can be accessed on the ACR web site at www.acr.org/ac.

I hope your society will encourage the participation of new representatives to assist in the development and review of these criteria. Representatives are expected to review, participate in the modified Delphi process (i.e. rating rounds) and provide comments on the topics. All work is done via e-mails and conference calls and no travel is required. Other panel members have reported that the overall time commitment is 3-4 hours per topic. Appointment terms are for one year, renewable up to three consecutive terms for a total period of 4 years. The new term start date is June 1, 2015.

If you wish to extend any of the current representatives' terms for another year, that would be fine too.

Please confirm that your organization would like to continue to participate by forwarding the names of physician representatives who are available to serve on the panels by **April 2, 2015**.

If you have further questions about the ACR AC program or the role of your society's representatives, please contact me at 800-227-5463, x4911 or rwyatt@acr.org.

We look forward to hearing from you.

Best regards,

Robin E. Wyatt
Department of Quality & Safety
American College of Radiology

cc: E. Kent Yucel, MD
Peter Angevine, MD
Langston Holly, MD

HEADQUARTERS
1891 Preston White Dr.
Reston, VA 20191-4326
703-648-8900

GOVERNMENT RELATIONS
505 Ninth St. N.W., Suite 910
Washington, DC 20004-2173
202-223-1670

CLINICAL RESEARCH
1818 Market St., Suite 1600
Philadelphia, PA 19103-3609
215-574-3150

Isabelle Germano, MD
Kathryn Holloway, MD
John O'Toole, MD
Joshua Rosenow, MD
Abhaya Kulkarni, MD
Konstantin Slavin, MD
J. Adair Prall, MD
John Myseros, MD
Patricia Raksin, MD
Christopher Winfree, MD
Christine Waldrip

Return to Agenda

ACR Appropriateness Criteria
2015 AANS/CNS representatives

NAME	PANEL(S)	TOPICS
John O'Toole	Musculoskeletal 1 Musculoskeletal 2	• Suspected Osteomyeletis of the Foot in Patients with Diabetes Mellitus • Suspected Spine Trauma • Chronic Neck Pain • Low Back Pain • Management of Vertebral Compression Fractures • Myelopathy
Langston Holly	Interventional Radiology 1 Musculoskeletal 1 & 2 Neurologic 2	• Follow-up of Malignant or Aggressive Musculoskeletal Tumors • Metastatic Bone Disease • Primary Bone Tumors • Suspected Osteomyeletis of the Foot in Patients with Diabetes Mellitus • Suspected Spine Trauma • Chronic Neck Pain • Myelopathy • Low Back Pain • Management of Vertebral Compression Fractures • Plexopathy
Isabelle Germano	Musculoskeletal 1 Neurologic 1 & 2 Radiation Oncology-Brain Metastases	• Follow-up of Malignant or Aggressive Musculoskeletal Tumors • Metastatic Bone Disease • Primary Bone Tumors • Headache • Hearing Loss and/or Vertigo • Neuroendocrine Imaging • Orbits, Vision, and Visual Loss • Single Brain Metastases*
Peter Angevine	Interventional Radiology 1 & 2 Musculoskeletal 2 Neurologic 2	• Chronic Neck Pain • Management of Vertebral Compression Fractures • Myelopathy • Plexopathy
Kathryn Holloway	Neurologic 1 & 2	• Ataxia • Cranial Neuropathy
Joshua Rosenow	Neurologic 1 & 2	• Ataxia • Cranial Neuropathy • Low Back Pain
Abhaya Kulkarni	Pediatric 1 & 2	• Suspected Physical Abuse-Child • Vomiting in Infants up to 3 Months of Age
John Myseros	Pediatric 1	• Headache-Child • Seizures (and Epilepsy)-Child
Konstantin Slavin	Neurologic 1 & 2	• Ataxia • Cranial Neuropathy
Christopher Winfree	Neurologic 2	• Chronic Neck Pain • Management of Vertebral Compression Fractures • Myelopathy • Plexopathy
J. Adair Prall	Neurologic 2	• Head Trauma • Suspected Spine Trauma
Patricia Raksin	Neurologic 2	• Head Trauma

*This topic will not be worked on in the upcoming year. You do not need to select a replacement for the RO-Brain Metastases panel.

Return to Agenda

American College of Radiology
ACR Appropriateness Criteria®
Table of Contents — February 2015

The ACR Appropriateness Criteria® are routinely revised. Refer to the ACR Website at www.acr.org/ac for the most current and complete version.

*This topic also includes pediatric imaging recommendations

- Radiologic Management of Iliofemoral Venous Thrombosis
- Radiologic Management of Infected Fluid Collections (Revised)
- Radiologic Management of Inferior Vena Cava Filters
- Radiologic Management of Lower Extremity Venous Insufficiency
- Radiologic Management of Lower Gastrointestinal Tract Bleeding (Revised)
- Radiologic Management of Mesenteric Ischemia
- Radiologic Management of Thoracic Nodules and Masses
- Radiologic Management of Upper Gastrointestinal Bleeding
- Radiologic Management of Urinary Tract Obstruction
- Radiologic Management of Uterine Leiomyomas

Expert Panel on Musculoskeletal Imaging

- Acute Hand and Wrist Trauma
- Acute Hip Pain—Suspected Fracture
- Acute Shoulder Pain
- Acute Trauma to the Ankle*
- Acute Trauma to the Foot* (Revised)
- Acute Trauma to the Knee* (Revised)
- Avascular Necrosis (Osteonecrosis) of the Hip
- Chronic Ankle Pain
- Chronic Elbow Pain
- Chronic Foot Pain*
- Chronic Hip Pain
- Chronic Neck Pain
- Chronic Wrist Pain
- Follow-up of Malignant or Aggressive Musculoskeletal Tumors
- Imaging after Total Knee Arthroplasty
- Management of Vertebral Compression Fractures
- Metastatic Bone Disease
- Nontraumatic Knee Pain*
- Osteoporosis and Bone Mineral Density*
- Primary Bone Tumors
- Soft-Tissue Masses
- Stress (Fatigue/Insufficiency) Fracture, Including Sacrum, Excluding Other Vertebrae
- Suspected Osteomyelitis of the Foot in Patients with Diabetes Mellitus
- Suspected Spine Trauma*

Expert Panel on Neurologic Imaging

- Ataxia*
- Cerebrovascular Disease
- Cranial Neuropathy
- Dementia and Movement Disorders
- Focal Neurologic Deficit
- Head Trauma
- Headache
- Hearing Loss and/or Vertigo
- Imaging in the Diagnosis of Thoracic Outlet Syndrome
- Low Back Pain
- Management of Vertebral Compression Fractures
- Myelopathy
- Neck Mass/Adenopathy*
- Neuroendocrine Imaging
- Orbits, Vision and Visual Loss*
- Plexopathy
- Seizures and Epilepsy

*This topic also includes pediatric imaging recommendations

- Sinonasal Disease
- Suspected Spine Trauma*

Expert Panel on Pediatric Imaging

- Developmental Dysplasia of the Hip — Child
- Fever Without Source — Child
- Headache — Child
- Head Trauma — Child
- Hematuria — Child
- Limping Child — Ages 0-5 Years
- Seizures — Child
- Sinusitis — Child
- Suspected Physical Abuse — Child
- Urinary Tract Infection — Child
- Vomiting in Infants up to 3 Months of Age (Revised)

The following topics also include pediatric imaging recommendations:

- Acute Onset of Scrotal Pain — without Trauma, without Antecedent Mass
- Acute Trauma to the Ankle
- Acute Trauma to the Foot
- Acute Trauma to the Knee
- Ataxia
- Chronic Foot Pain
- Crohn Disease
- Neck Mass/Adenopathy
- Nontraumatic Knee Pain
- Orbits, Vision and Visual Loss
- Osteoporosis and Bone Mineral Density
- Right Lower Quadrant Pain — Suspected Appendicitis
- Suspected Spine Trauma

Expert Panel on Thoracic Imaging

- Acute Respiratory Illness in Immunocompetent Patients
- Acute Respiratory Illness in Immunocompromised Patients (Revised)
- Blunt Chest Trauma
- Chronic Dyspnea — Suspected Pulmonary Origin
- Hemoptysis
- Imaging in the Diagnosis of Thoracic Outlet Syndrome
- Intensive Care Unit Patients (Revised) (Old Name: Routine Chest Radiographs in ICU Patients)
- Non-invasive Clinical Staging of Bronchogenic Carcinoma
- Occupational Lung Diseases (New)
- Pulmonary Hypertension
- Radiographically Detected Solitary Pulmonary Nodule
- Rib Fractures
- Routine Admission and Preoperative Chest Radiography
- Routine Chest Radiographs in Uncomplicated Hypertension
- Screening for Pulmonary Metastases

Expert Panel on Urologic Imaging

- Acute Onset Flank Pain — Suspicion of Stone Disease
- Acute Onset of Scrotal Pain — without Trauma, without Antecedent Mass* (Revised)
- Acute Pyelonephritis
- Hematospermia
- Hematuria
- Incidentally Discovered Adrenal Mass
- Indeterminate Renal Mass

*This topic also includes pediatric imaging recommendations

- Lower Urinary Tract Symptoms: Suspicion of Benign Prostatic Hyperplasia
- Post-treatment Follow-up of Prostate Cancer
- Post-treatment Follow-up of Renal Cell Carcinoma
- Post-treatment Surveillance of Bladder Cancer
- Pretreatment Staging of Invasive Bladder Cancer
- Prostate Cancer-Pretreatment Detection, Staging and Surveillance
- Recurrent Lower Urinary Tract Infections in Women (Revised)
- Renal Cell Carcinoma Staging
- Renal Failure
- Renal Transplant Dysfunction
- Renal Trauma
- Renovascular Hypertension
- Staging of Testicular Malignancy
- Suspected Lower Urinary Tract Trauma

Expert Panel on Vascular Imaging

- Abdominal Aortic Aneurysm: Interventional Planning and Follow-up
- Blunt Abdominal Trauma
- Blunt Chest Trauma — Suspected Aortic Injury (Revised)
- Claudication — Suspected Vascular Etiology
- Follow-up of Lower Extremity Arterial Bypass Surgery
- Imaging for Transcatheter Aortic Valve Replacement
- Imaging in the Diagnosis of Thoracic Outlet Syndrome
- Imaging of Mesenteric Ischemia
- Nontraumatic Aortic Disease
- Pulsatile Abdominal Mass, Suspected Abdominal Aortic Aneurysm
- Radiologic Management of Upper Gastrointestinal Bleeding
- Recurrent Symptoms Following Lower Extremity Angioplasty
- Sudden Onset of Cold, Painful Leg
- Suspected Lower Extremity Deep Vein Thrombosis
- Upper Extremity Swelling (Revised) (Old Name: Suspected Upper Extremity Deep Vein Thrombosis)

Expert Panel on Women's Imaging

- Abnormal Vaginal Bleeding
- Acute Pelvic Pain in the Reproductive Age Group
- Assessment of Gravid Cervix (Revised)
- Clinically Suspected Adnexal Mass
- First Trimester Bleeding
- Growth Disturbances — Risk of Intrauterine Growth Restriction
- Infertility (New)
- Multiple Gestations
- Ovarian Cancer Screening
- Pelvic Floor Dysfunction
- Pretreatment Evaluation and Follow-up of Endometrial Cancer
- Pretreatment Planning of Invasive Cancer of the Cervix
- Second and Third Trimester Bleeding
- Staging and Follow-up of Ovarian Cancer

Expert Panel on Radiation Oncology–Bone Metastases

- Metastatic Epidural Spinal Cord Compression and Recurrent Spinal Metastasis (New)
- Non-Spine Bone Metastases (Revised)
- Spinal Bone Metastases

Expert Panel on Radiation Oncology–Brain Metastases

- Follow-up and Retreatment of Brain Metastases (Revised)
- Multiple Brain Metastases
- Pre-Irradiation Evaluation and Management of Brain Metastases
- Single Brain Metastasis

Expert Panel on Radiation Oncology–Breast

- Conservative Surgery and Radiation — Stage I and II Breast Carcinoma
- Ductal Carcinoma in Situ (Revised)
- Local-Regional Recurrence and Salvage Surgery — Breast Cancer
- Locally Advanced Breast Cancer
- Postmastectomy Radiotherapy

Expert Panel on Radiation Oncology–Gastrointestinal

- Anal Cancer
- Local Excision in Rectal Cancer
- Rectal Cancer — Metastatic Disease at Presentation
- Recurrent Rectal Cancer (Revised)
- Resectable Rectal Cancer
- Resectable Stomach Cancer (New)

Expert Panel on Radiation Oncology– Gynecology

- Advanced Cervical Cancer
- Advanced Stage Endometrial Cancer
- Definitive Therapy for Early Stage Cervical Cancer
- Management of Locoregionally Advanced Squamous Cell Carcinoma of the Vulva
- Management of Vaginal Cancer
- Pretreatment Evaluation and Follow-up of Endometrial Cancer
- Pretreatment Planning of Invasive Cancer of the Cervix
- Role of Adjuvant Therapy in the Management of Early Stage Cervical Cancer

Expert Panel on Radiation Oncology–Head and Neck

- Adjuvant Therapy for Resected Squamous Cell Carcinoma of the Head and Neck
- Aggressive Nonmelanomatous Skin Cancer of the Head and Neck (New)
- Ipsilateral Radiation for Squamous Cell Carcinoma of the Tonsil
- Local-Regional Therapy for Resectable Oropharyngeal Squamous Cell Carcinomas
- Retreatment of Recurrent Head and Neck Cancer after Prior Definitive Radiation
- Thyroid Carcinoma
- Treatment of Stage I T1 Glottic Cancer

Expert Panel on Radiation Oncology–Lung

- Early Stage Non-Small-Cell Lung Cancer
- Induction and Adjuvant Therapy for N2 Non-Small-Cell Lung Cancer
- Non-invasive Clinical Staging of Bronchogenic Carcinoma
- Nonsurgical Treatment for Locally Advanced Non-Small-Cell Lung Cancer: Good Performance Status/Definitive Intent
- Nonsurgical Treatment for Non-Small-Cell Lung Cancer: Poor Performance Status or Palliative Intent
- Radiation Therapy for Small-Cell Lung Cancer

Expert Panel on Radiation Oncology–Lymphoma

- Diffuse Large B-Cell Lymphoma (New)
- Follow-up of Hodgkin Lymphoma
- Hodgkin's Lymphoma — Favorable Prognosis Stage I and II
- Hodgkin's Lymphoma — Stage III and IV
- Hodgkin's Lymphoma — Unfavorable Clinical Stage I and II
- Localized Nodal Indolent Lymphoma
- Pediatric Hodgkin Lymphoma

Expert Panel on Radiation Oncology–Prostate

- Definitive External Beam Irradiation in Stage T1 and T2 Prostate Cancer
- External Beam Radiation Therapy Treatment Planning for Clinically Localized Prostate Cancer
- High Dose Rate Brachytherapy for Prostate Cancer
- Locally Advanced (High Risk) Prostate Cancer
- Permanent Source Brachytherapy for Prostate Cancer
- Postradical Prostatectomy Irradiation in Prostate Cancer
- Prostate Cancer-Pretreatment Detection, Staging and Surveillance

NEUROSURGERY
THE REGISTER OF THE NEUROSURGICAL MEME
CONGRESS OF NEUROLOGICAL SURGEONS 1951

Spine and *Neurosurgery*: A Natural Partnership

NEUROSURGERY
THE REGISTER OF THE NEUROSURGICAL MEME

Editorial Board

John O'Toole (Section Editor),

Associate Editors:

Chris Wolfla	Daniel Refai
Dean Chou	Anthony Sin
Daryl Fourney	Justin Smith
William Krauss	Peter Angevine
Shekar Kurpad	Mark Bilsky
Paul Park	R. John Hurlburt

…as well as many ad hoc reviewers.

Spine Submissions

- In 2015 YTD, Spine submissions represent approximately 15% of the total submissions to *Neurosurgery*

- The acceptance rate for Spine papers is approximately 55%, which reflects the same rigorous review applied to other sections

Published Spine Articles

- Citation of Spine papers in *Neurosurgery* accounts for approximately 8% of our total citation rate

- We now feature a Collection of the best spine articles from the last 10 years (selected by “Most Read” and “Most Cited” data) on our homepage: www.neurosurgery-online.com

Spine Initiatives

- In March, we published a special issue of the journal; "best of" articles from the last few years, hand selected by John O'Toole
- AO Spine North America Focus Issue (The Aging Spine) - expected to publish in Fall 2015
- **Another AO Spine project under discussion (Fehlings).**
- **Metastatic Spine Tumor Guidelines (Ryken)**
- **Recruitment of 2 Ortho Spine luminaries – Dr Steve Glassman and Dr Dan Riew to Ed Board to serve as portals, promoters and reviewers for Spine content**
- **Partnership with the JSSPN – Mummaneni, Kanter and Justin Smith - Chair, SPC and Education Chair as specialty scientific Liaisons**
- **Joint Orthopedics – Neuro Spine Reviews Series led by Dan Riew, and John O'Toole, Guest editors**

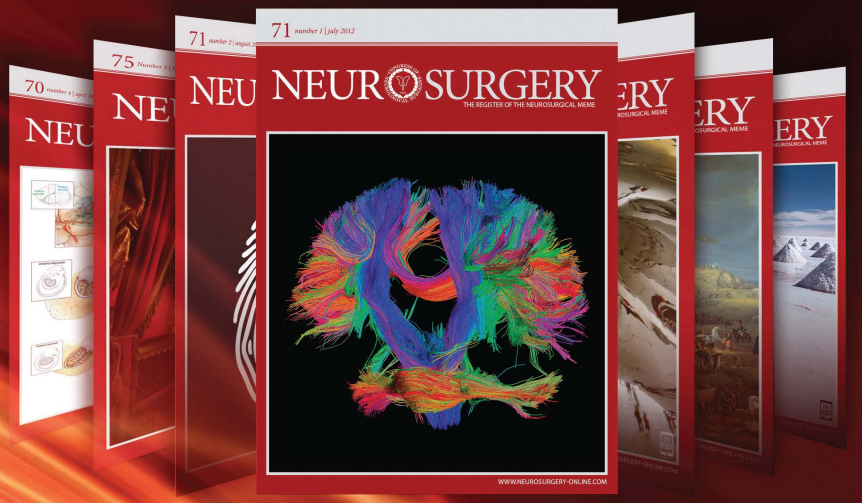
NEUROSURGERY
THE REGISTER OF THE NEUROSURGICAL MEME
CONGRESS OF NEUROLOGICAL SURGEONS 1951

Call for Papers

- *Neurosurgery* *does* want Spine papers!
- We recognize that these topics are the "bread and butter" of practice for many of our readers, and these topics are important to us.
- We realize that you have options when selecting your "first choice" journal, but we hope it will be *Neurosurgery*. We offer more than just impact!

NEUROSURGERY
THE REGISTER OF THE NEUROSURGICAL MEME

Publish Your Next Paper in *Neurosurgery*



More Than Just IMPACT

***Neurosurgery* offers authors:**

- **IMPACT**
  Neurosurgery's Impact Factor: 3.031*
  5-year Impact Factor: 3.539*
  * 2013 *Journal Citation Reports*® (Thomson Reuters, 2014)
- **VISIBILITY**
  More than 600,000 online visits a year
  More than 280,000 online article views
- **GLOBAL REACH**
  Read in 96 countries worldwide
  Available in nearly 5,000 institutions via Ovid
- **QUICK REVIEW**
  First decision within 20 days on average
  Accepted papers posted online ahead of print
- **PRESTIGE**
  Official journal of the Congress of Neurological Surgeons (CNS)
  Leader in neurosurgical education and innovation, with nearly 7,000 members worldwide

VIEW INSTRUCTIONS FOR AUTHORS: www.editorialmanager.com/neu

CNS

Wolters Kluwer

NEUROSURGERY

THE REGISTER OF THE NEUROSURGICAL MEME

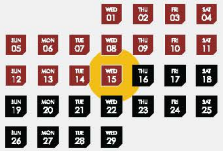
CONGRESS OF NEUROLOGICAL SURGEONS · 1951

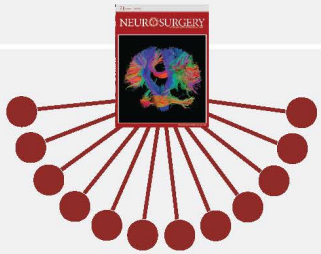
Neurosurgery by the Numbers

KEY FACTS FOR AUTHORS

21 days on average from submission to first decision

15 days on average from acceptance to posting online—your paper is indexed, read, and cited faster





12 Papers are published in more than subspecialty categories, including Spine, Pediatrics, Sports & Rehabilitation, and Evidence-Based Medicine

Submissions received from more than **58** countries

Neurosurgery podcasts highlight key articles in 9 languages: English, Chinese, Spanish, Korean, Japanese, Portuguese, Italian, French, and Russian

9 LANGUAGES

Read in **96** countries worldwide

SUBMIT YOUR PAPER AT WWW.EDITORIALMANAGER.COM/NEU

NEUROSURGERY
THE REGISTER OF THE NEUROSURGICAL MEME

Partnership

You are our best ambassadors!

- Submit to us
- Give us your ideas
- Review for us
- Encourage your colleagues with great presentations to send their work to us
- Help us combat the misperception that spine papers are better received at other journals

Return to Agenda

** SAVE THE DATE **

Section Chair Dr. Praveen Mummaneni invites you to attend:
32nd Annual Meeting of the AANS/CNS Section on Disorders of the

Spine & Peripheral Nerves

March 16 – 19, 2016

" Global Challenges : Universal Solutions "

Orlando, Florida

Loews Universal Resort

Honored Guests :

Christopher Shaffrey, MD

Larry Lenke, MD

Return to Agenda